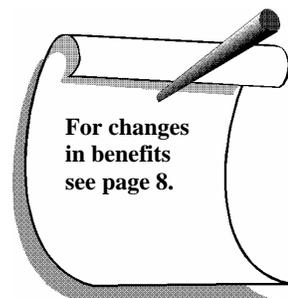




## A Health Maintenance Organization with a point of service product

**Serving:** All of Hawaii

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**



*This Plan has "Full" Accreditation from  
NCQA. See the 2006 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**  
Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

# Notice of the United States 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 United States 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 Government Accountability Office when conducting audits.

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

- For Government health care 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](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 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  
United States 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 United States 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 are effective April 14, 2003.

## **Important Notice from the HMSA Plan About Our Prescription Drug Coverage and Medicare**

OPM has determined that the HMSA Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and the HMSA Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

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### **Please be advised**

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If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

#### **Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug coverage from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Table of Contents

---

Introduction.....	3
Plain Language .....	3
Stop Health Care Fraud! .....	3
Preventing medical mistakes.....	4
Section 1. Facts about this HMO plan .....	6
We also have Point of Service (POS) benefits.....	6
How we pay providers .....	6
Your Rights.....	7
Service Area.....	7
Section 2. How we change for 2006 .....	8
Changes to this Plan.....	8
Section 3. How you get care .....	9
Identification cards .....	9
Where you get covered care.....	9
• Plan providers .....	9
• Non-Plan providers .....	9
• Plan facilities.....	9
What you must do to get covered care.....	9
• Primary care .....	9
• Specialty care .....	10
• Hospital care .....	10
Circumstances beyond our control.....	10
Services requiring our prior approval .....	11
Section 4. Your costs for covered services .....	13
Copayments .....	13
Deductible.....	13
Eligible Charges.....	13
Coinsurance .....	13
Your catastrophic protection out-of-pocket maximum .....	13
Carryover .....	13
Section 5. Benefits – OVERVIEW .....	14
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	16
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	29
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	34
Section 5(d) Emergency services/accidents .....	37
Section 5(e) Mental health and substance abuse benefits .....	40
Section 5(f) Prescription drug benefits .....	42
Section 5(g) Special features .....	47
• Integrated Case Management.....	47
• Drug Benefits Management Program.....	47
• Routine Care Associated With Clinical Trials .....	47
Section 5(h) Dental benefits.....	48
Section 5(i) Point of Service benefits .....	50
Section 5(j) Non-FEHB benefits available to Plan members.....	52
• CancerCare Plan.....	52
Section 6. General exclusions – things we don’t cover.....	53
Section 7. Filing a claim for covered services .....	54

Section 8. The disputed claims process.....	56
Section 9. Coordinating benefits with other coverage .....	58
When you have other health coverage .....	58
What is Medicare? .....	58
• Should I enroll in Medicare? .....	58
• The Original Medicare Plan (Part A or Part B).....	59
• Medicare Advantage (Part C).....	60
• Medicare prescription drug coverage (Part D).....	60
TRICARE and CHAMPVA.....	62
Workers' Compensation .....	62
Medicaid .....	62
When other Government agencies are responsible for your care.....	62
When others are responsible for injuries.....	62
Section 10. Definitions of terms we use in this brochure.....	63
Section 11. FEHB Facts.....	65
Coverage information .....	65
• No pre-existing condition limitation .....	65
• Where you can get information about enrolling in the FEHB Program .....	65
• Types of coverage available for you and your family .....	65
• Children's Equity Act .....	66
• When benefits and premiums start .....	66
• When you retire.....	66
When you lose benefits.....	66
• When FEHB coverage ends .....	66
• Spouse equity coverage.....	67
• Temporary Continuation of Coverage (TCC) .....	67
• Converting to individual coverage .....	67
• Getting a Certificate of Group Health Plan Coverage.....	67
Section 12. Two Federal Programs complement FEHB benefits.....	68
The Federal Flexible Spending Account Program – <i>FSAFEDS</i> .....	68
The Federal Long Term Care Insurance Program.....	71
Index .....	72
Summary of benefits for the HMSA Plan - 2006.....	75
2006 Rate Information for Hawaii Medical Service Association Plan .....	77

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## Introduction

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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 United States Office of Personnel Management, 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. Rates are shown at the end of this brochure.

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## Plain Language

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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 United States 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that 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.
- 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:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

- 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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.

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## **Preventing medical mistakes**

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An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

**1. Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

**2. Keep and bring a list of all the medicines you take.**

- Bring the actual medications or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.

- Know how to use your medication. Especially note the times and conditions when your medicine should and should not be taken.
3. **Get the results of any test or procedure.**
- Ask when and how you will get the results of tests or procedures.
  - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
  - Call your doctor and ask for your results.
  - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
  - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
  - Ask your surgeon:
    - Exactly what will you be doing?
    - About how long will it take?
    - What will happen after surgery?
    - How can I expect to feel during recovery?
  - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ [www.talkaboutrx.org/index.jsp](http://www.talkaboutrx.org/index.jsp). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1. Facts about this HMO plan

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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 pay only the copayments and coinsurance 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 POS benefits. This means you can receive covered services 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.

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 Web site ([www.opm.gov/insure](http://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 67<sup>th</sup> 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 Web site at [www.hmsa.com/portal/fedplan87/](http://www.hmsa.com/portal/fedplan87/).

## **Service Area**

To enroll in this Plan, 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.

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## Section 2. How we change for 2006

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Do not rely on these change descriptions; this Section 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.

### Changes to this Plan

- Your share of the non-Postal premium will increase by 3% for Self Only or 3% for Self and Family.
- We expanded the list of services requiring precertification. See Section 3 “Services requiring our prior approval”.
- Sigmoidoscopy screening through HealthPass will be covered every 5 years for ages 50 and above instead of every 3-5 years. See Section 5(a), “Preventive care, adult”.
- Double contrast barium enema will be covered every 5 years for ages 50 and above instead of every 5-10 years. See Section 5(a), “Preventive care, adult”.
- We now cover a one-time only ultrasound screening for abdominal aortic aneurysm for men ages 65-75. See Section 5(a), “Preventive care, adult”.
- We have changed the in vitro fertilization (IVF) benefit to include IVF procedures using donor eggs or sperm. We will continue to exclude any cost of donor eggs or donor sperm. We have clarified that we do not cover any donor-related services, including but not limited to collection, storage and processing of donor eggs and sperm. In addition, we have clarified that services of a surrogate are not covered. See Section 5(a), “Infertility Services”.
- We clarified that the diagnosis of infertility is covered. The infertility benefits have been expanded to include injectable fertility drugs under Section 5(a), “Infertility services” and oral fertility drugs under Section 5(f), “Prescription drug benefits.”
- We have expanded our Care Connection programs to include chronic renal diseases (End-Stage Renal Disease and Chronic Kidney Disease). See Section 5(a), “Educational classes and programs”.
- For prescription nicotine patches only, you are no longer limited to one treatment cycle per calendar year and you are no longer limited to two treatment cycles per lifetime. See Section 5(f), “Prescription drugs benefits”.
- We have removed the classifications of diaphragms (preferred and other brand). Your copayment at a Plan pharmacy is \$10. At a non-Plan pharmacy your copayment is \$10 plus 20% of the remaining eligible charge and any difference between the actual and eligible charge. Please see Section 5(f), “Prescription drug benefits”.
- We have clarified the definition of medical necessity. See Section 10.

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## Section 3. How you get care

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### 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 electronic enrollment system (such as 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 Web site at [www.hmsa.com/portal/fedplan87/](http://www.hmsa.com/portal/fedplan87/).

### 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 of 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 the provider directory, which we update periodically. The list is also on our Web site.

#### • 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-BlueCard PPO providers, even if they participate in other 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. The list is also on our Web site.

### 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.

- **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 some 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 specialist, ask if you can see your current specialist.
- If you are seeing a specialist and your specialist leaves the 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 and 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 program 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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

- **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, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification. Precertification is a special approval process to ensure 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:

- Autologous chondrocyte implants
- Biological Therapeutics/Biopharmaceuticals
- Bone Density Test
- 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)
- Genetic testing – if predictive in asymptomatic individuals with the following:
  - Family history of breast cancer
  - Family history of ovarian cancer
  - Familial adenomatous polyposis
  - Hereditary nonpolyposis colorectal cancer
- Growth hormone therapy
- Hepatitis C Treatment with combined Interferon (including Peginterferon) and Ribavirin Therapy
- High Dose Rate Brachytherapy
- Home IV Therapy
- In vitro fertilization
- Injectable Drugs
  - Amevive
  - Avastin
  - Enbrel
  - Erbitux
  - Forteo
  - Lupron
  - Raptiva
  - Remicade

**Services requiring our  
prior approval**  
*(continued)*

- Synagis
- Velcade
- Xolair
- Zevalin
- Intensity Modulated Radiation Therapy (IMRT)
- Kyphoplasty
- Lung Volume Reduction Surgery
- Organ and tissue transplants listed in Section 5(b)
- Physical Therapy and Occupational Therapy Visits
  - You must receive approval from HMSA for any outpatient physical therapy visits, occupational therapy visits, or a combination of both beyond the first 10 visits.
- Positron Emission Tomography (PET)
- Routine care associated with clinical trials listed in Section 5(g) of this brochure
- Stereotactic radiosurgery utilizing particle beams
- Surgeries, therapies or procedures employing new technology
- Surgery for hyperhidrosis
- Surgery to correct morbid obesity
- Transplant evaluations, except for cornea and kidney transplant evaluations

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

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## Section 4. Your costs for covered services

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You must share the costs 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 allowance that you must pay for your care.

Example: When you receive an annual routine chest x-ray, you pay a coinsurance of 20% for Plan providers.

### **Your catastrophic protection out-of-pocket maximum**

After your copayments total \$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/copayments. We will also keep records of your coinsurance/copayments and track your catastrophic protection out-of-pocket maximum.

### **Carryover**

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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## Section 5. Benefits – OVERVIEW

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See page 8 for how our benefits changed this year and page 75 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 Web site at [www.hmsa.com/portal/fedplan87/](http://www.hmsa.com/portal/fedplan87/).

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	16
Diagnostic and treatment services.....	16
Lab, X-ray and other diagnostic tests.....	16
Preventive care, adult.....	17
Preventive care, children.....	19
Maternity care.....	21
Family planning.....	21
Infertility services.....	22
Allergy care.....	23
Treatment therapies.....	23
Physical and occupational therapies.....	24
Speech therapy.....	24
Hearing services (testing, treatment, and supplies).....	24
Vision services (testing, treatment, and supplies).....	25
Foot care.....	25
Orthopedic and prosthetic devices.....	26
Durable medical equipment (DME).....	26
Home health services.....	27
Chiropractic.....	27
Alternative treatments.....	27
Educational classes and programs.....	27
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	29
Surgical procedures.....	29
Reconstructive surgery.....	31
Oral and maxillofacial surgery.....	31
Organ/tissue transplants.....	32
Anesthesia.....	33
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	34
Inpatient hospital.....	34
Outpatient hospital or ambulatory surgical center.....	35
Extended care benefits/Skilled nursing care facility benefits.....	36
Hospice care.....	36
Ambulance.....	36
Section 5(d) Emergency services/accidents.....	37
Emergency within our service area.....	37
Emergency outside our service area.....	38
Ambulance.....	39
Section 5(e) Mental health and substance abuse benefits.....	40
Mental health and substance abuse benefits.....	40
Section 5(f) Prescription drug benefits.....	42
Covered medications and supplies.....	44
Section 5(g) Special features.....	47
Integrated Case Management.....	47
Drug Benefits Management Program.....	47
Routine Care Associated With Clinical Trials.....	47
Section 5(h) Dental benefits.....	48
Accidental injury benefit.....	48

Section 5(i) Point of Service benefits ..... 50  
    Point of Service (POS) Benefits..... 50  
Section 5(j) Non-FEHB benefits available to Plan members..... 52  
    CancerCare Plan ..... 52  
Summary of benefits for the HMSA Plan - 2006..... 75  
2006 Rate Information for Hawaii Medical Service Association Plan ..... 77

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

**Here are some important things you should 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.
- Precertification is required for certain services, supplies, and drugs. Please refer to the precertification information shown in Section 3 to be sure which services, supplies, and drugs require precertification.

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians	
<ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Medical consultations – inpatient and outpatient</li> <li>• At home</li> </ul>	<p>Plan Provider \$15 per visit</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as:	Plan Provider
<ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• Pre-surgical labs</li> </ul>	<p>Nothing</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• Cat Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> <li>• Pre-surgical diagnostic testing</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

Preventive care, adult	You pay
Routine screenings, limited to: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – one per calendar year</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>– Fecal occult blood test – one every calendar year, age 50 and above</li> <li>– Sigmoidoscopy, screening – every 5 years starting at age 50</li> </ul> </li> </ul>	Nothing, if you receive services as a HealthPass screening
<ul style="list-style-type: none"> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men age 50 and older</li> <li>• Routine Pap test – one per calendar year</li> <li>• Routine mammogram – covered for women age 35 and older, as follows:               <ul style="list-style-type: none"> <li>– From age 35 through 39, one during this five year period</li> <li>– From age 40 and older, one every calendar year</li> </ul> </li> </ul> <p>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</p>	Plan Provider Nothing  Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Complete Blood Count – one per calendar year</li> <li>• Fecal Occult Blood – one every calendar year, age 50 and above</li> <li>• Urinalysis – one per calendar year</li> <li>• Glucose screening – one every 3 years, age 45 and above</li> <li>• Fasting lipoprotein profile (Total cholesterol, LDL, HDL, and triglycerides), once every 5 years</li> <li>• Chlamydial infection screening</li> </ul>	Plan Provider Nothing  Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>• Routine Chest X-Ray – one per calendar year</li> <li>• TB Tine Test – one per calendar year</li> <li>• Sigmoidoscopy screening – every 5 years, age 50 and above</li> <li>• Colonoscopy – once every 10 years, age 50 and above</li> <li>• Double contrast barium enema (DCBE) – once every 5 years, age 50 and above</li> <li>• Abdominal aortic aneurysm ultrasound screening – one-time only for men ages 65-75</li> </ul>	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 – continued on next page.*

Preventive care, adult <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>Routine Physical Exam – one per calendar year</li> <li>Well Woman Exam – one per calendar year</li> </ul>	Plan Provider Nothing  Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Immunizations are covered in accord with guidelines set by the Advisory Committee on Immunization Practices (ACIP) <ul style="list-style-type: none"> <li>Standard Immunizations</li> <li>Immunizations for high risk conditions such as Hepatitis B</li> <li>Travel Immunizations</li> </ul>	Plan Provider 20% of eligible charges  Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
<ul style="list-style-type: none"> <li>HealthPass</li> </ul> <p>You and any dependent defined below are eligible for one routine physical exam or HealthPass exam listed in this section per calendar year.</p> <p>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.</p> <p>You are eligible to receive a health risk assessment through HealthPass. For more information, contact the Customer Service Department at 808/948-6499.</p> <p>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.</p>	Plan Provider Nothing  Non-Plan Provider Not a benefit

*Preventive care, adult – continued on next page.*

Preventive care, adult <i>(continued)</i>	You pay
<p>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:</p> <ul style="list-style-type: none"> <li>– Height and weight measurements</li> <li>– Body fat analysis</li> <li>– Blood pressure measurement</li> <li>– Blood cholesterol, HDL and glucose screening tests</li> </ul> <p>If applicable, we may recommend that you attend programs to learn more about:</p> <ul style="list-style-type: none"> <li>– Nutrition</li> <li>– Smoking cessation</li> <li>– Weight management</li> <li>– Exercise</li> </ul> <p>If you have certain risk factors that become apparent during your initial screening, you'll be eligible for coverage for additional screenings. Examples include:</p> <ul style="list-style-type: none"> <li>– Health maintenance physical examination</li> <li>– Sigmoidoscopy</li> <li>– Bone density testing for osteoporosis</li> <li>– Fecal occult blood test</li> </ul> <p>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.</p>	<p>Plan Provider</p> <p>Nothing</p> <p>Non-Plan Provider</p> <p>Not a benefit</p>
Preventive care, children	
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics.</li> </ul>	<p>Plan Provider</p> <p>Nothing</p> <p>Non-Plan Provider</p> <p>Any difference between our eligible charge and the actual charge</p>

*Preventive care, children – continued on next page.*

Preventive care, children ( <i>continued</i> )	You pay
<p>Examinations, such as:</p> <ul style="list-style-type: none"> <li>• Eye exams through age 17 to determine the need for vision correction. See Vision services.</li> </ul>	<p>Plan Optometrist \$7 per visit</p> <p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<ul style="list-style-type: none"> <li>• Ear exams through age 17 to determine the need for hearing correction.</li> <li>• Examinations through age 12 according to the following schedule: <ul style="list-style-type: none"> <li>– Birth up to 24 months: eight visits (one additional visit is covered when a newborn child is discharged within 48 hours of birth)</li> <li>– Age two through twelve: one visit each calendar year</li> </ul> </li> </ul>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p>Laboratory tests through age 12:</p> <ul style="list-style-type: none"> <li>• 2 tuberculin tests (tine or skin sensitivity)</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p>Laboratory tests through age 12:</p> <ul style="list-style-type: none"> <li>• 3 blood tests (Hemoglobin or Hematocrit)</li> <li>• 3 urinalysis</li> </ul>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>

Maternity care	You pay
<p>Complete maternity (obstetrical) care, includes physician or certified nurse-midwife services for routine:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• We pay hospitalization, surgeon services (delivery), anesthesiology, lab and ultrasound the same as for illness and injury. See Section 5(c) for hospital benefits, Section 5(b) for Surgery and Anesthesia benefits, and Section 5(a) for Lab, X-ray and other diagnostic tests.</li> <li>• See page 16, Professional Services of Physicians, and page 34, Hospital Benefit, for how we pay benefits for other circumstances, such as complications of pregnancy and extended stays for you or your baby.</li> <li>• You do not need to precertify your delivery and extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• We cover newborn circumcision under the surgical procedures benefits. See Section 5(b) <i>Surgery benefits</i>.</li> </ul>	<p>Plan Provider</p> <p>Nothing</p> <p>Non-Plan Provider</p> <p>30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> </ul>	<p>Plan Provider</p> <p>Nothing</p> <p>Non-Plan Provider</p> <p>30% of eligible charges plus any difference between our payment and the actual charges</p>

*Family planning – continued on next page.*

Family planning <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms/Cervical Caps</li> </ul> <p>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</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling.</i></li> <li>• <i>Contraceptives such as condoms, foam, or creams which do not require a prescription</i></li> </ul>	<p><i>All charges.</i></p>
Infertility services	
<ul style="list-style-type: none"> <li>• Diagnosis of infertility</li> <li>• Treatment of infertility limited to: <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>– <i>intravaginal insemination (IVI)</i></li> <li>– <i>intra-cervical insemination (ICI)</i></li> <li>– <i>intrauterine insemination (IUI)</i></li> </ul> </li> <li>• In Vitro Fertilization</li> </ul> </li> </ul> <p>Note: Coverage is limited to a one time only benefit for one outpatient in vitro procedure in accord with our criteria and in compliance with Hawaii law.</p> <ul style="list-style-type: none"> <li>• Injectable fertility drugs</li> </ul> <p>Note: We cover oral fertility drugs under the prescription drug benefit. See Section 5(f).</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to ART procedures except in vitro fertilization</i></li> <li>• <i>Services of a surrogate</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> <li>• <i>Any donor-related services, including but not limited to collection, storage and processing of donor eggs and sperm</i></li> </ul>	<p><i>All charges.</i></p>

Allergy care	You pay
<ul style="list-style-type: none"> <li>• Testing (one per calendar year) and treatment</li> <li>• Allergy injections</li> <li>• Treatment materials</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p>Allergy serum</p>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
Treatment therapies	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 32.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy, self-administered injections, Outpatient injections and Intravenous nutrient solutions for primary diet</li> </ul> <p>Note: Home IV Therapy and some injections require prior approval. See Services requiring our prior approval in Section 3.</p> <ul style="list-style-type: none"> <li>• Medical foods and low-protein modified food products for the treatment of inborn errors of metabolism in accord with Hawaii Law and Plan guidelines</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: We 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 the GHT is medically necessary. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>

Physical and occupational therapies	You pay
<p>Short term therapy for the services of each of the following:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p>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 visits of outpatient physical therapy, outpatient occupational therapy, or a combination of both, 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, an updated treatment plan is required with documentation of your progress. Plan providers obtain approval for you, non-Plan providers do not.</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Long-term rehabilitative therapy</li> <li>• Exercise programs</li> <li>• Cardiac Rehabilitation</li> </ul>	<p><i>All charges.</i></p>
Speech therapy	
<p>25 visits per calendar year</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> <li>• Diagnostic hearing test</li> <li>• Hearing Aids – one every five years</li> </ul> <p>Note: Hearing testing for children through age 17 (see Section 5(a) <i>Preventive care, children.</i>)</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other hearing testing</li> <li>• Repair of hearing aids</li> <li>• Hearing aid evaluation</li> </ul>	<p><i>All charges.</i></p>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses for certain medical conditions such as aphakia, cataract, and keratoconus.</li> </ul>	Plan Provider 20% of eligible charges  Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges
<ul style="list-style-type: none"> <li>• Annual vision exam</li> <li>• Annual eye refractions</li> </ul> Note: For eye exams for children see Section 5(a) <i>Preventive care, children</i> .	Plan Optometrist \$7 per visit  Plan Provider 20% of eligible charges  Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses, except as shown above</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> <li>• Contact lens fitting</li> </ul>	<i>All charges.</i>
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.  Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	Plan Provider 20% of eligible charges  Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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)</li> </ul>	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>• Prosthetic devices, such as artificial limbs and lenses following cataract removal</li> <li>• Orthopedic devices, such as braces</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Podiatric shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics, except for specific diabetic conditions</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Bionic services and devices</i></li> </ul>	<p><i>All charges.</i></p>
Durable medical equipment (DME)	
<p>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:</p> <ul style="list-style-type: none"> <li>• Hospital beds;</li> <li>• Wheelchairs;</li> <li>• Crutches;</li> <li>• Walkers;</li> <li>• Blood glucose monitors; and</li> <li>• Insulin pumps.</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Convenience items such as motorized wheelchairs</i></li> </ul>	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> <li>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 or if you leave home, doing so requires a considerable and taxing effort</li> <li>Services provided for up to 150 visits per calendar year</li> </ul> <p>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.</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges plus any difference between our payment and the actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li><i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<p><i>All charges.</i></p>
Chiropractic	
<p><i>No Benefit</i></p>	<p><i>All charges</i></p>
Alternative treatments	
<p><i>No Benefit</i></p>	<p><i>All charges</i></p>
<p><i>Not covered:</i></p> <p><i>Biofeedback and other forms of self-care or self-help training and any related diagnostic testing</i></p>	<p><i>All charges</i></p>
Educational classes and programs	
<ul style="list-style-type: none"> <li>Smoking Cessation – Ready, Set, Quit</li> </ul> <p>A program for smokers who need help to quit smoking. For more information call 808/952-4400 on Oahu or 1-888-225-4122 toll-free from the neighbor islands.</p>	<p>Nothing</p>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>Life Style Management – Health Odyssey</li> </ul> <p>HMSA's Health Odyssey programs provide a series of practical, fun-filled health education classes to help you create a healthier, happier life.</p> <p>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.</p>	<p>Nothing</p>

*Educational classes and programs – continued on next page.*

Educational classes and programs <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Disease Management</li> </ul> <p>HMSA provides new and individualized programs to help you better manage chronic illnesses. These disease management programs allow you to take a much larger and more responsible role in controlling your illness.</p> <p>HMSA's Care Connection programs currently available to help you and your physician are for:</p> <ul style="list-style-type: none"> <li>– Asthma</li> <li>– Chronic Obstructive Pulmonary Disease</li> <li>– Diabetes</li> <li>– Cardiac conditions (Coronary Artery Disease and Heart Failure)</li> <li>– Mental Health or Substance Abuse</li> <li>– Chronic Renal Diseases (End-Stage Renal Disease or Chronic Kidney Disease)</li> </ul> <p>To find out if these programs are right for you, talk with your primary care physician.</p> <p>Prenatal Care Program</p> <p>The Good Pregnancy – He Hapai Pono</p> <p>He Hapai Pono is designed to help you have a healthy pregnancy and delivery. As soon as you become pregnant, you'll want to ask your primary care physician to register you in our program. You'll receive personally tailored information, your choice among several best selling books on pregnancy and childcare for free, and continued education and support from a nurse care manager through your pregnancy and delivery. To register call 888/400-2776 or visit the Web site at <a href="http://www.hmsa.com/myhealth/">www.hmsa.com/myhealth/</a>.</p>	Nothing
<p><i>Not covered except as offered through HMSA programs:</i></p> <ul style="list-style-type: none"> <li>• <i>Weight reduction programs</i></li> <li>• <i>Smoking Cessation programs</i></li> <li>• <i>Nutrition Counseling</i></li> </ul>	<i>All charges</i>

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

**Here are some important things you should 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.
- 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.

Benefit Description	You pay
<b>Surgical procedures</b>	
<p><b>Cutting Surgery</b> includes preoperative and postoperative care.</p> <p>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.</p>	
<p><b>Cutting &amp; Non-cutting surgical</b> procedures, such as:</p> <ul style="list-style-type: none"> <li>• Operative Procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Acne treatment destruction of localized lesions by chemotherapy (excluding silver nitrate)</li> <li>• Cryotherapy</li> <li>• Diagnostic injections including catheters injections into joints, muscles, and tendons</li> <li>• Electrosurgery</li> <li>• Correction of amblyopia and strabismus</li> <li>• Diagnostic and Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> </ul>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>

*Surgical procedures - continued on next page.*

Surgical procedures <i>(continued)</i>	You pay
<p><b>Cutting and Non-cutting surgical procedures</b> <i>(continued)</i></p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Treatment of burns</li> <li>• Newborn Circumcision</li> <li>• Surgery for morbid obesity (bariatric surgery) is covered with the following criteria: <ul style="list-style-type: none"> <li>– Patient is morbidly obese, which is defined as at least 100 pounds over or twice the ideal weight according to current underwriting standards OR patient has a body mass index greater than 40 OR patient has a BMI between 35 and 40 with a high-risk comorbidity, such as: severe sleep apnea, Pickwickian syndrome, heart problems or severe diabetes</li> <li>– There is documentation of at least three years of failure to lose weight</li> <li>– Only those surgical procedures that have proven long term efficacy and safety in peer reviewed scientific literature will be approved</li> <li>– Prior approval is required for this surgery. See Services requiring our prior approval in Section 3</li> </ul> </li> </ul>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>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.</p>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>
<p>Not covered:</p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>

*Oral and maxillofacial surgery - continued on next page.*

Oral and maxillofacial surgery (continued)	You pay
<p>Not covered:</p> <ul style="list-style-type: none"> <li>• Oral implants and transplants</li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</li> <li>• Dental surgeries generally done by dentists and not physicians</li> <li>• Services, drugs or supplies for nondental treatment of temporomandibular joint (TMJ) syndrome</li> </ul>	<p>All charges.</p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• 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</li> <li>• Autologous tandem transplants for testicular or other germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>

*Organ/tissue transplants - continued on next page.*

Organ/tissue transplants <i>(continued)</i>	You pay
<p>This coverage is secondary and the living donor's coverage is primary when:</p> <ul style="list-style-type: none"> <li>You are the recipient of an organ from a living donor, and</li> <li>The donor's health coverage provides benefits for organs donated by a living donor</li> </ul> <p>Transplant evaluations:</p> <ul style="list-style-type: none"> <li>Must receive our approval (with the exception of corneal and kidney transplant evaluations)</li> <li>Means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a hospital or facility uses in evaluating a potential transplant candidate</li> </ul> <p>Transplant (with the exception of corneal and kidney) must:</p> <ul style="list-style-type: none"> <li>Receive our approval. Without our approval for specific transplants, benefits are not available.</li> <li>Be received from a facility that: <ul style="list-style-type: none"> <li>is under contract with us for that type of transplant; and</li> <li>accepts you as a transplant candidate.</li> <li>This restriction does not apply to intestinal transplants.</li> </ul> </li> </ul> <p><b><i>Please refer to the precertification information shown in Section 3</i></b></p>	<p>Plan Provider (cutting) Nothing (non-cutting) 20% of eligible charges</p> <p>Non-Plan Provider (cutting and non-cutting) 30% of eligible charges and any difference between our payment and the actual charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li><i>Implants of artificial organs</i></li> <li><i>Transplants not listed as covered</i></li> <li><i>Non-human organs</i></li> </ul>	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> <li>Hospital (inpatient)</li> <li>Hospital outpatient department</li> <li>Skilled nursing facility</li> <li>Ambulatory surgical center</li> <li>Office</li> </ul> <p>Note: Professional services include general anesthesia; regional anesthesia; and monitored anesthesia when you meet the Plan's high risk criteria.</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

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

### Here are some important things you should 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.
- 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 in Sections 5(a) or (b).

Benefit Description	You pay
<b>Inpatient hospital</b>	
<p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• Semiprivate accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>Plan Provider Nothing (based on semiprivate room rate)</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge (based on semiprivate room rate)</p>
<p>Special care units, such as:</p> <ul style="list-style-type: none"> <li>• Intensive care</li> <li>• Cardiac care units</li> </ul>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma cost, blood processing, blood bank services</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

*Inpatient hospital - continued on next page.*

Inpatient hospital <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care, rest cures, domiciliary or convalescent care</i></li> <li>• <i>Non-covered facilities, such as adult day care, intermediate care facilities, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Additional charges for autologous blood</i></li> </ul>	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	
<p>Outpatient medical services provided by a hospital or ambulatory surgical center, such as:</p> <ul style="list-style-type: none"> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Pre-surgical testing is covered but only when you meet our criteria</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<p>Services associated with outpatient surgery and provided by a hospital or ambulatory surgical center, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma cost, blood processing, blood bank services</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics</li> <li>• Anesthesia service (Section 5(b))</li> </ul> <p>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.</p>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Skilled nursing facility (SNF):</p> <p>A facility that provides continuous skilled nursing services as ordered and certified by your attending physician</p> <p>Room and Board is covered, but only for semiprivate rooms when:</p> <ul style="list-style-type: none"> <li>• You are admitted by your physician</li> <li>• Care is ordered and certified by your physician</li> <li>• We approve the confinement</li> <li>• Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care</li> <li>• 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</li> <li>• The confinement is not longer than 100 days in any one calendar year</li> </ul> <p>Services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits</p>	<p>Plan Provider</p> <p>Nothing(based on semiprivate room)</p> <p>Non-Plan Provider</p> <p>30% of eligible charges and any difference between our payment and the actual charge</p>
<p><i>Not covered: Custodial care, rest cures, domiciliary or convalescent care</i></p>	<p><i>All charges.</i></p>
Hospice care	
<p>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</p> <ul style="list-style-type: none"> <li>• Inpatient residential room and board</li> <li>• Referral visits</li> </ul>	<p>Plan Provider</p> <p>Nothing</p> <p>Non-Plan Provider</p> <p>Not a benefit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing</i></li> <li>• <i>Homemaker services</i></li> </ul>	<p><i>All charges.</i></p>
Ambulance	
<p>Ground professional ambulance service is covered when:</p> <ul style="list-style-type: none"> <li>• Medically appropriate</li> <li>• Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient</li> </ul>	<p>Nothing</p>

## Section 5(d) Emergency services/accidents

**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.

**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 within or outside our Service Area. Please refer to the “You Pay” column below for the applicable emergency care copayment and coinsurance for Plan and non-Plan providers.

Benefit Description	You pay
<b>Emergency within our service area</b>	
Professional emergency services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• As an outpatient or inpatient at a hospital</li> <li>• In an emergency room</li> </ul>	Plan Provider \$15 per visit  Non-Plan Provider 20% of eligible charges
<ul style="list-style-type: none"> <li>• Emergency diagnostic tests</li> <li>• Emergency x-rays</li> <li>• Emergency surgery (non-cutting)</li> </ul>	Plan Provider 20% of eligible charges  Non-Plan Providers 20% of eligible charges

*Emergency services/accidents - continued on next page.*

Emergency within our service area <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Emergency laboratory tests</li> <li>• Emergency surgery (cutting)</li> </ul>	Plan Provider Nothing  Non-Plan Provider 20% of eligible charges
<ul style="list-style-type: none"> <li>• Emergency room facility</li> </ul> <p>Note: If you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.</p>	Plan Provider \$50  Non-Plan Provider 20% of eligible charges
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
Professional emergency services of physicians <ul style="list-style-type: none"> <li>• In physician's office</li> <li>• In an urgent care center</li> <li>• As an outpatient or inpatient at a hospital</li> <li>• In an emergency room</li> </ul>	Plan Provider \$15 per visit  Non-Plan Provider 20% of eligible charges
<ul style="list-style-type: none"> <li>• Emergency diagnostic tests</li> <li>• Emergency x-rays</li> <li>• Emergency surgery (non-cutting)</li> </ul>	Plan Provider 20% of eligible charges  Non-Plan Providers 20% of eligible charges
<ul style="list-style-type: none"> <li>• Emergency laboratory tests</li> <li>• Emergency surgery (cutting)</li> </ul>	Plan Provider Nothing  Non-Plan Provider 20% of eligible charges

*Emergency services/accidents - continued on next page.*

Emergency outside our service area <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Emergency room facility</li> </ul> <p>Note: If you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.</p>	<p>Plan Provider \$50</p> <p>Non-Plan Provider 20% of eligible charges</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Ambulance	
<p>Ground professional ambulance service when the following apply:</p> <ul style="list-style-type: none"> <li>• Transportation begins at the place where an injury or illness occurred or first required emergency care</li> <li>• Transportation ends at the nearest facility equipped to furnish emergency treatment</li> <li>• Transportation is for the purpose of emergency treatment</li> </ul>	Nothing
<p>Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii.</p> <p>See Section 5(c) for non-emergency service.</p>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

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

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.

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>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.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers, or advanced practice registered nurses (APRN)</li> <li>• Medication management</li> </ul>	<p>Plan Provider \$15 per visit</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>Plan Provider 20% of eligible charges</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>• Laboratory tests</li> </ul>	<p>Plan Provider Nothing</p> <p>Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge</p>

*Mental health and substance abuse benefits – continued on next page.*

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Inpatient services provided by a hospital or other facility</li> <li>• Inpatient services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization</li> </ul>	Plan Provider Nothing  Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All charges.</i></p>

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## Section 5(f) Prescription drug benefits

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### 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 44.
- 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.
- 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.

**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. For example, if your physician prescribes a 30-day supply of a drug that is packaged in less than a 30-day quantity, such as a 28-day quantity, the pharmacy will fill the prescription by dispensing one package of the drug. You would owe the copayment for a 30-day supply.
  - 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.

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*Prescription drug benefits begin on page 44.*

## Prescription drugs (*continued*)

- 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 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. For example, if your physician prescribes a 90-day supply of a drug that is packaged in less than a 30-day quantity, such as a 28-day quantity, the Plan mail order pharmacy will fill the prescription by dispensing three packages of the drug. This amounts to a 84 day quantity since each package contains a 28-day quantity. You will owe the mail order copayment for a 90-day supply.

- **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 do 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.

*Prescription drug benefits begin on the next page.*

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>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:</p> <p>Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>.</p> <ul style="list-style-type: none"> <li>• Injectable drugs limited to: <ul style="list-style-type: none"> <li>– Imitrex</li> <li>– Epinephrine emergency kit</li> <li>– Glucagon</li> </ul> </li> </ul> <p>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.</p> <ul style="list-style-type: none"> <li>• Nicotine patches for the cessation of smoking by prescription only</li> <li>• Drugs for sexual dysfunction</li> </ul> <p>Benefits are limited to the following:</p> <ul style="list-style-type: none"> <li>– Up to four doses every 30 days</li> <li>– Up to three months dispensed at a time (Multiple copayments will apply)</li> <li>– Retail pharmacy access only (not available through mail order)</li> <li>– Covered for gender approved by FDA</li> <li>– Physician must certify in advance that the patient has impotence due to organic causes from vascular or neurological disease</li> </ul> <ul style="list-style-type: none"> <li>• Oral contraceptive</li> <li>• Oral Fertility Drugs</li> </ul>	<p><b>Generic:</b></p> <p>Plan Pharmacy - \$5 copayment</p> <p>Non-Plan Pharmacy - \$5 plus 20% of remaining eligible charge and any difference between the actual and eligible charge</p> <p><b>Preferred Brand:</b></p> <p>Plan Pharmacy - \$20 copayment</p> <p>Non-Plan Pharmacy - \$20 plus 20% of remaining eligible charge and any difference between the actual and eligible charge</p> <p><b>Other Brand:</b></p> <p>Plan Pharmacy - 50% of eligible charge not less than \$20</p> <p>Non-Plan Pharmacy - 50% of eligible charge not less than \$20 plus any difference between the actual and eligible charge</p>

*Covered medications and supplies – continued on next page.*

Covered medications and supplies <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>Internally implanted time-release contraceptive drugs</li> <li>Contraceptive drugs injected periodically and intrauterine devices</li> </ul>	<p>Plan Provider - 20% of eligible charges</p> <p>Non-Plan Provider - 30% of eligible charges and any difference between our payment and the actual charge</p>
<ul style="list-style-type: none"> <li>Diaphragms</li> </ul>	<p>Plan Pharmacy - \$10 copayment</p> <p>Non-Plan Pharmacy - \$10 copayment plus 20% of remaining eligible charge and any difference between the actual and eligible charge</p>
<ul style="list-style-type: none"> <li>Insulin</li> </ul> <p>Note: When obtained by prescription, with a copayment charge applied to each 30-day supply or fraction thereof</p>	<p><b>Preferred Brand Insulin:</b></p> <p>Plan Pharmacy - \$5 copayment</p> <p>Non-Plan Pharmacy - \$5 plus 20% of eligible charge and any difference between the actual and eligible charge</p> <p><b>Other Brand Insulin:</b></p> <p>Plan Pharmacy - \$20 copayment</p> <p>Non-Plan Pharmacy - \$20 copayment plus 20% of eligible charge and any difference between the actual and eligible charge</p>
<p>Diabetic Supplies include:</p> <ul style="list-style-type: none"> <li>Insulin syringes</li> <li>Needles</li> <li>Lancets</li> <li>Auto-lancet devices</li> <li>Glucose test tablets and test tapes</li> <li>Acetone test tablets</li> </ul>	<p><b>Preferred Brand Diabetic Supplies:</b></p> <p>Plan Pharmacy - Nothing</p> <p>Non-Plan Pharmacy - Any difference between the actual and eligible charge</p> <p><b>Other Brand Diabetic Supplies:</b></p> <p>Plan Pharmacy - \$20 copayment</p> <p>Non-Plan Pharmacy - \$20 copayment plus any difference between the actual and eligible charge</p>

*Covered medications and supplies – continued on next page.*

Covered medications and supplies <i>(continued)</i>	You pay
<p><b>Mail Order Drug Program:</b></p> <ul style="list-style-type: none"> <li>• Generic Drugs</li> <li>• Preferred Brand Name Drugs</li> <li>• Other Brand Name Drugs</li> <li>• Preferred Brand Name Insulin</li> <li>• Other Brand Insulin</li> <li>• Preferred Diabetic Supplies</li> <li>• Other Brand Name Diabetic Supplies</li> </ul>	<p>\$10 Copayment</p> <p>\$45 Copayment</p> <p>\$80 Copayment</p> <p>\$10 Copayment</p> <p>\$45 Copayment</p> <p>Nothing</p> <p>\$45 Copayment</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Smoking cessation drugs except for nicotine patches and Zyban prescription drug</i></li> </ul>	<p><i>All charges.</i></p>

## Section 5(g) Special features

Feature	Description
<b>Integrated Case Management</b>	<p>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.</p>
<b>Drug Benefits Management Program</b>	<p>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.</p> <p>We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require precertification. The criteria for precertification are that:</p> <ul style="list-style-type: none"> <li>• The drug is being used as part of a treatment plan,</li> <li>• There are no equally effective drug substitutes, and</li> <li>• The drug meets the “medical necessity” criteria and other criteria as established by us.</li> </ul> <p>A list of these drugs in the HMSA Select Prescription Drug Formulary has been distributed to all Participating Providers.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• You have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and</li> <li>• Your doctor has determined that the drug is effective.</li> </ul>
<b>Routine Care Associated With Clinical Trials</b>	<p>Routine care associated with clinical trials is covered in accord with criteria established by us.</p> <p>These services require precertification. Please refer to the precertification information shown in Section 3.</p>

## Section 5(h) Dental benefits

**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 cover hospitalization for dental procedures only when a non-dental 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.

Benefit Description	You pay
<b>Accidental injury</b>	
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
<b>Dental Service</b>	
Preventive dental care for permanent teeth only <ul style="list-style-type: none"> <li>• Annual exam/visit</li> <li>• Annual cleaning (prophylaxis)</li> </ul>	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 <ul style="list-style-type: none"> <li>• X-rays (2 annual bite wings and one full mouth series every 5 years)</li> <li>• Fillings (composite resin for anterior teeth and single, stand alone facial surfaces of bicuspid only, amalgam and silicate)</li> <li>• Extractions</li> <li>• Root canal treatment</li> <li>• Treatment for diseases of the gum</li> <li>• Space maintainers</li> <li>• Anesthesia</li> </ul>	Plan Provider 30% of eligible charges  Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge

*Dental service – continued on next page.*

Dental Service <i>(continued)</i>	You pay
<p>Dental Surgery</p> <ul style="list-style-type: none"> <li>• Incision and drainage of abscess</li> <li>• Alveolectomy</li> <li>• Excision of cysts</li> </ul>	<p>Plan Provider 30% of eligible charges</p> <p>Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge</p>
<p>Occlusal Splint</p> <p>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.</p> <ul style="list-style-type: none"> <li>• A removable acrylic appliance is used in conjunction with the therapy</li> <li>• The disorder is present at least one month prior to the start of the therapy and the therapy does not exceed ten weeks</li> <li>• The therapy does not result in any irreversible alteration in the occlusion</li> <li>• It is not intended to be for the treatment of bruxism</li> <li>• It is not for the prevention of injuries of the teeth or occlusion</li> <li>• The benefit is limited to one treatment episode per lifetime</li> <li>• The member must be 15 years of age or older</li> </ul>	<p>Plan-Provider or Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge Note: Maximum Plan payment not to exceed \$125</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other dental services, including topical application of fluoride</i></li> <li>• <i>Dental appliances, such as false teeth, crowns, bridges, and repair of dental appliances</i></li> <li>• <i>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</i></li> <li>• <i>Osseointegration (dental implants) and all related services</i></li> </ul>	<p><i>All charges</i></p>

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## Section 5(i) Point of Service benefits

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### **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 provided by physicians and other health care professionals (Section 5(a))
- Surgical and anesthesia services provided by physicians and other health care professionals (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. 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.

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 (based on semiprivate room rate) and in addition, you are responsible for any difference between our payment and the actual charge. 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 within or outside our service area, 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).

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

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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.

<b>Plan Features:</b>	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.

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## Section 6. General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under Services requiring our prior approval on pages 11-12.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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.

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## Section 7. Filing a claim for covered services

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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 and hospital 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 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); and
- Receipts, if you paid for your services.

**Submit your claims to:**

**For Physician claims  
HMSA-HCFA 1500 claims  
P.O. Box 44500  
Honolulu, Hawaii 96804-4500  
808/948-6499**

**For Facility claims  
HMSA-UB92 claims  
P.O. Box 32700  
Honolulu, Hawaii 96803-2700  
808/948-6499**

### Prescription drugs

**Submit your claims to:**

**HMSA-Drug Claims  
P.O. Box 13400  
Honolulu, Hawaii 96801-3400  
808/948-6499**

**Other supplies or services**

**Submit your claims to:**

**For Dental claims  
HMSA-Dental claims  
P.O. Box 13400  
Honolulu, Hawaii 96801-3400  
808/948-6499**

**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.

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## Section 8. The disputed claims process

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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 preauthorization/prior approval:

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: Hawaii Medical Service Association, Attn: Appeals Coordinator, P.O. Box 1958, Honolulu, Hawaii 96805-1958; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>Copies of all letters you sent to us about the claim;</li><li>Copies of all letters we sent to you about the claim; and</li><li>Your daytime phone number and the best time to call.</li></ul>

## The disputed claims process (*continued*)

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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 preauthorization/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 preauthorization/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 Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### 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 for covered services.

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 or 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 four 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 1-800-MEDICARE 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or

more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

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). Your regular plan benefits will be applied to your claim and you are responsible for any applicable copayments or costs.

**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 claim 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 or see our Website at [www.hmsa.com/portal/fedplan87/](http://www.hmsa.com/portal/fedplan87/).
- If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**We waive some costs if the Original Medicare Plan is your primary payer** – For services paid by Medicare, we will waive some out-of-pocket costs as follows:

- Plan physician visit copayments
- Plan emergency room copayments

**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.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, and for services paid by a Medicare Advantage plan we will waive our Plan physician visit and emergency room copayments. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

### Primary Payer Chart

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and ...		✓
• You have FEHB coverage on your own or through your spouse who is also an active employee		
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		✓
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

\* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

## **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 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.

## **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 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**

If your medical expenses are or may be covered under workers' compensation insurance or automobile insurance, benefits under this plan may not be available to you. When others may be responsible for payment of your medical expenses (due to tort liability, insurance or otherwise), our Third Party Liability Rules apply, and you should request a copy of these Rules from HMSA. You must give us prompt written notice of your injuries, claims and demands for recovery, and recoveries received, and must promptly fill out and return to us all papers we require to determine coverage and to secure our reimbursement rights for any amounts we pay. We have a lien and right of reimbursement to the full extent of any expenses paid.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	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.
<b>Deductible</b>	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.
<b>Eligible Charge</b>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"><li>• For most services, supplies, or procedures, we consider:<ul style="list-style-type: none"><li>– increases in the cost of medical and non-medical services in Hawaii over the previous year;</li><li>– the relative difficulty of the services compared to other services;</li><li>– changes in technology; and</li><li>– payment for the service under federal, state, and other private insurance programs.</li></ul></li><li>• 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.</li></ul> <p>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.</p>

## **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.
- Reliable evidence shall mean only:
  - Published reports and articles in authoritative medical and scientific literature;
  - The written protocol or protocols used by the treating facility or the protocols(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or
  - The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

## **Medical necessity**

Care, treatment, service, drug 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, drug or level of service that can safely be provided; and
- Consistent with our medical guidelines and policies.

The fact that a physician may prescribe, order, recommend, or approve a service, drug or supply does not in itself mean that the service, drug or supply is medically necessary, even if it is listed as a covered service.

## **Us/We**

Us and We refer to HMSA

## **You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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](http://www.opm.gov/insure) for enrollment as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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; and
- When the next open season for enrollment begins.

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

- **Types of coverage available for you and your family**

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive 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.

- **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 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. 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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 provide 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 Web site, [www.opm.gov/insure](http://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 Federal 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](http://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.
  
- **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 at [www.opm.gov/insure/health](http://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 information about Federal and State agencies you can contact for more information.

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## Section 12. Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- **Online:** visit [www.fsafeds.com](http://www.fsafeds.com) and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

#### What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDSs accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

## • How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## • What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 75 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include:

- Physician visit copayments
- Prescription drug copayments
- Hospital services coinsurance
- Vision appliances
- Dental appliances
- Orthopedic and corrective shoes

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS

(372-3337), who will be able to answer your specific questions.

• **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

• **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

**Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m., Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## **The Federal Long Term Care Insurance Program**

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

## Index

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

<b>Accidental injury</b> .....	48	<b>Eyeglasses</b> .....	25	<b>Pap test</b> .....	16, 17
Allergy tests .....	23	<b>Family planning</b> .....	21	Physician .....	16, 29, 75
Allogeneic (donor) bone marrow transplant .....	32	Fecal occult blood test .....	17	Point of Service (POS) .....	6, 50, 75
Ambulance .....	36, 39	Fraud .....	3, 4	Precertification .....	11
Anesthesia .....	33	<b>General exclusions</b> .....	53	Prescription drugs .....	42, 75
Autologous bone marrow transplant .....	32	<b>Home health services</b> .....	27	Preventive care, adult .....	17
<b>Blood and blood plasma</b> .....	34, 35	Hospital .....	10, 34, 75	Preventive care, children .....	19
<b>Casts</b> .....	34, 35	<b>Immunizations</b> .....	18, 19	Prior approval .....	11
Catastrophic protection out-of-pocket maximum .....	13, 76	Infertility .....	22	Prosthetic devices .....	26
Changes for 2006 .....	8	Inpatient hospital benefits .....	34	Psychologist .....	40
Chemotherapy .....	23	<b>Maternity benefits</b> .....	21	<b>Radiation therapy</b> .....	23
Cholesterol tests .....	17	Medicaid .....	62	Room and board .....	34
Claims .....	54	Medical necessity .....	64	<b>Skilled nursing care facility</b> .....	36
Coinsurance .....	13, 63	Medicare .....	58	Social worker .....	40
Colorectal cancer screening .....	17	Original .....	59	Speech therapy .....	24
Congenital anomalies .....	31	Members		Splints .....	34
Contraceptive drugs and devices .....	22, 44	Associate .....	77	Substance abuse .....	40
Covered services .....	63	Family .....	65	Surgery .....	29, 30
Crutches .....	26	Mental Health/Substance Abuse Benefits .....	40	Anesthesia .....	33
<b>Deductible</b> .....	13, 63	<b>Newborn care</b> .....	21	Oral .....	31
Definitions .....	63, 75	Nurse		Reconstructive .....	31
Dental care .....	48, 75	Advanced practice registered nurse .....	40	<b>Temporary Continuation of Coverage (TCC)</b> .....	66, 67
Diagnostic services .....	16, 34, 40, 75	Nurse Anesthetist (NA) .....	34	Transplants .....	32
Donor expenses .....	32	<b>Occupational therapy</b> .....	24	Treatment therapies .....	23
Dressings .....	34, 35	Office visits .....	16	<b>Vision care</b> .....	25, 75
<b>Effective date of enrollment</b> .....	66	Oral and maxillofacial surgical .....	31	<b>Wheelchairs</b> .....	26
Emergency .....	37, 50, 75	Out-of-pocket expenses .....	13	Workers Compensation .....	62
		Oxygen .....	26, 34, 35	<b>X-rays</b> .....	16, 34, 35

**NOTES:**

**NOTES:**

## Summary of benefits for the HMSA Plan - 2006

- **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 higher out-of-pocket costs. You generally must pay any difference between our eligible charge and the billed amount.

Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
• Physician visits	\$15 copayment	16
• Other diagnostic and treatment services provided in the office	20% of eligible charges	16
<b>Services provided by a hospital:</b>		
• Inpatient	Nothing	34
• Outpatient	20% of eligible charges	35
<b>Emergency benefits</b>		
• In-area • Out-of-area	\$15 physician visit copay; \$50 emergency room facility copay; Nothing for laboratory tests; and 20% of eligible charges for other emergency services  \$15 physician visit copay; \$50 emergency room facility copay; Nothing for laboratory tests; and 20% of eligible charges for other emergency services	37–38
<b>Mental health and substance abuse treatment</b>	Regular benefits	40
<b>Prescription drugs</b>	\$5 copayment for generic drugs \$20 copayment for preferred brand name drugs 50% copayment of eligible charges not less than \$20 copayment for other brand name drug	42
<b>Dental care</b>	Nothing for preventive dental care	48
<b>Vision care</b>	\$7 copayment for optometrist 20% of eligible charges for other Plan providers	25

Benefits	You pay	Page
<b>Point of Service benefits – Yes</b>		50
<b>Protection against catastrophic costs</b> (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

## 2006 Rate Information for Hawaii Medical Service Association Plan

**Non-Postal rates** apply to most non-Postal employees. 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.

**All of Hawaii**

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u> Gov't Share	<u>Biweekly</u> Your Share	<u>Monthly</u> Gov't Share	<u>Monthly</u> Your Share	<u>Biweekly</u> USPS Share	<u>Biweekly</u> Your Share
Self Only	871	\$114.14	\$38.04	\$247.29	\$82.43	\$135.06	\$17.12
Self and Family	872	\$254.07	\$84.69	\$550.49	\$183.49	\$300.65	\$38.11