

HMSA's Conversion Plan 10

HMSA's Health Plan for Group Members Converting to Individual Coverage

Basic & High Options

January 2010



HMSA



Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross
and Blue Shield Association

Working for a Healthier Hawaii

HMSA's Health Plan for Group Members Converting to Individual Coverage

The following is a brief benefit summary of HMSA's Conversion Plan 10: Basic and High Options. It provides general information only and is not to be used as the Guide to Benefits for this plan.

Everyone needs financial protection against the cost of illness and medical emergencies. And everyone wants the best coverage at the lowest cost. HMSA's Conversion Plan 10 provides you and your family with an opportunity to continue your HMSA health care coverage after leaving group coverage. It also meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

There are two options: Basic and High. You choose the option that best meets your financial and health care needs. Each option provides coverage for office visits, diagnostic tests, emergency room visits, and surgical and hospital services, as well as preventive services to keep you and your family healthy.

With HMSA's Conversion Plan 10, your prior HMSA or group plan membership applies toward satisfying waiting periods for maternity, hospital, surgery and pre-existing conditions.



There are more good reasons to select HMSA's Conversion Plan 10:

- ***Guaranteed Membership***

If you apply within 31 days following your last day of your HMSA or group plan membership and you reside in the state of Hawaii, your acceptance is assured, regardless of your health status. If you are eligible for HIPAA, you must apply within 62 days from your last day of group plan membership. To determine if you are HIPAA-eligible, please refer to page 12 or call HMSA's Account Management & Sales department.

- ***Large Network of Providers***

HMSA's Conversion Plan 10 provides you with access to a large network of medical providers throughout Hawaii. You and each eligible dependent select a health center from which to receive all medical services. Then you select a personal care provider within that health center who will coordinate all your health care needs.

- ***Preventive Services to Maintain Good Health***

Staying healthy is the best way to control your medical costs. Take care of yourself all year long. See your doctor early. This will allow you to manage minor health problems, preventing them from becoming major health problems if left unattended. If enrolled in this plan, we encourage you to take advantage of your preventive care benefits, which are a part of this plan.

Early detection of health conditions is important. That's why HMSA is committed to providing you with benefits for routine and preventive health services. Healthier lifestyles, immunizations and early detection and treatment can prevent many serious disorders.

This plan provides coverage for both routine and preventive services to maintain our members' good health.

This plan also includes health education programs approved by HMSA such as prenatal care programs (The Good Pregnancy - *He Hāpai Pono*), RSVP (Reminder for Screening and Vaccination Program), and the Care Connection disease management program, to name a few.

- ***Financial Protection***

This plan features an annual copayment maximum per calendar year, which has been designed to provide

our members with financial protection. Once you meet the annual copayment maximum, you are no longer responsible for copayment amounts.

The annual copayment maximums per calendar year are:

- **High Option (BA)**

\$5,000 per person

\$15,000 (maximum) per family contract

or

- **Basic Option (BG)**

\$7,500 per person

\$22,500 (maximum) per family contract

- ***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, visit the BlueCard doctor and hospital finder website (www.BCBS.com) or call BlueCard Access at 1 (800) 810-BLUE (2583). 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. For trips to the Neighbor Islands, contact the customer service office on the island you are visiting.

- ***Integrated Case Management***

This is a plan benefit when approved by HMSA. Integrated Case Management is a special program to assist members with certain medical conditions that require costly, long-term care and when a hospital may not be the most appropriate setting for your treatment. If you meet HMSA's criteria, your coverage provides you with alternative benefits to help meet health care needs resulting from extreme illness or injury (providing that costs do not exceed inpatient facility costs). You, your physician and the hospital can work with our case managers to identify and arrange alternative treatment plans to meet your special needs and to assist

in preserving your health care benefits. Your physician will contact us on your behalf to identify and arrange alternative treatment plans.

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 risks 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; and
- 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 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.

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

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 your local HMSA office.

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 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.

Dental, Drug and Vision

- Dental care (including orthodontics).
- Drugs (except diabetic 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 (except as described in the plan's *Guide to Benefits*).
- Growth hormone therapy.
- Hair loss.
- Hypnotherapy.
- Intradiscal Electro Thermal Therapy (IDET).
- Motor vehicles.
- Personal convenience items and supplies.
- Provider's stand-by time.
- 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 or lodging costs.
- Travel immunizations.
- Vertebral Axial Decompression (VAX-D).
- Vitamins, minerals and food supplements.
- Weight reduction programs.
- Wigs.

Eligible Charges

We calculate our payment and your copayment based on the eligible charge. The eligible charge is the lower of either the provider's actual charge or the amount we establish as the maximum allowable fee.

If you receive a noncovered service, you are responsible for the entire amount charged by your provider.

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 participating provider, HMSA uses the lower of the provider's actual charge of the negotiated price passed on to HMSA by the on-site Blue Cross and/or Blue Shield plan.

Waiting Periods

Waiting periods are another way we keep your monthly dues affordable. A waiting period is a specified amount of time, beginning on your effective date, that you, and each of your dependents, may have to wait before benefits for certain conditions are available under this coverage. During these waiting periods, this plan will not cover conditions or services listed in this waiting periods section.

Waiting periods apply to months of continuous coverage under this plan for you and each of your dependents.

If you or your dependents were covered by another HMSA group plan or another Blue Cross and Blue Shield plan immediately prior to joining this plan, your waiting periods will be reduced by the amount of time spent in that plan.

Individuals who transfer immediately into this plan from HMSA's Student Plan 19 because they no longer meet that plan's age requirements may apply the time spent in that plan toward meeting these waiting periods.

Exceptions to Waiting Periods

You and each of your dependents must meet any applicable waiting periods, except as indicated below:

- Your newborn child, including an adopted newborn, is not subject to any waiting period provided you enroll the child as a dependent within 31 days after the date of birth.
- An adopted child, who is not a newborn child as described above, is not subject to any waiting period provided you enroll the child as a dependent within 31 days after the date of initial eligibility.
- In addition, we will waive the waiting periods of this plan for you if your most recent coverage was a group, government or church plan, and you meet all of the requirements listed immediately below:
 - You were continuously covered for 18 months without a break in coverage of 63 days or more;
 - You were not terminated from the most recent prior coverage due to nonpayment of premiums or fraud;
 - You are ineligible for other group coverage, Medicare, Medicaid, or other health insurance;
 - You have exhausted any eligible COBRA coverage or are ineligible for COBRA; and
 - You have no other health insurance coverage.

Waiting Periods for Maternity Care, Pregnancy, Childbirth and Related Conditions

You are subject to a **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.

Transplant Waiting Period

You are subject to a **12-month** waiting period for transplants. The transplant waiting period applies to transplants and any service related to a transplant.

Waiting Period for Certain Conditions

You are subject to a 12-month waiting period for any service related to diagnosis or treatment of 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.
- Ostomyelitis.
- Osteoporosis.
- Pelvis inflammatory disease.
- Polycystic ovarian syndrome.
- Pterygium.
- Radiculopathy.
- Reconstructive surgery for a previous illness or injury.
- Sleep apnea.
- Spinal disc problems.
- Surgery and related services for:
 - Hemorrhoids.
 - Hernia.
 - Tonsils.
 - Adenoids.
 - Varicose veins.

- Thyroid conditions, including goiter.
- Tuberculosis.
- Ulcers.
- Urinary incontinence.

If You are Hospitalized When Coverage Begins

You are subject to a waiting period if you are an inpatient in a hospital or skilled nursing facility on your effective date (the day your coverage under this plan begins). This waiting period applies until your discharge date. We will not cover the illness or injury requiring your stay. However, we will pay benefits for covered services received for that injury or illness after the discharge date as long as all other requirements of this plan are met.

Who Can Apply

To be eligible for coverage, all of the following must be true:

- You are a legal resident of the state of Hawaii.
- You reside within the plan's service area.

In addition, you must meet one of the following qualifications:

- You qualify under the requirements of HIPAA. A HIPAA-eligible person must:
 - Have at least 18 months continuous creditable coverage without a break in coverage of 63 days or more. (Creditable coverage includes coverage under a group health plan, Medicare, Medicaid, military health, Indian Health Service, state high-risk pool, FEHBP, or any public health plan, Peace Corps Plan, or other insurance coverage.);
 - Have the most recent coverage through a group health plan; and
 - Be ineligible for COBRA or have elected and exhausted COBRA or a similar state program benefit.
- You apply within 31 days of your last day of HMSA coverage under a group plan.
- You apply within 31 days of your last day of Blue Cross and Blue Shield plan coverage.

We reserve the right to request documentation at anytime, which demonstrates, in our sole discretion and to our satisfaction, that you meet the above criteria.

If you do not meet any of the qualifications listed, you may submit an application and HMSA health statement for this plan. Your application will be reviewed and

acceptance is based on your health status. Completion of these forms does not guarantee acceptance into this plan.

If accepted on this plan, you must pay your dues in advance every month to be eligible for coverage. You and your eligible dependents are also subject to any applicable waiting periods.

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 and, upon enrollment, will be subject to all applicable waiting periods and exclusions as defined in the plan's *Guide to Benefits*. For more information on enrolling your eligible dependent, please call HMSA's Account Management & Sales department.

BENEFIT SUMMARY

This brochure is for general information only. It is intended to give you a summary of HMSA's Conversion Plan 10 benefits and is not to be used as the *Guide to Benefits* for this plan. Upon joining, members will receive a *Guide to Benefits*, which gives further information on benefits, limitations and exclusions.

In the case of a discrepancy between this summary and the language contained in the *Guide to Benefits*, the *Guide to Benefits* will take precedence. All percentages listed in the benefit description are based on eligible charges, as defined on page 5.

You are responsible for payments for any services not covered by these plans.

HMSA's Conversion Plan 10 BENEFIT DESCRIPTION

Your Copayment

| | High Option (BA) | Basic Option (BG) |
|---|---|--|
| TYPE OF PLAN | These are health maintenance organization plans. They include benefits for emergency services, illness or injury, physical exams, and preventive care to help keep you healthy. You and your eligible dependents must each select a personal care provider from a participating health center who will provide, arrange and manage all your services to help you reach your optimal health. | |
| ANNUAL DEDUCTIBLE | \$300 per member; \$900 per family contract | \$500 per member; \$1,500 per family contract |
| | Annual deductible applies unless otherwise noted. | |
| ANNUAL MAXIMUM COPAYMENT | \$5,000 per member; \$15,000 per family contract | \$7,500 per member; \$22,500 per family contract |
| PHYSICIAN VISITS | | |
| Office visit (including vision exam) | \$17 | \$17 |
| Home visit | \$25 | \$35 |
| Hospital visit – Inpatient | \$17 | \$25 |
| Skilled nursing facility visit | \$17 | \$17 |
| Well-child care visit (age 5 and younger) | \$17 ¹ | \$17 ¹ |
| Online Care visit | \$10 for up to 10 minutes ¹ \$5 for an additional 5-minute extension | \$10 for up to 10 minutes ¹ \$5 for an additional 5-minute extension |
| PHYSICAL EXAMINATIONS (routine annual checkup) | \$17 ¹ | \$17 ¹ |
| SURGERY | | |
| Surgical procedures | 20% (outpatient surgical center) 20% (outpatient professional charge) 10% (hospital operating room) 20% (inpatient professional charge) | 30% (outpatient surgical center) 30% (outpatient professional charge) 30% (hospital operating room) 30% (inpatient professional charge) |
| Anesthesia | 20% | 30% |
| IMMUNIZATIONS | | |
| Member 18 years or younger | No copayment ¹ | No copayment ¹ |
| Member 19 years or older | \$10 ¹ | \$10 ¹ |
| Influenza and pneumococcal | No copayment ¹ | No copayment ¹ |
| Unexpected mass immunizations | 50% ¹ | 50% ¹ |

¹Not subject to the annual deductible

HMSA's Conversion Plan 10

Your Copayment

| BENEFIT DESCRIPTION | High Option (BA) | Basic Option (BG) |
|---------------------|------------------|-------------------|
|---------------------|------------------|-------------------|

HOSPITAL AND FACILITY SERVICES

| | | |
|--|------|------|
| Room and board — based on semiprivate room rates | 10%* | 30%* |
| Ancillary services | 10% | 30% |
| Outpatient facility | 10% | 30% |

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

MATERNITY CARE

| | | |
|--|-----|-----|
| Routine pre/post natal care and delivery | 10% | 10% |
|--|-----|-----|

EMERGENCY SERVICES

| | | |
|----------------------------------|---|---|
| Emergency room facility services | \$50 per visit (in-state and BlueCard provider) 20% (out-of-state non-BlueCard provider) | \$50 per visit (in-state and BlueCard provider) 20% (out-of-state non-BlueCard provider) |
| Emergency room physician visits | \$25 (in-state and BlueCard provider) | \$35 (in-state and BlueCard provider) |
| Ground and air ambulance | 20% | 20% |

SKILLED NURSING FACILITY BENEFITS

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

| | | |
|----------------|-----|-----|
| Room and board | 10% | 30% |
|----------------|-----|-----|

TEST, LABORATORY AND X-RAYS

| | | |
|--|--|--|
| Allergy testing | \$17 (office visit) 10% (hospital inpatient) | \$25 (office visit) 30% (hospital inpatient) |
| Diagnostic tests | 20% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 10% (hospital inpatient) | 30% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 30% (hospital inpatient) |
| Evaluation for the use of hearing aids | \$17 (office visit) | \$17 (office visit) |
| Genetic testing | 20% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 10% (hospital inpatient) | 30% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 30% (hospital inpatient) |
| Laboratory and pathology | 20% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 10% (hospital inpatient) | 30% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room) 30% (hospital inpatient) |
| X-ray and other radiology | 20% (office visit, hospital outpatient, ambulatory surgical center, or emergency room) 10% (hospital inpatient) | 30% (office visit, hospital outpatient, ambulatory surgical center, or emergency room) 30% (hospital inpatient) |

HMSA's Conversion Plan 10

Your Copayment

| BENEFIT DESCRIPTION | High Option (BA) | Basic Option (BG) |
|---------------------|------------------|-------------------|
|---------------------|------------------|-------------------|

HOSPICE CARE BENEFITS

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

HOME HEALTH CARE BENEFITS

| | | |
|--|----------------|----------------|
| Limited to 150 days per calendar year from a qualified home health agency or health center | \$25 per visit | \$35 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 visits per calendar year)** | 20% | 30% |
| Inpatient sessions (30 visits per calendar year) | 20% | 30% |

Hospital/Facility

| | | |
|--|------|------|
| Based on semiprivate room rate (30 days per calendar year) | 10%* | 30%* |
|--|------|------|

Psychological Testing

| | | |
|------------|-----|-----|
| Outpatient | 50% | 50% |
| Inpatient | 20% | 30% |

Rehabilitation Therapy Services and Miscellaneous Medical Treatments

| | | |
|---|--|--|
| Occupational and physical therapy, chemotherapy – Infusion/Injections | \$17 (office visit) 20% (hospital inpatient and outpatient) | \$17 (office visit) 20% (hospital inpatient and outpatient) |
|---|--|--|

| | | |
|-------------------------|-----|-----|
| Speech therapy services | 50% | 50% |
|-------------------------|-----|-----|

| | | |
|--|------|------|
| Medical equipment, appliances, and supplies (including glucose monitors) | 50%* | 50%* |
|--|------|------|

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

| | | |
|--------------------------|-----|-----|
| Blood and blood products | 20% | 20% |
|--------------------------|-----|-----|

¹Not subject to the annual deductible

HMSA's Conversion Plan 10

BENEFIT DESCRIPTION

Your Copayment

PRESCRIPTION DRUGS AND SUPPLIES

Chemotherapy – Oral Drugs

Chemotherapy – Oral

Network Pharmacy¹
None

Non-Network Pharmacy¹
You owe the entire charge and
HMSA reimburses you 100% of the eligible charge

Contracted Mail Order Pharmacy¹
None

Diabetic Drugs, Supplies and Insulin

Diabetic drugs

Network Pharmacy¹
20% of eligible charge (Generic)
20% of eligible charge (Preferred Brand Name)
30% of eligible charge (Other Brand Name)

Non-Network Pharmacy¹
You owe the entire charge and HMSA reimburses you
100% of the remaining eligible charge after deducting:
20% of eligible charge (Generic)
20% of eligible charge (Preferred Brand Name)
30% of eligible charge (Other Brand Name)

Contracted Mail Order Pharmacy¹
20% of eligible charge (Generic)
20% of eligible charge (Preferred Brand Name)
30% (Other Brand Name)

Diabetic supplies

Network Pharmacy¹
50% of eligible charge

Non-Network Pharmacy¹
You owe the entire charge and HMSA reimburses you
50% of the eligible charge

Contracted Mail Order Pharmacy¹
50% of eligible charge

Insulin

Network Pharmacy¹
20% of eligible charge (Preferred Brand Name)
30% of eligible charge (Other Brand Name)

Non-Network Pharmacy¹
You owe the entire charge and HMSA reimburses you
100% of the remaining eligible charge after deducting:
20% of eligible charge (Preferred Brand Name)
30% of eligible charge (Other Brand Name)

Contracted Mail Order Pharmacy¹
20% of eligible charge (Preferred Brand Name)
30% (Other Brand Name)

¹Not subject to the annual deductible

continued from page 7

When Coverage Begins

This coverage takes effect and you are eligible to receive benefits on your effective date, providing all of the following are met:

- Your initial dues were paid.
- We accepted your application by giving written notice to you of your effective date. By submitting the application, you also accept and agree to the provisions of our constitution and bylaws now in force and as amended in the future.
- You are not in the hospital on the day coverage goes into effect. If you are confined in a hospital or other inpatient facility at the time this coverage begins, then coverage for any services related to the hospitalization does not begin until the day after your discharge from the hospital. Please call us if this limitation applies to you so we can assist you in determining your rights to coverage.

When Coverage Ends

Your coverage will terminate at the end of the month in which any of the following takes place:

- You choose to terminate this coverage. In this case, you must provide us written notice of your intent to terminate 31 days before the termination date.
- You fail to make payments to us when due.
- We terminate our agreement with you by providing you written notice 30 days prior to termination.
- For the member, upon termination of the agreement.
- For the member's spouse, upon termination of coverage or upon the dissolution of the marriage.
- For the member's children, when any of the following occurs:
 - The member's coverage terminates; or
 - The child fails to meet the enrollment criteria. The enrollment criteria states that the child must be your naturally born or legally adopted child, a stepchild, or a child for whom you are the court-appointed guardian. The child is under 19 years old, and is not married.

How to Apply

- Please complete the application and first two months' dues. Be sure to indicate the participating health center

and personal care provider for you, your spouse and each eligible dependent. The personal care provider must be within your designated health center.

- Additionally, if you are HIPAA-eligible, please also submit certificate of coverage, showing at least 18 months of creditable coverage (without break in coverage of 63 days or more), with the most recent coverage being a group plan.
- If you are converting from a Blue Cross and Blue Shield coverage other than HMSA, please submit your certificate of coverage, showing at least 12 months of continuous coverage.

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

- To ensure continuous coverage, submit completed application 31 days from your last date of coverage.

Rates

These benefits and the following rates are effective from Jan. 1, 2010.

| 2010 Member Dues | | |
|------------------|--------------|-------------|
| | BASIC OPTION | HIGH OPTION |
| Single | \$273.25 | \$530.75 |
| Two-Party | \$547.25 | \$1,062.25 |
| Family | \$820.75 | \$1,594.25 |

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 for more information.

Questions

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