

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

**Serving:** All of Hawaii

**Enrollment code:**

**871 Self Only**  
**872 Self and Family**

**Service area:** Services from Plan providers are available only in the following area:  
The islands of Hawaii, Kauai, Maui, and Oahu

**Enrollment area:** You must live in the state of Hawaii to enroll in this Plan.

## Hawaii Medical Service Association Plan

The Hawaii Medical Service Association, **an independent licensee of the Blue Cross and Blue Shield Association**, 818 Keeaumoku Street, Honolulu, Hawaii 96814 has entered into a contract (CS 1058) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Hawaii Medical Service Association Plan, HMSA, or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1997, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at **948-5166** and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE  
202/418-3300

The Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, N.W. Room 6400 Washington, C  
Washington, D. C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page xx. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

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General Information continued

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care

setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

### Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

### Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, **except for emergency benefits.**

- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.
- Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

#### Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

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 General Information continued

#### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

## Notification and election requirements

Separating employees – Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children – You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses – You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

**Important:** The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

## Conversion to individual coverage

When none of the above choices are available – or chosen – when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must

apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

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 Facts about this Plan

**This Plan is a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive.**

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan places great emphasis on preventive benefits such as office visits, physicals, immunizations and well-child care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

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

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

Participating providers will file their claims with the Plan. When services are provided by non-Plan providers, you must file a claim with the Plan and payment will be sent to you. Claim forms are available from the Plan by calling the Plan at **808/948-6499**.

**Benefit payments for covered services received out-of-area are based on the contract negotiated between the out-of-area Blue Cross and/or Blue Shield plans and their participating hospitals and doctors. Such contracts have**

copays that are based on the discounted charges negotiated by the out-of-area Blue Cross and/or Blue Shield plan or copays that are based on the hospital or doctor's actual charges. You will have lower copays for covered services when the contracted amount is based on the hospital or doctor's discounted charges rather than if the contracted amount is based on the hospital or doctor's actual charges. You are encouraged to contact the out-of-area Blue Cross and/or Blue Shield plans for information regarding specific hospitals or doctors in their areas. Benefit payments for covered services rendered outside Hawaii by hospitals or doctors who are not Blue Cross and/or Blue Shield plan participating hospitals or doctors are based on the eligible charges for the same or comparable services rendered by non-Plan hospitals or doctors in Hawaii.

(Eligible charges are those charges that conform to the standards HMSA uses to calculate a benefit payment for a covered service - charges for most medical care are based on the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, or the charge listed on a schedule of maximum allowable charges.)

#### Role of a primary care doctor

The first and most important decision each member should make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained.

#### Choosing your doctor

The Plan's provider directory lists (**generally family practitioners, pediatricians and internist**), with their locations and phone numbers, **and notes whether or not the doctor is accepting new patients**. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at **808/948-6499**. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

In the event a member is receiving services from a doctor who terminates a participation agreement, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

#### Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you should contact your primary care doctor for a referral before seeing any other doctor or obtaining special services.

When you receive a referral from your primary care doctor, you should return to the primary care doctor after the consultation. On referrals, the primary care doctor may give specific instructions to the consultant as to what services are needed. If additional services or visits are suggested by the consultant, you should first check with your primary care doctor. **If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.**

#### Hospital care

If you require hospitalization, your primary care doctor or specialist will make the necessary arrangements and continue to supervise your care.

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Facts about this Plan continued

#### Deductibles

##### Calendar year

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

##### Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

#### Other

If you did not meet the deductible for the previous calendar year, any portion of the deductible paid during the last three months of the previous calendar year (i.e., October, November, and December) may be carried over to meet the deductible for the current calendar year. This carryover provision does not apply if Major Medical Benefits were paid in the previous calendar year.

#### Out-of-pocket maximum

The Plan has established a copayment maximum of \$2,500 per member per calendar year of total copayment charges for Major medical benefits covered by the Plan. This copayment maximum includes the \$250 deductible. After the \$2,500 maximum is reached, you pay nothing for Major medical eligible charges.

#### Lifetime maximum

There is a lifetime maximum of \$10,000 under Major medical benefits for inpatient psychiatric treatment. There is a separate lifetime maximum for private duty nursing of \$2,000 per person.

#### Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

#### The Plan's service and enrollment areas

The service area for this Plan, where Plan providers and facilities are located, is the same as the enrollment area listed on the front cover of this brochure (the area in which you must live to enroll in the Plan).

If you or a member of your family travels frequently or if a member lives away from home part of the year, you should be aware that benefits for care outside the area may be limited, see page 5 for details.

If you or a covered family member move outside the Enrollment Area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

#### General Limitations

## Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. (Determinations concerning medical necessity of services provided by non-Plan doctors are made by the Plan.) No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. **This brochure is based on text included in the contract between OPM and this Plan and is a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.**

## Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

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 General Limitations continued

### Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

### Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

### Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One Plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

#### CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

#### Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

#### Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency

under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured from the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or is entitled to that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. **If you need more information about subrogation, the Plan will provide you with its subrogation procedures.**

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General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition. The following are excluded:

- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program

- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

## Medical and Surgical Benefits

### What is covered

#### Basic benefits

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

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

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

- Surgery (cutting)
- Non-cutting surgery (diagnostic endoscopic procedures; diagnostic and therapeutic injections, including catheters; orthopedic castings; acne treatment; and destruction of localized lesions by chemotherapy, cryotherapy or electrosurgery)
- Podiatric services
- Immunizations and boosters
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a doctor or a certified nurse-midwife. The eligible charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery,

these payments will be considered an advance of payment and will be deducted from the maximum allowance for delivery. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.

- Voluntary sterilization **and** family planning services
- Diagnosis and treatment of diseases of the eye (diagnostic tests covered under "Outpatient X-ray and laboratory benefits section" - see page 10)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, kidney, single/double lung, heart/lung, pancrea/s kidney, and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions; acute lymphocytic or non-lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer, multiple myeloma, and epithelial ovarian cancer. Transplant coverage for breast cancer, multiple myeloma and epithelial ovarian cancer is subject to approval by the Plan based on protocols established by the National Cancer Institute (NCI). Related medical and hospital expenses of the donor are covered.

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

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

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## Medical and Surgical Benefits continued

### What is covered (continued)

- Dialysis
- Surgical treatment of morbid obesity
- Home health services, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- Up to 150 visits per calendar year for home health services of nurses and health aides from a Plan approved home health care agency, when medically necessary and prescribed by your doctor, who must certify that you are homebound due to illness or injury and periodically review the program for continuing appropriateness and need

### Limited benefits

Well-child care is limited to six visits during the first 12 months, two visits during the next 12 months, one visit each year during ages 2 through 12, and appropriate immunizations and laboratory tests in accordance with prevailing medical standards.

Routine health appraisals are limited to one check-up every year; only routine laboratory tests and X-rays are covered during the exam and they are paid at 50% of eligible charges. Routine health appraisals may be substituted with the Plan's HealthPass benefit. Under HealthPass, members may obtain through Plan providers an annual health risk assessment and follow-up visits as necessary for education programs, diagnostic screening and physical examinations.

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

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

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

Outpatient X-rays, laboratory tests, radiation therapy, and routine screening by low-dose mammography are covered at 50% of eligible charges,

with the following exceptions: X-rays ordered within 48 hours following an injury are covered at 100% of eligible charges; and radiation therapy in the treatment of malignant conditions is covered at 100% of eligible charges; benefits will only be paid for routine chest X-ray, urinalysis, complete blood count, pap smear, and tine test when part of annual health appraisals. Laboratory tests in connection with well-child care visits are limited to the following tests through age 12: two tuberculin tests (tine or skin sensitivity), three blood tests (hemoglobin or hematocrit) and three urinalysis. Screening by low-dose mammography is limited to one baseline mammogram for women ages 35 through 39, one mammogram every two years for women ages 40 through 49, and one mammogram every 12 months for women 50 years of age and older. In addition, a woman with a history of breast cancer, or whose mother or sister has had a history of breast cancer, is eligible for a mammogram under this benefit at any age upon the recommendation of the woman's physician.

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

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

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Diagnosis and treatment of infertility is covered; Artificial insemination is covered; Cost of donor sperm is not covered. Fertility drugs are **not** covered. Other assisted reproductive technology (ART) procedures such as embryo transfer are not covered, except one in vitro fertilization per qualified married couple **per lifetime** (diagnostic procedures are covered under "Medical and Surgical Limited benefits - Outpatient X-rays and laboratory tests;" treatment services are covered under "Medical and Surgical-Basic benefits").

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 Medical and Surgical Benefits continued

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel

- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids (**covered under Major Medical Benefits**)
- Foot orthotics, **except for specific diabetic conditions**
- Chiropractic services
- Homemaker services
- Radial keratotomy
- Treatment of TMJ dysfunction

Special Notice: Many services that are not listed in the Medical and Surgical section or the Hospital/Extended Care section are covered as Major medical benefits (see page 16). In addition, Major medical benefits will provide additional benefits for many services listed under the Medical and Surgical section or the Hospital/ Extended Care section.

#### Hospital/Extended Care Benefits

##### What is covered

##### Hospital care

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

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

##### Extended care

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

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

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

#### Hospice care

Supportive and palliative care for a terminally ill member is covered by a Plan hospice agency for up to 150 continuous days of service. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

#### Birthing center

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

#### Ambulance service

Automobile ambulance service to and between hospitals is paid at 100% of eligible charges (see page 16 -17 --- Major medical benefits" for air ambulance service).

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Hospital/Extended Care Benefits continued

#### Limited benefits

##### Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services, unless the services

are covered under dental benefits. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

#### Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the doctor determines that outpatient management is not medically appropriate. See page 14 for nonmedical substance abuse benefits.

#### Ambulatory surgical center or outpatient hospital

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

#### What is not covered

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

#### Emergency Benefits

##### What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

##### Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. Your primary care doctor will provide the necessary care, refer you to other Plan providers or make arrangements with other providers. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest

hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

**If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. 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 the service area**

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

### **Emergencies outside the service area**

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

#### What is covered

- . Emergency care at a doctor's office or an urgent care center
- . Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- . Ambulance service (see page 11 "Hospital/Extended Care Benefits" -- for automobile ambulance, and pages 16-17 "Major medical benefits" -- for air ambulance)

#### Filing claims for non-Plan providers

Participating providers will file their claims (submitted on the HCFA 1500 claim form) with the Plan. When services are provided by non-Plan providers, you must file a claim with the Plan and payment will be sent to you. Claim forms are available from the Plan by calling the Plan at 808-948-6499. Submit itemized bills and your receipts to the Plan along with an explanation of the services and your claim form. A payment will be sent to you, unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. You may request reconsideration in accordance with the disputed claims procedure set forth on page 19.

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Mental Conditions/Substance Abuse Benefits

Mental conditions

## What is covered

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

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

## Outpatient care

Up to 20 outpatient visits to doctors, consultants, or other psychiatric personnel each calendar year; If you use Plan providers—You pay a 20% copay of eligible charges for diagnostic evaluation and psychiatric treatment and a 50% copay of eligible charges for psychological testing.

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

Approval from the Plan's Benefit Manager must be obtained in advance for mental conditions **or substance abuse** services recommended by a non-Plan provider. If review by the Benefit Manager is not obtained, any benefits otherwise payable will be reduced by \$300. See below for details.

## Inpatient care

Up to 30 days of hospitalization each calendar year; additional benefits for inpatient psychiatric care available under Major medical benefits (see page 16-17);

If you use Plan providers—You pay nothing for up to 30 days of hospitalization. In addition, services of a Plan psychiatrist or psychologist in an inpatient setting are paid at the same benefit rate as outpatient care for up to 30 visits per calendar year.

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

Approval from the Plan's Benefit Manager must be obtained in advance for mental conditions **or** substance abuse services recommended by a non-Plan provider. If review by the Benefit Manager is not obtained, any benefits otherwise payable by the Plan for the services in question will be reduced by \$300.

You are required to contact the Plan's Benefit Manager for a review when services for treatment of mental conditions or substance abuse are recommended by a non-Plan provider. Call the Benefit Manager on Oahu at 808/948-6464. Neighbor Islands, call toll-free at 1-800/344-6122. In case of emergency, you, your physician, or a member of your family must contact the Benefit Manager within 24 hours or on the first working day thereafter, whichever is later. The Benefit Manager will be available 24 hours a day.

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

If you do not contact the Benefit Manager and obtain a review before obtaining mental conditions/substance abuse services recommended by a non-Plan provider, benefits otherwise payable by the Plan for those services will be reduced by \$300.

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

What is not covered

- Care for psychiatric conditions that in the professional judgment of the Plan are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by the Plan to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

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Mental Conditions/Substance Abuse Benefits continued

Substance abuse

What is covered

This Plan provides detoxification services (see page 11 for Acute inpatient detoxification) and diagnosis and treatment of alcohol and drug dependence or abuse. You are eligible for two treatment programs per lifetime—a treatment program is an admission for treatment under a plan designed to produce remission in those who complete treatment. A complete program includes assessment and referral, initial rehabilitative care (up to 30 days), and aftercare (up to 30 hours). Once you start your first treatment program, the entire program must be completed within 12 months.

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

You pay a 20% copay of eligible charges for covered inpatient and outpatient services if a Plan provider is used; if a non-Plan provider is used, you pay any difference between the Plan's payment and the actual charges, including a 30% copay of eligible charges for covered services. You pay all charges after two authorized treatment programs.

The Plan has contracted with a limited number of providers to become program providers of substance abuse services. Benefits for a Plan provider shall be paid only for services rendered by such program providers.

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

Approval from the Plan's Benefit Manager must be obtained in advance for substance abuse services recommended by a non-Plan provider. See page 13 for details. If review by the Benefit Manager is not obtained, any benefits otherwise payable by the Plan for the substance abuse services in question will be reduced by \$300. No benefits will be provided for substance abuse services recommended by a non-Plan provider which would not have been approved if the Benefit Manager's review had been obtained.

Prescription Drug Benefits

## What is covered

Prescription drugs prescribed by a doctor and obtained at a pharmacy will be dispensed with a maximum limit of a 30-day supply **or fraction thereof**, and paid upon submission of a claim to the Plan. When certain generic drugs which are recognized by the Plan for extended dispensing limits are prescribed in quantities of 100 units or a 60-day supply **or fraction thereof**, whichever is greater, a single copay charge will apply.

If you use a Plan pharmacy –You pay a \$2 copay per prescription unit or refill for generic drugs; a \$7 copay for preferred drugs; a \$10 copay for other name brand drugs costing less than \$50; and a 20% copay of eligible charges for other name brand drugs costing more than \$50.

If you use a non-Plan pharmacy –You pay any difference between the Plan's payment and the actual charge, including a 20% copay of the remaining eligible charges after a \$5 copay per prescription unit or refill for generic drugs; a \$7 copay for preferred drugs; and a \$10 copay for other name brand drugs.

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

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

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

Participating pharmacists may also dispense a maximum of a 30-day supply or fraction thereof for first time prescriptions of maintenance drugs. For subsequent refills, the participating pharmacist may dispense a maximum 90-day supply or fraction thereof after confirming that you have tolerated the drug without adverse side effects that may cause you to discontinue using the drug and your doctor has determined that the drug is effective.

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

If you use the Mail Order Drug Program –You pay a \$2 copay per prescription unit or refill for generic drugs and a \$7 copay for name brand drugs.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Digitalis
- Insulin **when obtained by prescription**, with a copay charge applied to each 30-day supply **or fraction thereof**

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 Prescription Drug Benefits continued

What is covered (continued)

- Diabetic supplies, including insulin syringes, needles, lancets, auto-lancet devices, glucose test tablets and test tape, and acetone test tablets
- Disposable needles and syringes needed to inject covered prescribed medication (only available at a Plan pharmacy); you pay 20% of eligible charges
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits. (only available at a Plan pharmacy); you pay 20% of eligible charges
- Nicotine patches for the cessation of smoking; limited to one treatment cycle per calendar year, with a limit of two treatment cycles per member per lifetime

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Medical supplies such as dressings, antiseptics and spacers for inhaled drugs
- Oral and injectable contraceptive drugs (unless used for hormonal disorder) or devices
- Vitamins, minerals, and nutritional substances
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, except nicotine patches

- Implanted contraceptive drugs, such as Norplant
- **All drugs related to the diagnosis or treatment of infertility**

#### Other Benefits

#### Dental care

#### What is covered

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

Services	If you use Plan dental center or Plan provider, you pay:	If you use non-Plan provider, you pay:
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Preventive dental care

Annual exam/visit; annual cleaning (prophylaxis)

Nothing

30% of eligible charges plus balance of actual charges

Standard dental services

For permanent teeth only: x-rays (2 annual bite wings and one full mouth series every 5 years); fillings (amalgam & silicate, you pay surcharge for gold); extractions; root canal treatment; treatment for diseases of the gum; space maintainers; anesthesia

30% of eligible charges

50% of eligible charges plus balance of actual charges

Dental surgery

Incision and drainage of abscess; alveolectomy; excision of cysts

30% of eligible charges

50% of eligible charges plus balance of actual charges

Occlusal Splint Therapy

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

Coverage of occlusal splint therapy is subject to the following limitations: a removable acrylic appliance is used in conjunction with the therapy; the disorder is present at least one month prior to the start of the therapy and the therapy does not exceed ten weeks; the therapy does not result in any irreversible alteration in the occlusion, and is not intended to be for the treatment of bruxism, for the prevention of injuries of the teeth or occlusion, or is related to other treatment of the occlusion; the benefit is limited to one treatment episode per lifetime; and the member must be 15 years of age and above.

### Accidental injury benefit

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

#### What is not covered

- All other dental services, including topical application of fluoride
- Dental appliances, such as false teeth, crowns, and bridges
- 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

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### Other Benefits continued

#### Vision care

##### What is covered

**In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, an annual vision exam and eye refraction (to provide a written lens prescription for eyeglasses) may be obtained.**

If you use Plan optometrists—You pay no more than \$7. If you use other Plan providers—You pay 20% of eligible charges. If you use non-Plan providers—You pay any difference between the Plan's payment and the actual charges, including a 30% copay of eligible charges for the eye refraction.

##### What is not covered

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

#### Cardiac rehabilitation

##### What is covered

Cardiac rehabilitation programs are covered at 50% of eligible charges, not to exceed a maximum Plan payment of \$300 per program. You pay 50% of eligible charges, plus all costs after the Plan maximum benefit has been paid, whether a Plan or non-Plan provider is used. Members must be referred

by their doctor for cardiac rehabilitation within three months after coronary bypass surgery or diagnosis of acute myocardial infarction, angina pectoris, or coronary disease. There is a lifetime maximum of two complete programs. Each program must consist of planned exercise to rehabilitate and strengthen the heart and education to provide information and motivation for behavior/lifestyle changes. Each treatment program must be completed within 180 days; no benefits are paid if the program is not completed.

### Major medical benefits

In addition to benefits described elsewhere in this brochure, Major medical benefits are paid for the services and supplies listed below. Each person must meet the \$250 deductible before he/she can receive reimbursement under Major medical benefits. Only eligible charges for services and supplies that are listed below and not covered by other Plan benefits count toward the deductible. Once the deductible is met, the Plan will add the Major medical benefit payment to benefits otherwise payable to cover the major portion of most allowable expenses. (See page 7 for additional information.) If you use Plan providers—You pay a 20% copay of eligible charges under Major medical benefits, after the \$250 deductible is met. If you use non-Plan providers—You pay any difference between the Plan's payment and the actual charges, including a 30% copay of eligible charges under Major medical benefits, after the \$250 deductible is met. After you have paid \$2,500 in Major medical eligible charges during a calendar year, you pay nothing for Major medical eligible charges for the rest of that calendar year.

### What is covered

- Doctor's visits, surgery and anesthesiology
- Hospital expenses
- Laboratory tests, audiograms, X-rays, allergy testing, radiotherapy and chemotherapy
- Blood and blood products, including cost of administration and blood bank service charges. Any additional charges for autologous blood (reserved for a beneficiary who donated the blood) are excluded as a benefit.
- Short-term physical and speech therapy when rendered by a registered/certified physical or speech therapist, and ordered by a doctor in an individualized treatment plan for restoration of a function impaired by illness or injury. Services of an occupational therapist are covered as physical therapy if the service is also performed by a physical therapist. Long-term maintenance therapy programs are not covered.

- Outpatient services and supplies for the injection or intravenous administration of either medication or nutrient solutions required for primary diet
- Prosthetic devices, such as artificial limbs and lenses following cataract removal; orthopedic devices, such as braces; rental or purchase of durable medical equipment, such as wheelchairs and hospital beds
- Air ambulance service limited to inter-island transportation within the state of Hawaii, from place where injury occurred or illness first required care, to nearest facility equipped to render proper care
- Hospitalization for dental surgery as a result of accidental injury or because of medical condition that makes hospitalization necessary
- Inpatient psychiatric care to a lifetime non-renewable maximum of \$10,000 as a Major medical benefit, in addition to the benefits shown on page 13

- **Hearing aids (one device per ear every 5 years)**

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#### What is not covered

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

#### Non-FEHB Benefits Available to Plan Members

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

#### CancerCare Plan

A known fact: Cancer strikes at any age and is the second leading cause of death in Hawaii.

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

CancerCare provides inpatient and outpatient benefits for cancer and 30 specified diseases. The plan pays cash benefits directly to you regardless of any other coverage you may already have. The extra funds can help pay for any out-of-pocket medical expenses and many non-medical expenses such as rent or mortgage, utility bills, etc.

Plan Features:

Hospital confinement

Surgery

Experimental treatment

Radiation/Chemotherapy

Blood Plasma

Transportation cost

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

If you are a Hawaii resident under the age 65, you can apply for coverage for yourself and your eligible family members. Please call us at 592-2100 for more information.

Long-term care

If an unforeseen long-term debilitating illness should strike you tomorrow, will you be prepared to pay for it?

With HMSA's long-term care plan, you have the flexibility of protecting your assets and your family's income while getting the care you need.

Our Plan offers you:

- Care at home option—provides benefits for nursing care, daily activity support, care at adult day centers and other care in your home.
- Comprehensive care option—provides you broader coverage in a full range of settings for times when you need both nursing home and home care.

If you are a Hawaii resident age 30 through 79, and concerned about your future long-term care needs, HMSA's long-term care plan may be the answer you're looking for.

For an individual appointment, group seminar or more information, please call your HMSA long-term care consultant at 948-6270.

Rates vary depending on your age, the type of plan, and the options you elect.

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

Benefits on this page are not part of the FEHB contract

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How to Obtain Benefits

#### Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Membership Services Office at one of the following locations: 818 Keeaumoku Street, Honolulu, Oahu, Phone 948-6499; 33 Lono Avenue, Suite 350, Kahului, Maui, Phone 871-6295; 670 Ponahawai Street, Suite 121, Hilo, Hawaii, Phone 935-5441; 75-167 Hualalai Road, Kailua-Kona, Hawaii, Phone 329-5291; 4366 Kukui Grove Street, Kukui Executive Center Phase II, Suite 103, Lihue, Kauai, Phone 245-3393.

#### Disputed claims review

#### Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after

receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

#### OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division , P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement – If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

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How HMSA Plan Changes January 1997

Do not rely on this page; it is not an official statement of benefits.

#### Clarifications

- The brochure has been clarified to show that procedures, services, drugs and supplies related to abortions are excluded 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.
- Under transplant benefits in the "Medical and Surgical Benefits" provision, single/double lung, heart/lung and pancreas/kidney transplants have been added to the list of other covered transplants under the conditions stated in the brochure.

- The definition of "Eligible Charges" has been revised to indicate that charges for most medical care are based on the lower of the actual charge on the claim, the discounted charge negotiated by the Plan, or the charge listed on a schedule of maximum allowable charges.
- The brochure has been clarified to show the requirements for deductible carryover.
- References to "Organ Transplants" have been revised to "Transplants," as not all transplants may involve solid organs.
- The brochure has been clarified to show the benefit limitations regarding Prostate Specific Antigen tests. Previously, this coverage was not shown.
- The brochure has been clarified to show that all drugs related to the diagnosis or treatment of infertility are not covered. Also listed is the "per lifetime" limitation of one in vitro fertilization per qualified married couple.
- The brochure has been clarified to show that "Foot Orthotics" is not covered except for specific diabetic conditions.
- The "Vision Care" provision has been clarified to show that an annual eye refraction (to provide a written lens prescription for eyeglasses) may not be obtained without a vision exam.
- The brochure has been clarified to show that "Hearing Aids (one device per ear every 5 years)" are covered under the "Major Medical Benefits" provision.
- The "Major Medical Benefits" provision now shows benefits and services that are not covered covered under this provision. Previously, excluded benefit were not shown.
- The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.
- Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.
- General Information When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the old plan, benefits under the new plan will begin for other family members on the effective date of the new enrollment.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition.

- Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).
- Temporary continuation of coverage (TCC) for employees or family member who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.
- "Conversion to individual coverage" does not require evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.
- The benefit "Nonexperimental implants" is now termed "The insertion of internal prosthetic devices."

#### Other changes

- Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.
- The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be determined by the Office of Workers Compensation Programs (OWCP) or an equivalent agency to be payable under workers' compensation or similar Federal or State law. The Plan is entitled to be reimbursed by OWCP for services it provided that were later found to be payable by OWCP or the agency.
- Disputed claims If your claim for payment or services is denied by the Plan, and you decide to ask OPM to review that denial, you must first ask the Plan to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.

Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim only with your written consent. Any lawsuit to recover benefits on a claim for

**treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.**

Summary of Benefits for HMSA Plan - 1997

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

SEE BROCHURE FOR DETAIL OF REDUCED PAYMENT FOR NON-PLAN PROVIDERS.

Benefits	Plan pays/provides	Page
Inpatient Care		
Hospital		
Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing for services of Plan providers.....		11-12
Extended care		
All necessary services up to 100 days per year. You pay nothing for services of Plan providers.....		11
Mental conditions		
Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing for Plan hospital services and a 20% copay of eligible charges for inpatient visits by Plan providers.....		13
Substance abuse		
Medical complications and acute detoxification covered under hospital benefits. Lifetime maximum of two 30-day substance abuse rehabilitation programs (includes inpatient residential and outpatient care); you pay a 20% copay of eligible charges for services of Plan providers.....		14

## Outpatient care

Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care, preventive care, including well-child care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay nothing for surgery (cutting) and well-child care immunizations; a 20% copay of eligible charges for non-cutting surgery, medical services and anesthesiology; a 50% copay for laboratory tests and X-rays.....9-11

## Home health care

Up to 150 visits per calendar year by nurses and health aides. You pay a 20% copay of eligible charges for services of Plan approved providers.....10

## Mental conditions

Up to 20 outpatient visits per year; you pay a 20% copay of eligible charges for diagnosis and treatment, and a 50% copay of eligible charges for psychological testing, for services of Plan providers.....13

## Substance abuse

Lifetime maximum of two substance abuse rehabilitation programs (includes inpatient residential and outpatient care); up to 30 days initial rehabilitative care and up to 30 hours after-care per program; you pay a 20% copay of eligible charges for services of Plan providers.....14

## Emergency care

Eligible charges for services and supplies required because of a medical emergency, to the extent these services would have been covered if received from Plan providers. You pay applicable copays as if routine services were rendered by Plan providers, regardless of whether a Plan or non-Plan provider is used, and any charges for services that are not covered benefits of this Plan.....12

## Prescription drugs

Drugs prescribed by a doctor and obtained at a Plan pharmacy. You pay a \$2 copay for generic drugs; a \$7 copay for preferred drugs; a \$10 copay for other name brand drugs costing less than \$50; and a copay of 20% of eligible charges for other name brand drugs costing more than \$50.....14-15

## Dental care

Accidental injury benefit; preventive dental care, and other services. You pay copayments for most services.....15

Vision care

One refraction annually. You pay 20% copay of eligible charges for Plan providers per refraction; if you use Plan optometrists, you pay no more than \$7 per refraction.....16

Out-of-pocket maximum

Copayments are required for some benefits; however, the Plan has set a maximum of \$2,500 per member per calendar year for total Major medical copayments you must pay for services covered by the Plan. This copayment maximum only applies to services covered under Major medical benefits.....7

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