

HMSA's 50 Plus

HMSA's Health Plan for Group Members Age 50-64 Converting to Individual Coverage

January 2010



HMSA



An Independent Licensee of the Blue Cross
and Blue Shield Association

Working for a Healthier Hawaii

HMSA's Health Plan for 50 Plus Members

Good health is essential for happiness. That's why the health plan you select should offer more than just financial protection. HMSA's 50 Plus provides value, peace of mind and special benefits that can help you achieve and maintain a healthy, happy lifestyle.



50 Plus is a unique health maintenance organization (HMO) plan designed to ensure continuous HMSA coverage for active people age 50 through 64 who may not be eligible for employer group plan coverage. When you join 50 Plus, there are no waiting periods. With broad coverage for medical services, worldwide coverage, mail order maintenance drugs, and vision and dental care, we think you'll agree that 50 Plus is the right choice for you!

Here are just a few of the special features 50 Plus has to offer:

- **Guaranteed Membership**

If you apply within 31 days of the last day of your HMSA group plan membership, are a legal resident of the state of Hawaii with at least two years of continuous HMSA group plan coverage, and are not eligible for a group retiree plan, COBRA, QUEST, or any other government program, **your acceptance is guaranteed!**

- **Health Centers and Providers**

With 50 Plus, you and your eligible family members can each choose your own health center and personal care provider from our expansive network of specially contracted providers. Your personal care provider will work closely with you to coordinate your overall health care. This helps to avoid costly duplication of service and ensures that you receive the most appropriate care for your needs.

All services must be arranged through your personal care provider and health center.

- **Set Copayments**

50 Plus members pay predictable, fixed copayments for physician office visits and other basic health care services. Payments are made at the time of service with no additional billing. HMSA will reimburse your provider directly, so there's no paperwork.

- **Away From Home Care**

To meet your health care needs while you are away from home, your coverage offers benefits for short trips and/or long-term stays in other service areas through a program called Away From Home

Care. This program is sponsored by the Blue Cross and Blue Shield Association and uses BlueCard providers. While the participation of providers in this program is extensive, some service areas do not have participating BlueCard providers. In these service areas, Away From Home Care benefits are not available. For a list of urgent care providers outside the state of Hawaii, all you have to do is call BlueCard Access at 1 (800) 810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder website at www.BCBS.com.

For trips to other countries, benefits are not available unless your medical condition requires emergency services. You would be responsible for paying the provider directly and filing a claim with us.

- **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; and
 - Services that are not known to be effective in improving health outcomes include, but are not limited to, services which are experimental or investigational.

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.

BENEFIT SUMMARY

This brochure is for general information only. It is intended to give you a summary of HMSA's 50 Plus plan benefits and is not to be used as the certificate for the plan. Upon joining, members will receive a 50 Plus certificate, which gives further information on benefits, limitations and

exclusions. In the case of a discrepancy between this summary and the language contained in the certificate, the certificate will take precedence. All percentages listed in the benefit description are based on eligible charges, as defined on page 9.

BENEFIT DESCRIPTION

Your Copayment

ANNUAL COPAYMENT MAXIMUM

\$5,000 per person
\$15,000 per family

PHYSICIAN VISITS

Office visit	\$17 per visit
Home visit	\$25 per visit
Emergency room visit	\$25 per visit (statewide)/20% (out-of-state non-Blue Card)
Hospital or skilled nursing facility visit	\$17 per visit
Online Care visit	\$10 for up to 10 minutes \$5 for an additional 5-minute extension

PHYSICAL EXAMINATIONS

(Routine annual check up)	\$17
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SURGERY

Surgical procedures	20%
Anesthesia	20%

IMMUNIZATIONS

Member 18 years or younger	None
Member 19 years or older	\$10
Influenza and pneumococcal	None
Unexpected mass immunizations	50%

HOSPITAL AND FACILITY SERVICES

Room and board —Based on semiprivate room rates	20%*
Hospital ancillary services	20%
Outpatient facility	20%

EMERGENCY SERVICES

Emergency room facility	\$50 per visit (statewide or Blue Card provider) 20% (out-of-state non-Blue Card)
Ground and air ambulance	20%

*You may owe amounts in addition to your copayment.
Please refer to the plan *Guide to Benefits* for more information.

BENEFIT DESCRIPTION

Your Copayment

SKILLED NURSING FACILITY BENEFITS

Up to 60 days per benefit period based on semiprivate room rates

Room and board and other inpatient services 20%

TESTING, LABORATORY AND RADIOLOGY

Allergy testing and treatment materials \$17

Diagnostic tests 20% (office visit)
50% (hospital outpatient, ambulatory surgical center, or emergency room)
20% (hospital inpatient)

Evaluation for the use of hearing aids \$17

Genetic testing 20% (office visit)
50% (hospital outpatient, ambulatory surgical center, or emergency room)
20% (hospital inpatient)

Laboratory and pathology 20% (office visit)
50% (hospital outpatient, ambulatory surgical center, or emergency room)
20% (hospital inpatient)

X-ray and other radiology 20% (office visit, hospital outpatient, ambulatory surgical center, or emergency room)
20% (hospital inpatient)

HOSPICE CARE BENEFITS

Care for a terminal illness from a qualified hospice and hospice referral visits No copayment

HOME HEALTH CARE BENEFITS

Limited to 150 visits per calendar year from a qualified home health agency or health center \$25 per visit

MENTAL HEALTH AND SUBSTANCE ABUSE

Licensed Physician, Psychiatrist, Psychologist, Clinical Social Worker, Marriage and Family Therapist, Licensed Mental Health Counselor, or Advanced Practice Registered Nurse

Physician Visits

Outpatient sessions (24 sessions per calendar year)* 20%
Inpatient session (30 sessions per calendar year) 20%

Hospital/Facility Services

Based on semiprivate room rate 20%
(30 days per calendar year)

Psychological Testing

One series per calendar year 50% (outpatient)
20% (inpatient)

PRESCRIPTION DRUGS AND SUPPLIES

CHEMOTHERAPY – ORAL DRUGS

Chemotherapy – Oral

NETWORK PHARMACY

None

NON-NETWORK PHARMACY

You owe the entire charge and
HMSA reimburses you for 100% of the eligible charge

CONTRACTED MAIL-ORDER PHARMACY

None

DIABETIC DRUGS, SUPPLIES AND INSULIN

Diabetic drugs

NETWORK PHARMACY

\$5 (generic)
\$15 (preferred brand name)
\$15 copayment plus \$35 other brand name cost share
(other brand name)

NON-NETWORK PHARMACY

You owe the entire charge and HMSA reimburses you 80%
of the remaining eligible charge after deducting:

\$5 (generic)
\$15 (preferred brand name)
\$15 copayment plus \$35 other brand name cost share
(other brand name)

CONTRACTED MAIL-ORDER PHARMACY

\$10 (generic)
\$35 (preferred brand name)
\$35 copayment plus \$105 other brand name cost share
(other brand name)

Diabetic supplies

NETWORK PHARMACY

None (preferred brand name)
\$15 (other brand name)

NON-NETWORK PHARMACY

You owe the entire charge and HMSA reimburses you
100% of the remaining eligible charge after deducting:

None (preferred brand name)
\$15 (other brand name)

CONTRACTED MAIL-ORDER PHARMACY

None (preferred brand name)
\$35 (other brand name)

DIABETIC DRUGS, SUPPLIES AND INSULIN (CONTINUED)

Insulin

NETWORK PHARMACY

\$5 (preferred brand name)
\$15 (other brand name)

NON-NETWORK PHARMACY

You owe the entire charge and HMSA reimburses you 80% of the remaining eligible charge after deducting:

\$5 (preferred brand name)
\$15 (other brand name)

CONTRACTED MAIL-ORDER PHARMACY

\$10 (preferred brand name)
\$35 (other brand name)

HMSA has contracted with a limited number of providers to make prescription maintenance medications available to you by mail.

Call your nearest HMSA office listed on the back cover of this guide for a current contracted provider.

We will pay benefits up to \$500 per calendar year for Generic Maintenance Drugs for each member and dependent. This is referred to as your Maximum Annual Allowance. Once you reach your Maximum Annual Allowance, you may continue to order your generic prescription maintenance medication at the Special Member Rates.

MAINTENANCE DRUGS

Generic Maintenance Drug

Before Maximum Annual Allowance is reached

The lower of: \$10 copayment or Special Member Rate

After Maximum Annual Allowance is reached

Special Member Rates

Brand Name Maintenance Drugs

Special Member Rates

Other Health Care Products

Special Member Rates

Vision Care Benefits

Your Copayment

<i>BENEFIT DESCRIPTION</i>	Participating Provider	Nonparticipating Provider
Vision Exam	\$10 annual deductible	All charges over \$40
Single Vision Lenses	\$10 annual deductible	All charges over \$16
Multifocal Lenses	\$10 annual deductible	All charges over \$25
Polycarbonate Lenses for children <18 years old	None	All charges over \$18
Contact Lens Fitting	All charges over \$45	All charges over \$20
Contact Lenses	All charges over \$130 plus \$25 annual deductible	All charges over \$50
Frames - every 24 months	\$15 annual deductible	All charges over \$12

If lenses are replaced without furnishing a new frame, the total allowance for both a frame and lenses may not be used toward the cost of such lenses or the cost of contact lenses.

More than one procedure, service or supply may be appropriate for the diagnosis and treatment of your condition. In that case, we reserve the right to approve the least costly appropriate treatment, service or supply.

You may ask your physician to contact us to determine whether the services you need meet our payment determination criteria before you receive the care.

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

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.

Services Not Covered Under the Medical Plan

Your health care coverage does not provide benefits for certain procedures, services or supplies.

The following is an overview of some of the services not covered by this plan. Upon joining, you will receive a plan *Guide to Benefits*, which gives further information on benefits, limitations and exclusions that are not described in this summary. You may also request a *Guide to Benefits* for this plan by calling your local HMSA office before enrolling in this plan.

Services not covered under the medical plan include:

Counseling Services

- Bereavement counseling.
- Genetic counseling.
- Marriage or family counseling.
- Nutritional counseling.
- Sexual identification counseling.

Coverage Under Other Programs or Laws

- **Military:** You are not covered for treatment, illness or injury related to military service when you receive treatment in a hospital operated by an agency of the United States government. You are not covered for service or supplies that are required to treat an illness or injury received while you are on active status in the military service.
- **Payment responsibility:** You are not covered when someone else has the legal obligation to pay for your care, and when, in the absence of this coverage, you would not be charged.
- **Third-party reimbursement:** You are not covered for services or supplies for an illness or injury caused or alleged to be caused by a third party and/or you have or may have a right to receive payment or recover damages in connection with the illness or injury; or an illness or injury for which you may recover damages or receive payment without regard to fault.

Dental, Drug and Vision

- Dental care (including orthodontics).
- Drugs (except diabetic and maintenance drugs).
- Eyeglasses, contacts and appliances.
- Vision services (except for one exam).

Fertility and Infertility

- Contraceptives or contraceptive services including implanted, oral or injected contraceptives and contraceptive devices.
- Supplies or services related to the diagnosis of infertility.
- Infertility treatment.
- Fertilization by artificial means (except for one-time only in-vitro fertilization program per qualified married couple).
- Sterilization reversal.

Preventive and Routine

- Health appraisal program.
- Immunizations (except for those described in the plan's *Guide to Benefits*).
- Physical examinations (for employment and insurance).
- Routine circumcision.
- Routine foot care.

Provider Type

- Chiropractic services.
- Complementary and alternative medicine provider.
- Hospice (nonparticipating).
- Services provided by physician assistants (unless P.A. is employed by a medical group, M.D., or D.O.).
- Private duty nursing.
- Social worker services (except for mental health or substance abuse services).

Transplants

- Living organ donor services if you are the organ donor.
- Living donor transport.
- Mechanical or non-human organs.
- Organ purchase.
- Transplant services or supplies (except as described in the plan's *Guide to Benefits*).
- Transportation related to organ and tissue transplants.

Miscellaneous Exclusions

- Act of war – Injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.
- Acupuncture.
- Airline oxygen.
- Biofeedback.
- Bionic devices.
- Blood and blood products (except as described in the plan's *Guide to Benefits*).
- Carcinoembryonic Antigen (CEA).
- Cardiac rehabilitation.
- Cosmetic services, surgery or supplies.
- Chemotherapy, high dose (except as described in the plan's *Guide to Benefits*).
- Complications of a non-covered procedure.
- Convenience treatments, services or supplies.
- Custodial care.
- Developmental delay.
- Ductal lavage.
- Electron Beam Computed Tomography (EBCT) or ultrafast CT.
- Environmental control equipment and supplies.
- Enzyme-potentiated Desensitization.
- Erectile dysfunction.
- Extracorporeal shock wave therapy.
- Foot orthotics (except for specific diabetic conditions).

- Genetic testing and screening.
- Growth hormone therapy.
- Hair loss.
- Hypnotherapy.
- Intradiscal Electro Thermal Therapy (IDET).
- Motor vehicles.
- Personal convenience items and supplies.
- Radiation, nonionizing/high dose (except as described in the plan's *Guide to Benefits*).
- Self-help or self-cure programs or equipment.
- Services or supplies gained by reason of a false statement or other misrepresentations.
- Services prior to plan effective date: You are not covered for services or supplies that you received before the effective date of this coverage.
- Sexual transformation.
- Sexual dysfunction.
- Supplies billed separately by your provider.
- Thoracic Electric Bioimpedance (outpatient).
- Topical hyperbaric oxygen therapy.
- Travel immunizations.
- Travel or lodging costs.
- Vertebral Axial Decompression (VAX-D).
- Vitamins, minerals and food supplements.
- Weight reduction programs.
- Wigs.

Please note: These services are not covered under the medical services section of your plan, but may be covered under dental, drug or vision care services.

Services Not Covered Under the Vision Plan

Your plan does not provide benefits for certain procedures, services or supplies.

The following is an overview of some of the services not covered by this plan. Upon joining, you will receive a plan *Guide to Benefits*, which gives further information on benefits, limitations and exclusions that are not described in this summary. You may also request a *Guide to Benefits* for this plan by calling your local HMSA office before enrolling in this plan. Services not covered under the vision care plan include:

- Sunglasses.
- Prescription inserts for diving masks or other protective eyewear.

- Nonprescription industrial safety goggles.
- Nonstandard items for lenses (including tinting and blending, oversized lenses and invisible bifocal or trifocals).
- Repair and replacement of frame parts and accessories.
- Vision services such as:
 - Refractive eye surgery to correct visual acuity problems.
 - Replacement of lost, stolen or broken lenses, or frames.
 - Vision training.
 - Aniseikonic studies and prescriptions.
 - Reading problem studies or other procedures determined to be special or unusual.

Eligible Charges

The eligible charge for a covered service is the lower of the actual charge on the claim, the discounted charge negotiated by HMSA, or the charge listed for the service in HMSA's schedule of maximum allowable charges.

In most cases, HMSA pays for covered services based on eligible charges of a participating provider. By using eligible charges, HMSA helps assure a fair and consistent level of benefit payment.

For covered services received outside the state of Hawaii by a Blue Cross and/or Blue Shield provider, benefit payments are based on the lower of the provider's actual charge or the negotiated price passed onto us by the on-site Blue Cross and/or Blue Shield Plans. For services from other out-of-state providers, benefits are based on the eligible charges for the same or similar services in Hawaii.

If Hospitalized on Effective Date

If you or your dependent is already confined in a hospital or skilled nursing facility when your HMSA coverage first becomes effective, benefits for the illness or injury requiring their confinement will not be paid. However, services that are a benefit of your plan that are received after your discharge date will be covered as long as these services are a benefit under your plan's contracted agreement.

Dependent Coverage Enrollment Information

There are different categories of coverage you may hold. This plan offers:

- Single coverage, where you, as the subscriber, are the only one covered.
- Two-party coverage, where you and one dependent (an eligible spouse or child) are covered. Your dependent must be listed on your application or may be added later as a new dependent.
- Family coverage, where you and two or more dependents are covered. Each eligible dependent being covered must be listed on your application or may be added later as a new dependent.

In general, you may enroll a child if the child meets all of the following requirements and is enrolled within 31 days of a qualifying event:

- The child is your natural child, your legally adopted child, a child placed with you for adoption, a stepchild, or a child for whom you are the court-appointed guardian.
- The child is under 19 years of age.
- The child is not married.

Dependent enrollment is subject to all applicable plan eligibility requirements.

If dependents are added to the plan after your initial enrollment, they are subject to the following waiting periods:

- 12 months for the following conditions:
 - Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV).
 - Alzheimer's disease.
 - Amyotrophic Lateral Sclerosis (ALS).
 - Anal fissures.
 - Anemia for congenital or hereditary blood disorders.
 - Arthritis.
 - Asthma.
 - Cancer of any type.
 - Cataracts.
 - Cerebral palsy.
 - Cirrhosis of the liver.
 - Congenital abnormalities. The waiting period applies to defects present from birth (for

- example, cleft lip or palate and webbed toes).
- Chronic Obstructive Pulmonary Disease (COPD).
- Crohn’s disease/Ulcerative colitis.
- Diabetes.
- Diverticulosis/Diverticulitis.
- Dysfunctional uterine bleeding.
- Endometriosis.
- End-Stage Renal Disease.
- Fibromyalgia.
- Gall bladder disease and gallstones.
- Gastroesophageal Reflux Disease (GERD), Dyspepsia, Gastritis.
- Hearing loss.
- Heart, blood and blood vessel diseases of any kind.
- Hepatitis (except Hepatitis A).
- High blood pressure.
- Multiple sclerosis.
- Osteomyelitis.
- Osteoporosis.
- Pelvic inflammatory disease.
- Polycystic ovarian syndrome.
- Pterygium.
- Radiculopathy.
- Reconstructive surgery for a previous illness or injury.
- Sleep apnea.
- Spinal disk problems.
- Surgery and related services for:
 - Hemorrhoids.
 - Hernia.
 - Tonsils.
 - Adenoids.
 - Varicose veins.
- Thyroid conditions, including goiter.
- Tuberculosis.
- Ulcers.
- Urinary incontinence.
- 12-month waiting period for all services related to maternity care, pregnancy, childbirth and related conditions including ambulance, X-rays, and hospital room and care. This waiting period does not apply to services related to the following conditions if the waiting period would have been met had the pregnancy gone the full term:
 - Miscarriage.
 - Abortion.
 - Premature birth.

Who Can Join

To be eligible to enroll in 50 Plus, you must meet the following criteria:

- Age 50 through 64.
- Must have had HMSA group plan coverage for the past two consecutive years.
- Apply for HMSA’s 50 Plus within 31 days of your last day of HMSA coverage under a group plan.
- Be ineligible for a group retiree plan, COBRA, QUEST, or any government program.
- Be a legal resident of the state of Hawaii, residing within the plan’s service area.

How to Join

To apply for HMSA’s 50 Plus, please submit the following items:

- Completed application form.
- Check or money order for first two months dues.

Mail to:

HMSA
6-AMS
P.O. Box 860
Honolulu, HI 96808-0860

With HMSA’s 50 Plus, there is no break in your HMSA membership. Coverage under 50 Plus begins the day after your membership with your previous HMSA group plan ends. Your spouse and eligible dependents may remain on 50 Plus after you have reached age 65 and are no longer eligible for this plan as long as they continue to meet eligibility criteria.

Rates

The following rates are effective from Jan. 1, 2010:

2010 Monthly Member Dues	
Single Membership	\$472.00
Two-Party Membership	\$946.00
Family Membership	\$1,418.50

Convenient Dues Payment

Dues Payment Service (DPS) is available to you at no additional cost upon joining the plan. With your authorization, HMSA will work directly with your local financial institution to transfer your fixed monthly dues payment to HMSA. DPS is a simple, convenient way to save time and expense of mailing monthly payments. Simply complete the enclosed authorization form or call HMSA's Account Management & Sales department.

Questions

If you have any questions, please call your HMSA sales representative at 948-5555 on Oahu or 1 (800) 620-4672 on the Neighbor Islands.

Privacy Policies & Practices for Member Financial Information

HMSA and our affiliated organizations throughout the state of Hawaii have always respected your privacy and are committed to safeguarding your personal health and financial information. HMSA values your business and the trust you have placed in selecting us as your provider of health care insurance. We strive to recognize and respect your expectations regarding the treatment of your personal information and have established the following policies and practices to:

- Maintain physical, electronic and procedural safeguards to protect the privacy, confidentiality and integrity of personal information.
- Ensure that those in our workforce who have access to or use your personal information need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following our policies and practices.
- Require that third parties who access your personal information on our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

Notice of Our Privacy Policies and Practices for Personal Financial Information Required by Law¹

Effective July 1, 2002, HMSA is required by state law to provide annual notice of our privacy policies and practices for personal financial information to members

who are enrolled in our individual health plans. This notice contains information regarding how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. Provisions of this notice apply to former as well as current HMSA members.

¹ Privacy of Consumer Financial Information, H.R.S. Chapter 431, Article 3A

Collection of Personal Financial Information

HMSA collects personal financial information about you that is necessary to administer your health plan. We may collect personal financial information about you from sources such as enrollment applications and other forms that you complete, and your transactions with us, our affiliates or others.

Sharing Personal Financial Information

HMSA may share with our affiliates and with nonaffiliated third parties any of the personal financial information that is necessary to administer your health plan, as permitted by law. Nonaffiliated third parties are those entities that are not part of the family of organizations controlled by HMSA. We do not otherwise share your personal financial information with anyone without your permission.

HMSA



HAWAII MEDICAL SERVICE ASSOCIATION
hmsa.com

HONOLULU • 818 Keeaumoku St. • 96814 • Phone: 948-6372

HILO, HAWAII • 670 Ponahawai St., Suite 121 • 96720 • Phone: 935-5441

KAILUA-KONA, HAWAII • 75-1029 Henry St., Suite 301 • 96740 • Phone: 329-5291

KAHULUI, MAUI • 33 Lono Ave., Suite 350 • 96732 • Phone: 871-6295

LIHUE, KAUAI • 4366 Kukui Grove St., Suite 103 • 96766 • Phone: 245-3393

If you are calling from the U.S. Mainland, please call 1 (800) 776-4672.
If you need to call a local Hawaii telephone number from the Mainland, the area code is 808.

HMSA is a Hawaii-based health care services organization dedicated, for over 70 years, to improving the health and wellness of individuals and our community. We will provide our customers real value and security by creating a broad range of products that gives them choices of health care plans, provider networks, prices, and other health care services, with a commitment to superior customer service.