

The HMSA Children's Plan

HMSA's Individual Health Plan for Children

January 2010



An Independent Licensee of the Blue Cross
and Blue Shield Association

Working for a Healthier Hawaii



The HMSA Children's Plan

This is an individual plan designed to provide affordable medical care to children age 31 days through 18 years, who may not have access to health care insurance.

We have designed this plan to give children the basic health care benefits needed to help keep them in good health.

The plan covers certain preventive services, immunizations, doctor visits, diagnostic tests, emergency care and mental health benefits. This plan also provides limited coverage for prescription drugs and dental.

Enrollment Eligibility

To qualify for The HMSA Children's Plan, your child must not have any other health care coverage (such as group or individual coverage, Medicare, state programs such as Medicaid or QUEST, or COBRA coverage) and must be a resident of the state of Hawaii. The child's residency is based on the parent or legal guardian's residency.

When applying, you may be asked to submit documentation of the child's uninsured status. Children who meet these eligibility qualifications will be accepted regardless of their health status.



BENEFIT SUMMARY

The following is a brief benefit summary of The HMSA Children's Plan. It provides general information only and is not to be used as the *Guide to Benefits* for the plan. Your child will receive a *Guide to Benefits* that provides complete information on benefits, limitations and exclusions for this plan after enrollment. You may also request a *Guide to Benefits* before enrollment.

The child's parent(s) or legal guardian is responsible for payments for any service not covered by this plan. This is a health maintenance organization (HMO) plan. Each applicant must choose a personal care provider. That provider is responsible for providing, arranging and managing all services provided for the child enrolled in this plan.

SERVICES

Your Copayment and Coverage

PHYSICIAN VISITS

Up to 12 outpatient physician visits per calendar year.

Office Visit

\$7 per visit; counted against the 12 visits per calendar year.

Online Care Visit

\$10 for up to 10 minutes
\$5 for an additional 5-minute extension.
(must be at least 18 years old)

ROUTINE AND PREVENTIVE

Well-Child Care

No copayment; counted against the 12 visits per calendar year.

Well-Child Immunizations

No copayment; standard childhood immunizations.

Gynecological Exam

No copayment; counted against the 12 visits per calendar year.

EMERGENCY SERVICES

Emergency services are covered within the state of Hawaii.

Emergency Room Facility Services

\$25 per visit for emergency room use within the state of Hawaii.

Inpatient Physician Visit

No copayment per visit.

SURGERY

Inpatient surgery is covered as long as hospital days are covered. For example, if the member doesn't have any more hospital days available, surgery won't be covered, even though it may be the first surgery.

Surgical Procedures

No copayment for inpatient or outpatient surgery.

Ambulatory Surgical Center

No copayment for facility charges for each covered surgery.

Anesthesia

No copayment.

SERVICES

Your Copayment and Coverage

HOSPITAL AND FACILITY SERVICES

(Including maternity benefits once the waiting period has been met.)

Room and Board

Limited to 5 days per calendar year for hospital room and board costs.

\$100 per day, based on a semi-private room rate; counted against the 5-day benefit maximum per calendar year.

Hospital Ancillary Services

No copayment as long as services are rendered during covered hospital stays.

Outpatient Facility

No copayment.

MATERNITY SERVICES

There is a 12-month waiting period for all maternity services.

Routine Pre/Post Natal Care and Delivery

No copayment (counted against 5-day inpatient hospital).

Room and Board

\$100 per day, based on a semi-private room rate; counted against the 5-day benefit maximum per calendar year.

MENTAL HEALTH AND SUBSTANCE ABUSE

Hospital/Facility Services

\$100 per day; counted against the 5-day benefit maximum per calendar year.

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

Physician Visit - Outpatient

\$7 for each individual or group session, up to 12 visits per calendar year.

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

When enrolling your child in this plan, you must choose a personal care provider from whom your child will receive all medical services. Your child’s personal care provider is responsible for coordinating all your child’s health care services. If your child receives services that are not arranged by a personal care provider, or are not covered by this plan, you are responsible for all payments associated with that care.

In some cases, applicants may choose a health center instead of a personal care provider for their care. The same rules would apply for coverage, in that your child must get all treatment and referrals from the health center that you chose.

Prescription Drug Benefits

Copayment amounts are for a maximum 30-day supply. The drugs are limited to generic antibiotics and oral contraceptives, which are within the formulary and are available only with your child’s doctor’s prescription at HMSA participating pharmacies:

Retail Pharmacy	You Pay
Generic antibiotic drugs	\$5
Oral contraceptives	\$5

Waiting Periods

Another way we keep monthly dues affordable is through the use of waiting periods for certain conditions. The HMSA Children’s Plan has a 12-month waiting period for maternity benefits. The waiting period begins from the plan’s effective date. During this waiting period, The HMSA Children’s Plan will not cover any condition or service related to pregnancy, maternity care, childbirth and related conditions including ambulance, X-rays, and hospital room and care. Services related to the birth of the baby, such as nursery care, are covered if the 12 -month waiting period is over. The parent or legal guardian should apply for The HMSA Children’s Plan coverage for the infant within 31 days from the date of birth. Coverage will be effective on the 31st day.

Services Not Covered Under the Plan

The following is an overview of some of the services not covered by this plan. Upon joining, you will receive a *Guide to Benefits* that provides detailed information on benefits, limitations and exclusions not described in this summary. You may also request a *Guide to Benefits* for this plan before enrolling in this plan by calling the HMSA’s Account Management and Sales department.

Counseling Services

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

Drug, Vision and Dental

- Drugs (except generic antibiotics and oral contraceptives).
- Eyeglasses, contacts and appliances.
- Vision services.
- Dental (except for preventive services).

Fertility and Infertility

- Implanted contraceptives, contraceptive services, injected contraceptives or contraceptive devices.
- Supplies or services related to the diagnosis of infertility.
- Infertility treatment.
- Fertilization by artificial means (including in-vitro fertilization).
- Sterilization reversal.

Preventive and Routine

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

Provider Type

- Chiropractic services.
- Complementary and alternative medicine provider.
- Hospice services.
- Private duty nursing.
- Provider is an immediate family member.
- Services provided by physician assistants (unless P.A. is employed by a medical group, M.D., or D.O.).
- Skilled nursing facility services.
- 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.
- 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.
- Allergy testing.
- Ambulance service.
- Biofeedback.
- Bionic devices.
- Blood.
- Carcinoembryonic antigen (CEA).
- Cardiac rehabilitation.
- Chemotherapy.
- Complications of a non-covered procedure.
- Convenience treatments, services or supplies.
- Cosmetic services, surgery or supplies.
- Custodial care.
- Developmental delays.
- Dialysis and supplies.
- Ductal lavage.
- Electron beam computed tomography (EBCT) or ultrafast CT.
- Emergency services outside of Hawaii.

- Environmental control equipment and supplies.
- Enzyme-potentiated desensitization.
- Erectile dysfunction.
- Evaluations for hearing aid.
- Extracorporeal shock wave therapy.
- Foot orthotics.
- Genetic testing and screening.
- Growth hormone therapy.
- Hair loss.
- Health appraisal.
- Home health visits.
- Home infusion therapy.
- Hypnotherapy.
- Inhalation therapy.
- Intradiscal electrothermal therapy (IDET).
- Medical equipment, appliances and supplies.
- Motor vehicle purchase or rental.
- Non-emergency services received after office hours.
- Occupational therapy.
- Outpatient injections.
- Personal convenience items and supplies.
- Physical therapy.
- Pre-term birth education.
- Provider's stand-by time.
- Radiation therapy.
- Self-administered injectables.
- Self-help or self-cure programs or equipment.
- Services not authorized by PCP.
- Services or supplies gained by reason of a false statement or other misrepresentations.
- Service outside of Hawaii.
- 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.
- Speech therapy services.
- Supplies filed separately by your provider.
- Thoracic Electric Bioimpedance (outpatient).
- Topical hyperbaric oxygen therapy.
- Travel or lodging costs.
- Urgent care.
- Vertebral axial decompression (VAX-D).
- Vitamins, minerals and food supplements.
- Weight reduction programs.
- Wigs.

Coverage Under Other Programs or Laws

- **Military:** You are not covered for treatment or 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.

Does the Care Meet 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 exist or if they exist but are outdated or contradictory, then by expert opinion.
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services that are not known to be effective in improving health outcomes include, but are not limited to, services that 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.

The fact that a provider 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 that are excluded from coverage without obtaining a written acknowledgement of financial responsibility from you or your representative.

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 only the least costly treatment, service, or supply.

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

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.

Personal Care Provider

A personal care provider, or PCP, is a provider you select to coordinate your child's medical care. This allows you to establish an ongoing relationship with one provider who is familiar with your child's medical history and who will provide or arrange for your child's health care needs.

Whenever your child requires medical attention, call or schedule an appointment with the PCP. The PCP must coordinate your child's medical care. If your child should need a referral to a specialist, your child's PCP will make the referral to an HMSA-contracted specialist or provider. In an emergency, there is no need to contact your child's PCP. Take your child to the hospital as soon as possible.

At the time of enrollment, you must select a PCP for your child. You may elect to change your child's PCP during the open enrollment period once a year or if you move away from your current service area. We have enclosed a listing of PCPs participating with The HMSA Children's Plan for your information.

In some cases, applicants may choose a health center instead of a personal care provider to deliver and coordinate their care. The same rules would apply for coverage, in that your child must get all treatment and referrals from the health center that you chose.

How to Join

Please submit the following to enroll your child in this plan:

- Completed application. A separate application must be completed for each child you wish to enroll. Be sure to complete all areas of the application, including selecting a personal care provider or health center for your child. The parent, legal guardian, or 18-year-old applicant should sign and date the application.
- A check or money order made payable to HMSA for your child's first month's dues. If you are enrolling more than one child in this plan, you may submit one check or money order for the combined dues owed for the first month of coverage.

Mail to:

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

Rates

These benefits and rates are effective Jan. 1, 2010.

Plan rate: \$60.00 per child, per month

Convenient Dues Payment

As a member of The HMSA Children's Plan, you may enroll in HMSA's Automatic Dues Payment Service. With your authorization, we will work directly with your financial institution to transfer monthly payments to HMSA for your child's health plan dues. HMSA's Automatic Dues Payment Service is a simple, convenient way to save the time and expense of mailing monthly payments. We have enclosed information and an application for this service.

Questions

For additional information, please call an HMSA sales representative at 948-5555 on Oahu, or 1 (800) 620-4672 toll-free on the Neighbor Islands.

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.