HMSA Plan

http://www.hmsa.com/portal/fedplan87/

HMSA

Blue Cross Blue Shield of Hawaii

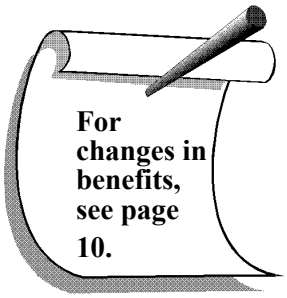
An Independent Licensee of the Blue Cross and Blue Shield Association

2011

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 9 for requirements.



This Plan has "Excellent" Accreditation from NCQA. See the 2011 Guide for more information on accreditation.

Enrollment codes for this Plan:

871 Self Only

872 Self and Family

FEHB

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-010

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

OPM has determined that the HMSA Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. 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 your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that 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 many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) 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, or call the SSA at 1-800-772-1213, (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Hawaii Medical Service Association (HMSA), an independent licensee of the Blue Cross and Blue Shield Association under our contract (CS 1058) with the 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, 2011 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011 and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HMSA.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits 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) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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 age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).

- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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 medicines 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.
- Contact your doctor or pharmacist if you have any questions.

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.

Patient Safety Links

- www.ahrq.gov/consumer/. 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. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report/toc.htm. 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.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use HMSA's preferred providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 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/**.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov .

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers Point-of-Services (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may 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. You may have to file a claim with us. We will then pay our benefits to you and you must pay the provider. 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. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Hawaii, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of Hawaii, you will obtain care from healthcare providers that have a contractual agreement (i.e., are participating providers) with the local Blue Cross and /or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

BlueCard® Participating Providers

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, HMSA will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside of Hawaii and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to HMSA.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over – and underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price HMSA uses for your claims because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Nonparticipating Providers Outside of Hawaii

When covered healthcare services are provided outside of Hawaii by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount the non-participating bills and the payment we will make for the covered services as set forth in this paragraph.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you will be liable for the difference between the amount that the non- participating healthcare provider bills and the payment we will make for covered services as set forth in this paragraph.

Dental Providers Outside of Hawaii

You can receive Plan dental benefits when you see a dental provider for covered services outside of Hawaii. To find a participating dentist, please visit our Web site at www.hmsa.com/portal/fedplan87.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, our providers, and our facilities. OPM's FEHB Web site (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 72nd 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/.

Your Medical and Claims Records Are Confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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.

Section 2. How we change for 2011

Do not rely only 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.

Program-wide changes

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 90.
- We clarified how we pay non-Plan providers; BlueCard participating providers; and non-participating providers and dental providers outside of Hawaii. See Section 1, “Facts about this HMO Plan”.
- We updated the list of services requiring our prior approval. See Section 3, “How you get care”.
- We clarified how we pay Plan facilities. See Section 4, “Your costs for covered services”.
- We clarified that thoracic electric bioimpedance performed in the office or outpatient setting is not covered. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We changed the benefit for screening tests, chest x-rays, sigmoidoscopy, colonoscopy, double contrast barium enema, abdominal aortic aneurysm ultrasound, and children's screening lab tests. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We clarified the HealthPass benefit. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We clarified the newborn benefit. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We updated our Physical and Occupational precertification requirement. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We clarified the benefit for hearing aids. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We clarified the vision services benefit. See Section 5 (a), “Medical services and supplies provided by physicians and other health care professionals”.
- We added benefits for bone marrow and stem cell transplant donors. See Section 5 (b), “Surgical Procedures”.
- We changed the benefits for non-Plan emergency services. See Section 5 (d), “Emergency services/accidents”.
- We changed the benefits for mental health and substance abuse. See Section 5 (e), "Mental health and substance abuse benefits".
- We clarified the benefit for drugs dispensed in unbreakable packages. See Section 5 (f), “Prescription drug benefits”.
- We have removed the list of injectable drugs and refer you to our HMSA formulary on our Web site at hmsa.com or call us at 808-948-6499 for the most current list of covered injectable drugs. See Section 5 (f), “Prescription drug benefits”.
- We changed your benefit for prescription drugs, smoking cessation drugs, inhaled drugs, and peak flow meters. See Section 5 (f), “Prescription drug benefits”.
- We clarified the information on the Drugs Benefit management Program. See Section 5 (f), “Prescription drug benefits”.
- We clarified the benefit for compound drugs. See Section 5 (f), “Prescription drug benefits”.

Section 3. How you get care

Identification cards

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

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

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.

You can receive Plan dental benefits when you see a dental provider for covered services outside of Hawaii. To find a participating dentist, please visit our Web site at www.hmsa.com/portal/fedplan87.

- **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 at www.hmsa.com/portal/fedplan87/.

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's 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 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 are hospitalized when your enrollment begins**

  We pay for covered services from the effective date of your enrollment. However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

  These provisions apply only to the benefits of the hospitalized person. 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 cases, 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:

- Artificial Disc Replacement - Cervical
- Autologous Chondrocyte Implantation (ACI)
- Bexxar
- Bi-PAP and Oral Appliances for the Treatment of Obstructive Sleep Apnea
- Blepharoplasty and Repair of Blepharoptosis
- Bone Mineral Density Studies (for members under 18 and for members determined to be at high risk for osteoporosis requiring studies more frequently than once every two years)
- Chemotherapy – Oral
  - Afinitor
  - Gleevac
  - Nexavar
  - Revlimid
  - Sprycel
  - Sutent
  - Tarceva
  - Tasigna
  - Tykerb
  - Zolinza
- Cinryze
- Computed Tomography (CT) - Outpatient (not required for emergency room)
- Certain kinds of drugs listed in our Select Prescription Drug Formulary (see Section 5(f) and 5(h) for more information)
- CT Colonography (virtual colonoscopy)
- Continuous Glucose Monitoring of Interstitial Fluid (Real time)
- Coronary CT Angiography
- Functional MRI
- Genetic Risk Assessment for symptomatic and asymptomatic individuals with the following:
  - Family history of breast cancer
  - Family history of ovarian cancer
- Genetic Risk Assessment for asymptomatic individuals with the following:
  - Familial adenomatous polyposis

- Hereditary nonpolyposis colorectal cancer

- Genetic Testing for:
  - BRCA1 and BRCA2 Mutations
  - Carrier Status for Spinal Muscular Dystrophy
  - Carrier Status for Tay-Sachs, Canavan Disease, Familial Dysautomia, and Gaucher's Disease
  - Cystic Fibrosis
  - Developmental Delay/Mental Retardation/Autism Spectrum Disorder
  - Factor V Leiden, Prothrombin G20210A Mutation and Reductase Gene Mutation
  - Fragile X Syndrome
  - Hereditary Hemochromatosis Mutations
  - Long QT Syndrome
  - Thiopurine Methyltransferase Gene
- Growth Hormone Therapy
- Hepatitis C Treatment with Interferons and Ribavirin
- Home IV Therapy
  - Albumin Therapy
  - Immune Globulin (IVIG) Therapy
  - Inotropic Infusion Therapy
  - Intravenous Anti-Infective Therapy (beyond standard duration of treatment)
  - Intravenous Hydration for Hyperemesis Gravidarum (after the first 14 days)
  - Intravenous Hydration Therapy for Adults (after the first seven days)
  - Pain Management Infusion Therapy
  - Total Parenteral Nutrition Therapy for Adults
- Home Pulse Oximeters (for children)
- Hyperbaric Oxygen Therapy (for diabetic wounds, osteoradionecrosis and soft tissue radiation necrosis)
- In vitro fertilization
- Injectable Drugs
  - Alimta
  - Avastin
  - Enbrel (for treatment of plaque psoriasis)
  - Erbitux
  - Erythropoiesis Stimulating Agents (for Myelodysplastic Syndrome and Anemia of Chronic Disease)
  - Flolan
  - Forteo
  - Humira (for treatment of plaque psoriasis)
  - Ilaris
  - Immune Globulin (for Chronic Inflammatory Demyelinating Polyneuropathy, Guillain-Barre Syndrome, Multifocal Motor Neuropathy, and Relapsing-Remitting Multiple Sclerosis)
  - Low Molecular Weight Heparin (if used beyond the FDA-indicated duration, beyond six months in patients with cancer, and perioperative bridge therapy)

  - Lupron (for treatment exceeding 3 months for anemia caused by fibroids or 6 months for management of endometriosis, for therapy beyond 11 years for girls and 12 years for boys for central precocious puberty, for off-label use in the palliative treatment of advanced breast cancer)
  - Nplate
  - Remodulin
  - Rituxin (for non-rheumatoid arthritis, non-cancer indications)
  - Stelera
  - Synagis
  - Vectibix
  - Velcade
  - Xolair
  - Zevalin
- Insulin Pumps
- Intensity Modulated Radiation Therapy (IMRT)
- Intrastromal Corneal Ring Segments for Keratoconus (INTACS)
- Knee Braces, Custom-fabricated
- Kuvan
- Kyphoplasty and Vertebroplasty
- Lung Volume Reduction Surgery
- Magnetic Resonance Angiography (MRA) and Magnetic Resonance Venography (MRV) – Outpatient (not required for emergency room)
- Magnetic Resonance Imaging (MRI) – Outpatient (not required for emergency room)
- Mental Health or Substance Abuse Residential Care Facility Services Outside the State of Hawaii
- Negative Pressure Wound Therapy
- Non-Coronary Brachytherapy
- Nuclear Cardiology – Outpatient (not required for emergency room)
- Occupational Therapy Services
- Off Label Drug Use (for drugs requiring precertification)
- Oncotype DX
- Organ and tissue transplants listed in Section 5(b)
- Oscillatory Device for Bronchial Drainage (The Vest)
- Panniculectomy/Abdominoplasty
- Photochemotherapy (for Pityriasis Rosea, Lichen Planus, and other Atopic Dermatitis and Related Conditions)
- Photodynamic Therapy (for superficial basal cell skin cancer and Bowen's disease)
- Physical Therapy Services
- Positron Emission Tomography (PET)
- Power Mobility Devices
- Promacta
- Prophylactic Mastectomy
- Prosthetics and Orthotics over $10,000
- Proton Beam Therapy

- Pulmonary arterial hypertension drugs
- Pulmonary Vein Ablation for Atrial Fibrillation
- Reduction Mammaplasty
- Routine care associated with clinical trials listed in Section 5(h) of this brochure
- Soliris
- Spinal Cord Stimulators for Pain Management
- Stem Cell transplant donor screening test
- Stereotactic Radiosurgery and Fractionated Sterotactic Radiotherapy Beams (Gamma-knife and X-knife Surgery)
- Surgeries, therapies or procedures employing new technology or representing a new application of existing technology
- Surgery for Hyperhidrosis
- Surgery to Correct Morbid Obesity (bariatric surgery)
- Torisel
- Transcutaneous Electrical Nerve Stimulation (TENS) Unit
- Transplant evaluations, except for cornea and kidney transplant evaluations
- Uterine Artery Embolization to Treat Fibroids
- Varicose Veins Treatment
- Wheelchairs (Pediatric Tilt-in-Space, Adult High Stregth Lightweight and Ultra Lightweight, and Custom Wheelchairs)
- Xenazine

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

Section 4. Your cost for covered services

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 certain services.

Example: When you use your Plan pharmacy, you pay a copayment of $7 for generic drugs.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance/copayments) for the covered care you receive.

Deductible

We do not have a deductible.

Eligible Charges

For most medical 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*.

For participating facilities, we calculate our payment based on the *maximum allowable fee*. Your coinsurance is based on the lower of the facility's actual charge or the *maximum allowable fee*. Your coinsurance and our payment will equal 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 x-ray, you pay a coinsurance of 20% for Plan providers.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total $2,500 per person or $7,500 per family enrollment in any calendar year, you are no longer responsible for any coinsurance/copayment amounts 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 even after you have met the out-of-pocket maximum:

- Dental Care
- Prescription Drugs
- Vision Care
- Medical Foods
- Online Care

The following amounts do not count toward meeting your catastrophic protection out-of-pocket maximum and you must continue to be responsible for the amounts below even after you have met the out-of-pocket maximum.

- Payment for services subject to a maximum once you reach the maximum.
- The difference between the actual charge and the eligible charge that you pay when you receive service from a non-Plan provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your coinsurance/copayment for covered services.

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.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits - OVERVIEW

See page 10 for how our benefits changed this year and page 89 for a benefits summary. Note: This benefits section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. 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/.

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

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
Diagnostic and treatment services	
Professional services of physicians • In physician's office • During a hospital stay • In a skilled nursing facility • Medical consultations – inpatient and outpatient • At home	Plan Provider $15 copayment per visit Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Online Care Note: Covered, when provided by HMSA Online Care at www.hmsa.com. You must be at least 18 years old. A member who is a dependent minor is covered when accompanied by an adult member. Care is available for 10 minute sessions which may be extended up to 5 additional minutes. Each session is limited to a total of 15 minutes.	Plan Provider $10 copayment for up to 10 minutes; $5 for an additional 5 minute extension Non-Plan Provider Not a benefit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Pre-surgical labs	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG • Pre-surgical diagnostic testing	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Outpatient thoracic electric bioimpedence in an outpatient setting which includes a physician's office.*	*All charges*

Benefit Description	You pay
Preventive care, adult	
Routine screenings include: • Routine Prostate Specific Antigen (PSA) test – one annually for men age 50 and older • Routine Pap test – one per calendar year • Routine mammogram – covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 and older, one every calendar year Note: A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Complete Blood Count - one per calendar year • Fecal Occult Blood - one every calendar year, age 50 and above • Urinalysis - one per calendar year • Glucose screening - one every three years, age 45 and above • Fasting lipoprotein profile (Total cholesterol, LDL, HDL, and triglycerides) - once every five years • Chlamydial infection screening • TB Test - one per calendar year	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Routine Chest X-Ray - one per calendar year • Sigmoidoscopy screening - every five years, age 50 and above • Colonoscopy - once every 10 years, age 50 and above • Double contrast barium enema (DCBE) - once every five years, age 50 and above • Abdominal aortic aneurysm ultrasound screening - one time only for men age 65- 75	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Routine Physical Exam – one per calendar year The following services are also covered when performed in conjunction with a covered routine physical exam: - Vision test - Hearing test Note: For vision and hearing tests not performed in conjunction with a routine physical exam, see Section 5(a) *Hearing services* (*testing, treatment, and supplies*) and *Vision services* (*testing, treatment, and supplies*). • Well Woman Exam – one per calendar year	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Adult immunizations are covered in accord with guidelines set by the Advisory Committee on Immunization Practices (ACIP) and endorsed by the Centers for Disease Control and Prevention (CDC). • Standard Immunizations • Immunizations for high risk conditions such as Hepatitis B	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• Travel Immunizations	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• HealthPass You and any dependent defined below are eligible for one HealthPass exam listed in this section per calendar year. HealthPass is a screening program that provides you with information about how to build a healthier life by looking at your current lifestyle, health habits, and health history. For members age 14 to 17, HealthPass for Teens offers an interactive web based teen health risk assessment, biometrics (blood pressure, body mass index) measurement, and individual counseling with a health professional to identify health risk. You are eligible to receive a health risk assessment questionnaire through our Web site at www.hmsa.com or you can call HealthPass for a paper questionnaire. To schedule your screening appointment, call HealthPass and for more information, contact the Customer Service Department at 808-948-6499. HealthPass will: • Evaluate your lifestyle, health habits, and health risks. • Measure your blood pressure, cholesterol, glucose and body composition. • Provide consultation on your screening results and work with you to develop a personal health and wellness goal. • Offer health coaching services to support you in achieving your health and wellness goals. • Refer you to healthy lifestyle programs, interventions and health eduction classes (Nutrition, Exercise, Weight Management, Stress Management and Smoking Cessation). Yearly visits will enable you to measure your progress and alert you to any changes that may need additional actions to meet your health and wellness goals. If you have certain risk factors that become apparent during your screening, HealthPass will refer you to your primary care physician (PCP) for follow-up care. Based on your age, gender, risk factors and health history, you may be eligible for coverage for certain preventive exams. Examples include: • Health maintenance physical examination • Osteoporosis Screening	Plan Provider Nothing Non-Plan Provider Not a benefit

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
HealthPass operates under the oversight of a program director and a physician who serves as the program's medical director. HealthPass health consultants and health coaches are trained in health promotion and disease prevention.	Plan Provider Nothing Non-Plan Provider Not a benefit
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, and attending schools or camp* • *Physical exams obtained for, or related to, the purpose of travel*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics.	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
• Routine sensory screening and developmental/behavioral assessments according to Bright Futures/American Academy of Pediatrics up to age 22 when performed in conjunction with a covered routine physical exam. Note: For vision and hearing tests not performed in conjunction with a routine physical exam, see Section 5(a) *Hearing services* (*testing, treatment and supplies*) and *Vision services* (*testing, treatment, and supplies*). • Examinations up to age 22 according to the following schedule: - Birth through age two: 12 visits - Age three through 21: one visit each calendar year	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charges
Laboratory tests through age five: • three urinalysis • laboratory tests as recommended by Bright Futures/American Academy of Pediatrics Note: Tests for children ages six and older, see Section 5(a), Preventive care, adult.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Maternity care	
Complete maternity (obstetrical) care, includes physician or certified nurse-midwife services for routine: • Prenatal care • Delivery • Postnatal care	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	
Note: Here are some things to keep in mind: • We pay hospitalization, surgeon services, 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 benefits. • See page 21, Professional services of physicians, and page 41, hospital benefits, for how we pay benefits for other circumstances, such as complications of pregnancy and extended stays for you or your baby. • You do not need to precertify your delivery and extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Your physician will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We cover care to treat a child's congenital defects and birth abnormalities for the first 31 days of birth. 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. Surgical benefits, not maternity benefits, apply to circumcision.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: Routine sonograms to determine fetal age, size, or sex.	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization. See Section 5(b) *Surgical procedures.*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms/Cervical Caps Note: Benefit payment for contraceptives is limited to one contraceptive method per period of effectiveness. We cover oral contraceptives under the prescription drug benefits. See Section 5(f) for benefit level.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Contraceptives such as condoms, foam, or creams which do not require a prescription*	*All charges*

Benefit Description	You pay
Infertility services	
Diagnosis of infertility Treatment of infertility limited to: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • In Vitro Fertilization 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. • Injectable fertility drugs Note: We cover oral fertility drugs under the prescription drug benefit. See Section 5(f) *Prescription drug benefits.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures except in vitro fertilization* • *Services of a surrogate* • *Cost of donor sperm* • *Cost of donor egg* • *Any donor-related services, including but not limited to collection, storage, and processing of donor eggs and sperm* • *Cryopreservation of oocytes, semen and embryos*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Treatment materials	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Allergy serum	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: Provocative food testing and sublingual allergy desensitization.	*All charges*

Benefit Description	You pay
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants starting on page 35. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy, self-administered injections, Outpatient injections, and Intravenous nutrient solutions for primary diet Note: Home IV Therapy and some injections require prior approval. See Section 3 *Services requiring our prior approval.* • Medical foods and low-protein modified food products for the treatment of inborn errors of metabolism in accord with Hawaii Law and Plan guidelines • Growth hormone therapy (GHT) Note: Growth hormone therapy (GHT) and any related services or supplies require prior approval. See Section 3 *Services requiring our prior approval.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Physical and occupational therapies	
Short term therapy, generally not longer than 90 days, for the services of each of the following: • qualified physical therapists • occupational therapists Note: We only cover therapy to restore lost or impaired bodily function when there has been a total or partial loss of bodily function due to illness or injury. Precertification is required after the first visit. Plan providers obtain approval for you, non-Plan providers do not.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cardiac Rehabilitation*	*All charges*
Speech therapy	
25 visits per calendar year	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
Note: • Hearing testing performed in conjuction with a physical exam for children through age 22, see Section 5(a), *Preventive care, children;* • See Section 5(a), *Orthopedic and prosthetic devices* for Hearing aids and Diagnostic hearing tests	
Vision services (testing, treatment, and supplies)	
• Eyeglasses or contact lenses for certain medical conditions such as aphakia, cataract, and keratoconus, limited to one pair of eyeglasses, replacement lenses, or contact lenses (or equivalent supply of disposable contact lenses) per incident.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Annual vision exam and eye refraction Note: For vision tests performed in conjunction with a routine physical exam, see Section 5(a) *Preventive care, adult and children.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Contact lens fitting*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing Aids, limited to: - one per ear every 60 months • Hearing aid evaluation Note: For hearing tests performed in conjunction with a routine physical exam, see Section 5(a) *Preventive care, adult and children.* • Diagnostic hearing test • Prosthetic devices, such as artificial limbs and lenses following cataract removal • Orthopedic devices, such as braces • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Nonstandard or deluxe hearing aids and hearing aid features including but not limited to:* - *Digital programming* - *Rush Service* - *Feedback control* - *Telecoil* - *Replacement Batteries* • *All other hearing tests* • *Repair of hearing aids* • *Orthopedic and corrective shoes* • *Podiatric shoes* • *Arch supports* • *Foot orthotics, except for specific diabetic conditions* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Bionic services and devices*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Mobility assistive equipment (wheelchairs, crutches, walkers, power mobility devices); • Blood glucose monitors; and • Insulin pumps. Appliances and medical equipment must meet all of the following criteria: • The item is: - Durable enough to withstand repeated use; - Primarily and customarily used to serve a medical purpose; - Not useful to a person in the absence of illness or injury; and - Appropriate for use in the home. • The item is necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. • The item is used in your home. *Home* means the place where you live other than a hospital or skilled or intermediate nursing facility. Please note: Benefit payment for the rental of appliances and medical equipment is limited to no more than the purchase price. Benefits for the rental or purchase of medical equipment is determined based on the following criteria: • Items intended for short-term use are only eligible for benefits when the item is rented. • Items intended for long-term use are eligible for benefits when the item is purchased, but only if the cost of renting will exceed the cost of purchasing the equipment. See Section 3 *Services requiring our prior approval.*	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Environmental Control Equipment and Supplies such as air conditioners, humidifiers, dehumidifiers, air purifiers or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags, and dust mite covers* • *Hygienic equipment* • *Exercise equipment* • *Educational equipment* • *Comfort or convenience items*	*All charges*

Benefit Description	You pay
Home health services	
• Home health care ordered by a Plan physician and provided by a qualified home health agency for the treatment of an illness or injury when you are homebound. *Homebound* means that due to an illness or injury, you are unable to leave home or if you leave home, doing so requires a considerable and taxing effort. • Services provided for up to 150 visits per calendar year. Note: If you need home health care services for more than 30 days, a physician must certify that there is further need for the services and provide a continuing plan of treatment at the end of each 30-day period of care.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
No Benefit	*All charges*
Alternative treatments	
No Benefit	*All charges*
Not covered: Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.	*All charges*
Educational classes and programs	
Coverage is provided for: • Smoking Cessation - Ready, Set, Quit A program for smokers who need help to quit smoking, including telephonic counseling and referrals to in-person smoking cessation classes. For more information call 808-952-4400 on Oahu or 1-888-225-4122 toll-free from the Neighbor Islands. Note: Physician prescribed over-the-Counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence, see Section 5(f) *Prescription drug benefits*. • Lifestyle Management – Health Odyssey HMSA's Health Odyssey programs provide a series of practical, fun-filled health education classes to help you create a healthier, happier life. Sessions are interactive and include a broad range of lifestyle 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.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	
• Disease Management 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. HMSA's Care Connection programs currently available to help you and your physician are for: - Asthma - Chronic Obstructive Pulmonary Disease - Diabetes - Cardiac conditions (Coronary Artery Disease and Heart Failure) - Mental Health or Substance Abuse - Chronic Kidney Disease To find out if these programs are right for you, talk with your primary care physician. • Prenatal Care Program The Good Pregnancy – He Hapai Pono He Hapai Pono 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 808-952-4454 on Oahu, or 1-888-400-2776 from the Neighbor Islands, or visit the Web site at www.hmsa.com/healthwellness/womenshealth/hehapaipono/.	Nothing
Not covered except as offered through HMSA programs: • *Weight reduction programs* • *Smoking Cessation programs* • *Nutrition Counseling*	*All charges*

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

Important 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.). Note: Organ/tissue transplant services billed by Blue Distinction Centers for Transplants and most Contracted Providers will include both the physician and facility charges.
- For cornea, kidney, and intestinal transplant related services billed by a Plan provider see section 5(a).
- **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
Surgical procedures	
Surgery includes preoperative and postoperative care. Note: Non-Plan providers may bill separately for preoperative care, the surgical procedure, and postoperative 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.	
Surgical procedures, such as: • Operative procedures • Treatment of fractures, including casting • Acne treatment destruction of localized lesions by chemotherapy (excluding silver nitrate) • Cryotherapy • Diagnostic injections including catheter injections into joints, muscles, and tendons • Electrosurgery • Correction of amblyopia and strabismus • Diagnostic and Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. See Section 5(a) *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns • Newborn circumcision	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Surgical treatment of morbid obesity (bariatric surgery) is covered with the following criteria: - 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 - There is documentation of at least three years of failure to lose weight - Only those surgical procedures that have proven long term efficacy and safety in peer reviewed scientific literature will be approved - Prior approval is required for this surgery. See Section 3 *Services requiring our prior approval.*	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot. See Section 5(a) Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. All stages of breast reconstruction surgery following a mastectomy, such as: • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; and • breast prostheses and surgical bras and replacements. See Section 5(a) *Orthopedic and prosthetic devices.* Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental surgeries generally done by dentists and not physicians* • *Services, drugs or supplies for nondental treatment of temporomandibular joint (TMJ) syndrome*	*All charges*
Organ/tissue transplants	
These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (De-novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Adrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast cancer - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogenic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) - Amyloidosis - Neuroblastoma	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocol. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell disease • Mini-transplants (non-myeloblative autologous, reduced intensity conditioning or RIC) for: - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive)	Blue Distinction Centers for Transplants (BDCT) Provider and Contracted Provider Nothing Non-Contracted Provider 30% of eligible charges and any difference between our payment and the actual charge
Transplant evaluation (office consultation) Note: For those procedures such as laboratory and diagnostic tests, and psychological evaluations used in evaluating a potential transplant candidate, see Section 5(a) *Lab, X-ray and other diagnostic tests* and Section 5(e) *Mental health and substance abuse benefits*.	Plan Provider $15 per visit Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Note: • We cover related medical and hospital expenses of the donor when we cover the recipient. • We cover donor screening for up to three potential donors and the actual donor for allogeneic bone marrow/stem cell transplants. • This coverage is secondary and the living donor's coverage is primary when: - You are the recipient of an organ from a living donor, and - The donor's health coverage provides benefits for organs donated by a living donor ***Please refer to the precertification information shown in Section 3.***	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor and for allogeneic bone marrow/stem cell transplant donors as shown above* • *Implants of artificial organs, except for total artifical hearts when used as a bridge to a permanent heart transplant* • *Transplants not listed as covered* • *Mechanical or non-human organs* • *Your transportation for organ or tissue transplant services* • *Transportation of organs or tissues* • *Organ Donor Services when you are donating an organ to someone else*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: Professional services include general anesthesia; regional anesthesia; and monitored anesthesia when you meet the Plan's high risk criteria.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

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

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
Inpatient hospital	
Room and board, such as: • Semiprivate accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Plan Provider $100 per admission (based on semiprivate room rate) Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge (based on semiprivate room rate)
Special care units, such as: • Intensive care • Cardiac care units	Plan Provider $100 per admission Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma cost, blood processing, blood bank services • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as adult day care, intermediate care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Additional charges for autologous blood*	*All charges*
Outpatient hospital or ambulatory surgical center	
All outpatient medical services provided by a hospital, unless otherwise identified below, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • X-rays • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma cost, blood processing, blood bank services • Pre-surgical testing (non-laboratory) is covered but only when you meet our criteria • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Anesthesia service (See Section 5(b) *Anesthesia*) Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures except those services that are described in the Dental Benefits section.	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Outpatient medical services provided by a hospital limited to: • Diagnostic laboratory tests and pathology services • Pre-surgical laboratory tests are covered but only when you meet our criteria • Immunizations	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Services associated with an outpatient surgery provided by an ambulatory surgical center (ASC only), such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
• Administration of blood, blood plasma, and other biologicals • Blood and blood plasma cost, blood processing, blood bank services • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Anesthesia service (See Section 5(b) *Anesthesia*) • Orthopedic and prosthetic devices (See Section 5(a) *Orthopedic and prosthetic devices*) Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures except those services that are described in the Dental Benefits section.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Extended care benefits/Skilled nursing care facility benefits	
Skilled Nursing Facility (SNF): A facility that provides continuous skilled nursing services as ordered and certified by your attending physician. Room and Board is covered, but only for semiprivate rooms when: • You are admitted by your physician • Care is ordered and certified by your physician • We approve the confinement • Confinement is not primarily for comfort, convenience, a rest cure, or domiciliary care • If days exceed 30, the attending physician must submit a report showing the need for additional days at the end of each 30-day period • The confinement is not longer than 100 days in any one calendar year Services and supplies are covered, including routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy benefits.	Plan Provider Nothing (based on semiprivate room) Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Not covered: Custodial care, rest cures, domiciliary or convalescent care	*All charges*

Benefit Description	You pay
Hospice care	
A hospice program provides care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. • Inpatient residential room and board • Referral visits	Plan Provider Nothing Non-Plan Provider Not a benefit
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
Ground professional ambulance service is covered when: • Medically appropriate • Services to treat your illness or injury are not available in the hospital or nursing facility where you are an inpatient	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge

Section 5(d). Emergency services/accidents

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
Emergency within our service area	
Professional emergency services of physicians • In physician's office • In an urgent care center • As an outpatient or inpatient at a hospital • In an emergency room	Plan Provider $15 copayment per visit Non-Plan Provider $15 copayment per visit and any difference between our payment and the actual charge
• Emergency diagnostic tests • Emergency x-rays	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our payment and the actual charge
• Emergency laboratory tests • Emergency surgery	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge

Emergency within our service area - continued on next page

Benefit Description	You pay
Emergency within our service area (cont.)	
• Emergency room facility Note: Other plan benefits may also apply in addition to the emergency room benefit. However, if you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.	Plan Provider $50 copayment Non-Plan Provider $50 copayment and any difference between our payment and the actual charge
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
Professional emergency services of physicians • In physician's office • In an urgent care center • As an outpatient or inpatient at a hospital • In an emergency room	Plan Provider $15 copayment per visit Non-Plan Provider $15 copayment per visit and any difference between our payment and the actual charge
• Emergency diagnostic tests • Emergency x-rays	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our payment and the actual charge
• Emergency laboratory tests • Emergency surgery	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge
• Emergency room facility Note: Other plan benefits may also apply in addition to the emergency room benefit. However, if you are admitted as an inpatient following a visit to the emergency room, hospital inpatient benefits apply and not emergency room benefits.	Plan Provider $50 copayment Non-Plan Provider $50 copayment and any difference between our payment and the actual charge
Not covered: Elective care or non-emergency care	*All charges*
Ambulance	
Ground professional ambulance service when the following apply: • Transportation begins at the place where an injury or illness occurred or first required emergency care • Transportation ends at the nearest facility equipped to furnish emergency treatment • Transportation is for the purpose of emergency treatment See Section 5(c) for non-emergency service.	Plan Provider Nothing Non-Plan Provider Any difference between our eligible charge and the actual charge

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	
Air ambulance is limited to intra-island or inter-island transportation within the state of Hawaii. Note: Non-Plan provider air ambulance services will be covered the same as Plan provider air ambulance services when our Plan provider is not available to respond to the emergency. To get this benefit, you must first contact the Plan provider. Once we are able to secure the confirmation in writing that they were unable to provide services, you will only be responsible for the copayment amount you would have paid had you received the service from a Plan provider.	Plan Provider 20% of eligible charges Non-Plan Provider 20% of eligible charges and any difference between our payment and the actual charge

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, 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.

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.
- 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.

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a provider and contained in a treatment plan. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as licensed physicians, psychiatrists, psychologists, or clinical social workers, marriage and family therapists, advanced practice registered nurses (APRN), or mental health counselors • Medication management	Plan Provider $15 copayment per visit Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Diagnostic tests • Psychological Testing • Laboratory tests	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Inpatient services provided by a hospital or other facility • Inpatient services in approved alternative care settings such as residential treatment, full-day hospitalization	Plan Provider $100 per admission Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	
• Partial hospitalization • Outpatient Facility	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge.
Not covered: • *Marriage and Family Counseling or other training services* • *Services we have not approved* • *Hypnotherapy* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 53.
- Your provider must obtain precertification for certain drugs.
- 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.

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:
- **Tier 1** Generic Drugs. A drug, which is prescribed or dispensed under its commonly used generic name, no longer protected by patent laws, or as determined by us (except for the single-source generic drugs described below).
- **Tier 2**
  - **Single Source Generic Drugs.** A Generic Drug which is manufactured by a single pharmaceutical company. Once a generic drug is available from more than one company, HMSA will re-evaluate it for possible tier lowering.§ **Preferred Drugs.** A Brand Name Drug, contraceptive, supply, or insulin that is listed on the HMSA Select Prescription Drug Formulary as Preferred.
- **Tier 3** Other Brand Drugs. A Brand Name Drug, contraceptive, supply, or insulin that is not classified as Preferred on the HMSA Select Prescription Drug Formulary.
- **Tier 4** Specialty Drugs. High cost drugs that are used to treat chronic, potentially life threatening diseases. They are often part of complex treatment regimens which requires special handling, high level of patient education, close supervision and monitoring on an ongoing basis.

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 dispensing one package of the drug. You would owe the copayment for a 30-day supply.
  - Drugs Dispensed in Manufacturer's Original Unbreakable package: Copayments for prescription drugs that are dispensed in a manufacturer's original package are determined by the number of calendar days that are covered by the prescription. You will owe one copayment for each prescription for up to 59 days, two copayments for 60-89 days, and three copayments for 90-119 days. Examples of drugs that come in unbreakable packages are insulin, eye drops and inhalers.
  - 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 generic copayment plus the difference in cost between the name brand drug and the generic.
- Mail order prescriptions are limited to prescribed maintenance medications.
- Mail order prescription drugs are available only from contracted providers. For a list of contracted providers call us at 808-948-6499.
- Mail order prescription 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 an 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.

Step Therapy is another type of precertification. Before we cover selected medications, you may be required to try one or more specific drugs to treat a particular condition.

Quantity Limitation. Certain medications may be covered up to a certain quantity. This quantity is not to exceed the FDA maximum recommended dose. Doses that exceed the quantity limits are subject to precertification.

Daily Allowable Consumption (DACON). You are limited to no more than one tablet per day of certain once-daily dosed medications.

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

Other Brand Name Drug Copayment Exceptions

You may qualify to purchase Other Brand Name drugs at the lower Preferred Brand copayment if you have a chronic condition that lasts at least three months, have tried and failed treatment with at least two comparable Generic, Preferred Brand, or Over-the-counter drugs (unless only one comparable alternative is available), or all other comparable Generic, Preferred Brand, or Over-the-counter drugs are contraindicated based on your diagnosis, other medical conditions, or other medication therapy.

You have failed treatment if you meet 1, 2, or 3 below:

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

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

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

This benefit requires precertification. You or your physician must provide legible medical records which substantiate the requirements of this section in accord with the Plan's polices and to the Plan's satisfaction.

When prescription drugs become available as therapeutically equivalent over-the-counter drugs, they are considered as comparable therapy for tier lowering.

This exception is not applicable to controlled substances, off label uses, Other Brand Name drugs if there is an FDA approved A rated generic equivalent, or if we have a drug specific policy which has criteria different from the criteria in this section. You can call us to find out if HMSA has a drug policy specific to the drug prescribed for you.

Lipid lowering agents are subject to slightly different Other Brand Name Drug Copayment exception criteria. These are described in HMSA's Medical Policy, Drug Tier Exception for Lipid Lowering Agents.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a licensed practitioner and obtained from a Plan or non-Plan Pharmacy, or through our mail order program: Drugs and medicines that, by Federal law of the United States, require a physician's prescription for their purchase, except those listed as *Not covered*. • Injectable drugs limited to those designated as covered in the HMSA formulary on our Web site at hmsa.com or call us at 808-948-6499 for the most current list of covered injectable drugs. 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*. • Drugs for sexual dysfunction Benefits are limited to the following: - Up to four doses every 30 days - Up to three months dispensed at a time (Multiple copayments will apply) - Covered for gender approved by FDA - Physician must certify in advance that the patient has impotence due to organic causes from vascular or neurological disease • Oral contraceptive • Oral fertility drugs • Vitamins and minerals limited to: - The treatment of an illness that in the absence of such vitamins and minerals could result in a serious threat to the member's life - Sodium fluoride if dispensed as a single drug to treat tooth decay • Compound Drugs made with non-bulk chemicals are subject to the copayment of the highest costing ingredient. • Specialty Drugs - Benefits are not available through HMSA's Prescription Drug Mail Order Program - You must purchase these drugs from a Plan Specialty Pharmacy Please refer to the precertification information shown in Section 3.	**Tier 1 (Generic):** Plan Pharmacy $7 copayment Non-Plan Pharmacy $7 copayment plus 20% of remaining eligible charges and any difference between the actual and eligible charge **Tier 2 (Single-Source Generic and Preferred Brand):** Plan Pharmacy $30 copayment Non-Plan Pharmacy $30 copayment plus 20% of remaining eligible charges and any difference between the actual and eligible charge **Tier 3 (Other Brand):** Plan Pharmacy $65 copayment Non-Plan Pharmacy $65 copayment plus 20% of remaining eligible charges and any difference between the actual and eligible charge **Tier 4 (Specialty):** Plan Specialty Pharmacy $75 copayment Non-Plan Pharmacy Not a benefit
• Smoking Cessation Drugs - Includes over-the-counter Smoking Cessation Drugs - You must receive a written prescription from your physician for Smoking Cessation Drugs	Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between the actual and eligible charge
• Spacers for inhaled drugs and peak flow meters are limited to those designated as covered in the HMSA formulary on our Web site at hmsa.com or call us at 808-948-6499 for the most current list of covered spacers for inhaled drugs and peak flow meters.	Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between the actual and eligible charge

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• Internally implanted time-release contraceptive drugs • Contraceptive drugs injected periodically and intrauterine devices	Plan Provider 20% of eligible charges Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• Diaphragms	Plan Pharmacy $10 copayment Non-Plan Pharmacy $10 copayment and any difference between the actual and eligible charge
• Over-the-Counter drug, Omeprazole OTC Benefits are subject to the following limitations: - You must receive a written prescription from your physician for Omeprazole OTC - Copayments are for any amount up to a 42-day supply - Benefits are not available through HMSA's Prescription Drug Mail Order Program	**Over-the-Counter Drugs:** Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between the actual and eligible charge
• Insulin Note: When obtained by prescription.	**Preferred Brand Insulin:** Plan Pharmacy $7 copayment Non-Plan Pharmacy $7 copayment plus 20% of eligible charges and any difference between the actual and eligible charge **Other Brand Insulin:** Plan Pharmacy $30 copayment Non-Plan Pharmacy $30 copayment plus 20% of eligible charges and any difference between the actual and eligible charge

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
Diabetic supplies include: • Insulin syringes • Needles • Lancets • Lancet devices • Glucose test tablets and test tapes • Acetone test tablets	**Preferred Brand Diabetic Supplies:** Plan Pharmacy Nothing Non-Plan Pharmacy Any difference between the actual and eligible charge **Other Brand Diabetic Supplies:** Plan Pharmacy $30 copayment Non-Plan Pharmacy $30 copayment and any difference between the actual and eligible charge
Mail Order Drug Program:	
Generic Drugs	$11 Copayment
Single-Source Generic Drugs	$11 Copayment
Preferred Brand Name Drugs	$65 Copayment
Other Brand Name Drugs	$175 Copayment
Preferred Brand Name Insulin	$11 Copayment
Other Brand Insulin	$65 Copayment
Preferred Brand Name Diabetic Supplies	Nothing
Other Brand Name Diabetic Supplies	$65 Copayment
Smoking Cessation Drugs	Nothing
Spacers for inhaled drugs and peak flow meters	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Vitamins, nutrients, and food supplements, except those identified above, even if a physician prescribes or administers them* • *Nonprescription medicines limited to those designated as covered in the HMSA formulary on our Web site at hmsa.com or call us at 808-948-6499 for the most current list of covered nonprescription medicines.* • *Medical supplies such as dressings and antiseptics*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• *Compound drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill* • *Compounded drugs that are available as a similar commercially available prescription drug product* • *Bulk chemicals* *Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking Cessation benefit. (See page 53)*	*All charges*

Section 5(g). Dental benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- 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 Desription	You Pay
Accidental injury Benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
Dental Service	
Preventive dental care • Annual exam/visit • Annual cleaning (prophylaxis)	Plan Provider Nothing Non-Plan Provider 30% of eligible charges and any difference between our payment and the actual charge
• X-rays [One set of bitewings (1-4 films) per calendar year and one full mouth series every 5 years] • Periapical X-rays	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge
Standard dental service for permanent teeth only • Fillings (composite resin for anterior teeth and single, stand-alone facial surfaces of bicuspids only; amalgam; and silicate) • Extractions • Root canal treatment • Treatment for diseases of the gum • Space maintainers • Anesthesia	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge

Dental Service - continued on next page

Benefit Desription	You Pay
Dental Service (cont.)	
Dental Surgery • Incision and drainage of abscess • Alveolectomy • Excision of cysts	Plan Provider 30% of eligible charges Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge
Occlusal Splint When precertified and determined by the Plan, occlusal splint therapy is covered for the treatment of temporomandibular disorder involving the muscles of mastication (chewing). Coverage of occlusal splint therapy is subject to the following limitations. • A removable acrylic appliance is used in conjunction with the therapy • The disorder is present at least one month prior to the start of the therapy and the therapy does not exceed ten weeks • The therapy does not result in any irreversible alteration in the occlusion • It is not intended to be for the treatment of bruxism • It is not for the prevention of injuries of the teeth or occlusion • The benefit is limited to one treatment episode per lifetime • The member must be 15 years of age or older	Plan Provider or Non-Plan Provider 50% of eligible charges and any difference between our payment and the actual charge Note: Maximum Plan payment not to exceed $125
Not covered: • *All other dental services, including topical application of fluoride* • *Dental appliances, such as false teeth, crowns, bridges, and repair of dental appliances* • *Dental prostheses, dental splints (except as covered under occlusal splint therapy), dental sealants, orthodontia, or other dental appliances regardless of the symptoms or illness being treated* • *Osseointegration (dental implants) and all related services*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Drug Benefits Management Program	We have arranged with Plan Pharmacies to assist in managing the usage of certain kinds of drugs, including drugs listed in the HMSA Select Prescription Drug Formulary. We have identified certain kinds of drugs listed in the HMSA Select Prescription Drug Formulary that require precertification. The criteria for precertification are that: • The drug is being used as part of a treatment plan; • There are no equally effective drug substitutes; and • The drug meets the "medical necessity" criteria and other criteria as established by us. Step Therapy is another type of precertification. Before we cover selected medications, you may be required to try one or more specific drugs to treat a particular condition. Quantity Limitation. Certain medications may be covered up to a certain quantity. This quantity is not to exceed the FDA maximum recommended dose. Doses that exceed the quantity limits are subject to precertification. Daily Allowable Consumption (DACON). You are limited to no more than one tablet per day of certain once-daily dosed medications. A list of these drugs in the HMSA Select Prescription Drug Formulary has been distributed to all participating providers.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	Plan Pharmacists will dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the Plan pharmacist may dispense a maximum 90-day supply or fraction thereof after confirming that: • You have tolerated the drug without adverse side effects that may cause you to discontinue using the drug, and • Your doctor has determined that the drug is effective.
Routine Care Associated With Clinical Trials	Routine care associated with clinical trials is covered in accord with criteria established by us. These services require precertification. Please refer to the precertification information shown in Section 3.

Section 5(i). Point of Service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care. When you obtain covered non-emergency medical treatment from a non-Plan doctor, you are subject to a higher copayment/coinsurance.

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

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

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(g))

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 costs. 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/copayment amounts 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 even after you have met the out-of-pocket maximum:

- Dental Care
- Prescription Drugs

- Vision Care
- Medical Foods
- Online Care

The following amounts do not count toward meeting your catastrophic protection out-of-pocket maximum and you must continue to be responsible for the amounts below even after you have met the out-of-pocket maximum.

- Payment for services subject to a maximum once you reach the maximum.
- The difference between the actual charge and the eligible charge that you pay when you receive service from a non-Plan provider.
- Payments for non-covered services.
- Any amounts you owe in addition to your coinsurance/copayment for covered services.

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. See Section 5(d) for your coinsurance for services from a non-Plan provider.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 808-948-6499.

CancerCare Plan

CancerCare provides benefits to a person who is diagnosed with cancer or 34 other specified diseases. The Plan pays cash benefits directly to you over and above any health plan coverage, and is designed to help pay for any out-of-pocket medical expenses and many non-medical expenses such as rent or mortgage, utility bills, etc.

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

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

Coverage is underwritten by USAble Life and is available locally through Benefit Services of Hawaii, Inc.

If you are a Hawaii resident under the age of 65, you can apply for coverage for yourself and your eligible family members. Please call us at 808-538-8900 for more information.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan provider 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 13-16.**

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 required according to accepted standards of medical, dental, or psychiatric practice;
- 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;
- Services, drugs, or supplies you receive without charge while in active military service;
- Treatments, services or supplies that are prescribed, ordered or recommended primarily for your convenience or the convenience of your provider;
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care; or
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types – Urgent care claims, Pre-service claims, and Concurrent review claims – usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims / requests and Section 10 for the definitions of these three types of claims.

The fourth type – Post-service claims – is the claim for payment of benefits after services or supplies have been received.

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 CMS-1500, Health Insurance Claim Form; facilities must file on the UB-04 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 payor – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

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

For Facility claims
HMSA-UB04 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

Filing a claim for covered services (cont.)

Other supplies or services	**Submit your claims to:** **For Dental claims** **HMSA-Dental claims** **P.O. Box 1320** **Honolulu, Hawaii 96801-1320** **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.
Urgent care claims procedures	If you have an urgent care claim, please contact our Medical Management Department at 808-948-6464 on Oahu or 1-800-344-6122 toll-free from the Neighbor Islands. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier. We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.
Concurrent care claims procedures	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
Pre-service claims procedures	As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

Please 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 required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit our Web site at www.hmsa.com/portal/fedplan87/.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; b) Send your request to us at: Hawaii Medical Service Association, Attn: Appeals Coordinator, P.O. Box 1958, Honolulu, Hawaii 96805-1958 (for Dental, send your request to P.O. Box 1320, Honolulu, Hawaii 96801-1320); c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by giving us your email address, we may be able to provide our decision more quickly.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care) or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial – go to step 4; or c) 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.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

The disputed claims process *(continued)*

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision;
- 120 days after you first wrote to us - if we did not answer that request in some way sithin 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Operations, Health Insurance (HI) 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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 you did not indicate that your claim was a claim for urgent care, then call our Medical Management Department at 808-948-6464 on Oahu or 1-800-344-6122 toll-free from the Neighbor Islands. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM’s Health Insurance (HI) 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. If a plan has no coordination rules, that plan will pay first.

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

When we are the secondary payor, we will pay after the primary plan pays. Payment will not exceed the amount this plan would have paid if it had been your only coverage. Additionally, when this plan is secondary, benefits will be paid only for those services or supplies covered under this plan.

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; and
- 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) 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, 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, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. We will coordinate benefits under this Plan up to the Medicare approved charge not to exceed the amount this Plan would have paid if it had been your only coverage. If you are entitled to Medicare benefits, we will begin paying benefits after all Medicare benefits (including lifetime reserve days) are exhausted. If you receive inpatient services and have coverage under Medicare Part B only, or have exhausted your Medicare Part A benefits, we will pay inpatient benefits based on our eligible charge less any payments made by Medicare for Part B benefits (i.e., for inpatient lab, diagnostic, and x-ray services). To find out if you need to do something to file your claim, call us at 808-948-6499 or see our Web site at www.hmsa.com/portal/fedplan87/.

We waive some costs if the Original Medicare Plan is your primary payor – 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 payor, 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.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) or at 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
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...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
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	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*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 TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

If you are participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 17.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 17.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance/copayments) for the covered care you receive.

Covered services

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

Custodial care

Helps you meet your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Custodial care lasting 90 days or more is sometimes known as long term care.

Deductible

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

Eligible Charge

The eligible charge for most medical services, 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.

For participating facilities, we calculate our payment based on the *maximum allowable fee*. Your coinsurance is based on the lower of the facility's actual charge or the *maximum allowable fee*. Your coinsurance and our payment will equal the maximum allowable fee.

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

- For most services, supplies, or procedures, we consider:
  - increases in the cost of medical and non-medical services in Hawaii over the previous year;
  - the relative difficulty of the services compared to other services;
  - changes in technology; and
  - payment for the service under federal, state, and other private insurance programs.

- For some facility-billed services (not to include practitioner-billed facility services), we use a per case, per treatment, or per day fee (per diem) rather than an itemized amount (fee for service). For Non-Plan hospitals, our maximum allowable fee for all-inclusive daily rates established by the hospital will never exceed more than if the hospital had charged separately for services.

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

Experimental or investigational service

Services, supplies, devices, procedures, drugs, or treatment that is not yet accepted as common medical practice.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity also referred to as Payment Determination Criteria

All care you receive must meet all of the following Payment Determination Criteria:

- For the purpose of treating a medical condition.
- The most appropriate delivery or level of service, considering potential benefits and harms to the patient.
- Known to be effective in improving health outcomes, provided that:
  - Effectiveness is determined first by scientific evidence;
  - If no scientific evidence exists, then by professional standards of care; and
  - If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion.
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services which are experimental or investigational and which are not known to be effective in improving health outcomes do not meet Payment Determination Criteria.

Definitions of terms and additional information regarding application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Requests should be submitted to HMSA's Customer Service Department.

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.

Except for BlueCard participating and BlueCard PPO providers, participating providers may not bill or collect charges for services or supplies that do not meet HMSA's Payment Determination Criteria unless a written acknowledgement of financial responsibility, specific to the service, is obtained from you or your legal representative prior to the time services are rendered.

Participating providers may, however, bill you for services or supplies which are excluded from coverage without obtaining a written acknowledgement of financial responsibility from you or your representative.

You may ask your physician to contact us to determine whether the services you need meet our Payment Determination Criteria or are excluded from coverage before you receive the care.

Post-service claims Any claims that are not pre-service claims. in other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Medical Management Department at 808-948-6464 on Oahu or 1-800-344-6122 toll-free from the Neighbor Islands. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to HMSA

You You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

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/health for enrollment information 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 Benefits*, 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;
- What happens 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. For information on your premium deductions, you must also contact your employing or retirement office.

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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster Children	Foster children are eligible for coverage up to age 26.

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, 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 26 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns age 26.

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 2011 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 2010 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

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 for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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.

- **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 26, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

- **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; 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.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

Notes

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Summary of benefits for the HMSA Plan - 2011

- **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
Medical services provided by physicians:		
• Physician visits	$15 copayment	21
• Other diagnostic and treatment services provided in the offfice	Nothing for laboratory and pathology services; 20% of eligible charges for X-rays	21
Services provided by a hospital:		
• Inpatient	Nothing	41
• Outpatient	20% of eligible charges	42
Emergency benefits:		
• In-area	$15 physician visit copay; $50 emergency room facility copay; Nothing for laboratory tests; and 20% of eligible charges for other emergency services	45
• 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	46
Mental health and substance abuse treatment:	$15 copayment for professional services and medication management; Nothing for diagostic tests, psychological testing, and laboratory tests; $100 per inpatient admission; and Nothing for partial hospitalization and outpatient facility	48
Prescription drugs:	$7 copayment for Tier 1 (generic drugs) $30 copayment for Tier 2 (single-source generic and preferred brand drugs) $65 copayment for Tier 3 (other brand drugs) $75 copayment for Tier 4 (specialty drugs)	53
Dental care:	Nothing for preventive dental care	57
Vision care:	20% of eligible charges for an annual vision exam	28
Point of Service benefits - Yes		61
Protection against catastrophic costs (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	17

2011 Rate Information for the 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 Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Services employees. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

All of Hawaii

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	871	$156.53	$52.18	$339.16	$113.05	$176.36	$32.35
High Option Self and Family	872	$348.43	$116.14	$754.93	$251.64	$392.56	$72.01