

# HMSA's HPH Conversion Plan

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

Everyone needs financial protection against the cost of illness and medical emergencies. And everyone wants the best coverage at the lowest cost. HMSA's HPH Conversion Plan provides you and your family with an opportunity to continue your HMSA medical plan coverage after leaving group coverage. HMSA's HPH Conversion Plan is the health maintenance organization plan that focuses on maintaining your good health.

The following is a brief benefit summary of HMSA's HPH Conversion Plan. It provides general information only and is not to be used as the *Guide to Benefits* for the plan.

## *Here are some good reasons to choose HMSA's HPH Conversion Plan:*

### • ***Guaranteed Membership***

If you apply within 31 days following your last day of Health Plan Hawaii group plan coverage and you reside in the state of Hawaii, your acceptance is assured, regardless of your health status.

### • ***Health Center and PCP***

Your health center is the group of providers from which all of your services are received. Your health center may be an actual clinic of providers or a group of providers who practice at various locations. Your health center is very important for two reasons:

- You must choose a personal care provider (PCP) from within your designated health center.
- If your condition requires the skills of a specialist, your PCP will arrange for you to receive care from a specialty provider within the health center.

Your PCP is the first point of contact whenever you require medical assistance. Maintaining an ongoing relationship with your PCP will help ensure that you receive optimal care.

### • ***Your Health Team***

Your health care team is made up of you and both of the following:

- Your designated health center.
- Your designated PCP.

To address individual health care needs, you and each covered dependent may choose their own PCP and health center within the Health Plan Hawaii network.

Your PCP is responsible for providing and arranging all your medical care. Having a continuous relationship with your PCP allows you the best possible care. If you need to change your PCP, you may do so now or you and your family members may continue with your existing health center and PCP under your HMSA HPH group plan.

Except for emergency services, annual vision examinations, annual gynecological examinations, annual HealthPass visits, Online Care, and mental

health and substance abuse, benefits are available only for care received from or arranged by your PCP.

### • ***Preventive Services Maintaining Your 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 and prevent them from becoming major health problems if left unattended.

Once 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 is 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. Routine and preventive care must be performed by your PCP.

This plan provides coverage for both routine and preventive services to help maintain our members' good health. HMSA's HPH Conversion Plan includes health education programs approved by HMSA such as a prenatal care program (The Good Pregnancy—*He Hāpai Pono*), RSVP (Reminder for Screening and Vaccination Program), and HMSA's Care Connection disease management program, to name a few.

We encourage you to make informed decisions about your health care. Be an active participant in your treatment. Talk with your provider and ask questions. Understand the treatment program and any risks, benefits and alternatives associated with it.

By taking advantage of our preventive programs, working with your PCP, and taking an active role in managing your health care, you will maximize your membership in this plan.

### • ***Financial Protection***

You pay a predictable copayment for each office visit, which means easy budgeting. And, for financial protection, you will not have to pay more than \$2,000 per person, up to a maximum of \$6,000 per family, each calendar year. Once the maximum amounts have been reached, the plan will pay 100 percent of the basic benefits for the rest of that calendar year.

## *There are more good reasons to select HMSA's HPH Conversion Plan:*

### **• *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](http://www.BCBS.com)) or call BlueCard Access at 1 (800) 810-BLUE (2583) toll-free.

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 upon your return. For trips to the Neighbor Islands, contact the HMSA 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.

## *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 exists 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 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 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 that are 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, 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 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 oral chemotherapy drugs).
- Eyeglasses, contacts and appliances.
- Vision services (except for one exam).

### ***Fertility and Infertility***

- You are not covered for any contraceptives or contraceptive services including implanted, oral or injected contraceptives and contraceptive devices.
- Infertility treatment.
- Sterilization reversal.

### ***Preventive and Routine***

- 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 provider).
- Provider is an immediate family member.
- 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 dysfunction.
- Sexual transformation.
- Supplies billed separately by your provider, or take home supplies.
- 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.

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

## Copayments

Copayment applies to most covered services and is either a fixed percentage of the eligible charge or a fixed dollar amount.

- When you receive multiple services from the same provider on the same day, you owe one fixed dollar copayment if fixed dollar copayments are applicable to the services you receive.
- You owe all copayments that are a percentage of eligible charge if eligible charge percentage copayments are applicable to the services you receive.
- If you receive some services with fixed dollar copayments and some with copayments that are a percentage of eligible charge, you owe one fixed dollar copayment and all copayments based on a percentage of eligible charge.
- If you receive services from more than one provider on the same day, more than one copayment may apply.

## ***Annual Copayment Maximum***

The copayment maximum is the maximum copayment amount you pay in a calendar year. Once you meet the copayment maximum, you are no longer responsible for copayment amounts unless otherwise noted. Copayment maximums are \$2,000 per person, or \$6,000 (maximum) per family contract.

The following amounts do not apply to meeting the copayment maximum:

- Any copayments for skilled nursing facility room and board, speech therapy, blood and blood products, inter-island transportation, medical foods, diabetic drugs and supplies, and insulin.
- Any amounts for services that exceed the benefit maximum.
- Any amounts for noncovered services.

In addition, you continue to be responsible for these amounts even after you have met the copayment maximum.

## ***Carryover of Benefits from Previous Coverage***

Any maximums you accrued under the previous HMSA coverage carry forward and count against the same types of maximum amounts under this coverage. Any copayment amounts you paid toward meeting your copayment maximum will also carry over.

## ***Who Can Join***

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

- You are applying within 31 days of losing your group-sponsored HMSA Health Plan Hawaii coverage.
- You are a legal resident of the state of Hawaii.
- You reside within the plan's service area.
- Eligible dependent children under the age of 19 may qualify.

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

If accepted on this plan, you must pay your dues in advance every month to be eligible for coverage.

## ***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 during open enrollment 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 during open enrollment 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 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 HPH Conversion Plan 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 HPH Conversion Plan

### BENEFIT DESCRIPTION

### Your Copayment

#### TYPE OF PLAN

This is a health maintenance organization plan. It includes 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 MAXIMUM COPAYMENT

\$2,000 per person;

\$6,000 per family

#### LIFETIME MAXIMUM

Unlimited

#### PHYSICIAN VISITS

Office visit (including vision exam)

\$15

Home visit

\$15

Inpatient/Outpatient hospital visit

\$15

Skilled nursing facility visit

No copayment

Well-child care visit

\$15

#### PHYSICAL EXAMINATIONS

\$15

#### SURGERY

Surgical procedures

Outpatient surgical center

No copayment

Outpatient professional charges

\$15

Hospital operating room

20%

Inpatient professional charges

No copayment

Anesthesia

Outpatient professional charges

\$15

Inpatient professional charges

No copayment

# HMSA's HPH Conversion Plan

## BENEFIT DESCRIPTION

## Your Copayment

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### IMMUNIZATIONS

Member 18 years or younger	No copayment
Member 19 years or older	\$10
Influenza and pneumococcal	No copayment
Unexpected mass immunizations	50%

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### INPATIENT CARE AND SERVICES

Ancillary services	20%
Hospital room and board — based on semiprivate room rates	20%*
Skilled nursing facility	20%
Private duty nursing	50%

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

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### MATERNITY SERVICES

Routine pre/post natal care and delivery	No copayment
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### EMERGENCY SERVICES

Emergency room facility services	
Services in Hawaii	\$50
Services outside Hawaii from a BlueCard provider	\$50
Services outside Hawaii from a non-BlueCard provider	20%
Emergency room physician visits	
Services in Hawaii	No copayment
Services outside Hawaii from a BlueCard provider	No copayment
Services outside Hawaii from a non-BlueCard provider	20%
Ground and air ambulance	20%

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### TEST, LABORATORY AND X-RAYS

Allergy testing	
Office visit	\$15
Hospital outpatient visit	\$15
Hospital inpatient visit	20%
Diagnostic tests	
Office visit	20%
Inpatient/Outpatient hospital visit	20%
Evaluation for the use of hearing aids	
Office visit	\$15

# HMSA's HPH Conversion Plan

## BENEFIT DESCRIPTION

## Your Copayment

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### TEST, LABORATORY AND X-RAYS

Genetic testing	
Office visit	20%
Inpatient/Outpatient hospital visit	20%
Laboratory and pathology	
Office visit	20%
Inpatient/Outpatient hospital visit	20%
X-ray and other radiology	
Office visit	20%
Inpatient/Outpatient hospital visit	20%

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### HOME HEALTH CARE AND HOSPICE

Home health care	No copayment
Hospice services	No copayment

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### MENTAL HEALTH AND SUBSTANCE ABUSE

Licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, mental health counselor, or advanced practice registered nurse

Hospital/Facility charges	20%
Hospital/Facility charges - for serious mental illness as defined by Hawaii law	20%
Physician visits	
Inpatient/Outpatient	20%
Physician visits - for serious mental illness as defined by Hawaii law	
Inpatient/Outpatient	\$15
Psychological Testing	20%

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### OTHER MEDICAL SERVICES

Physical and occupational therapy, chemotherapy (infusion/injections), and radiation therapy	
Office visit	\$15
Hospital outpatient visit	\$15
Hospital inpatient visit	20%
Speech therapy	
Outpatient visit	\$15
Inpatient visit	20%
Medical equipment, appliances and supplies	50%*
Blood and blood products	20%

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

# HMSA's HPH Conversion Plan

## BENEFIT DESCRIPTION

## Your Copayment

### CHEMOTHERAPY – ORAL DRUGS

Network pharmacy	None
Non-network pharmacy	You owe the entire charge and HMSA reimburses you 100% of the eligible charge
Contracted mail-order pharmacy	None

### DIABETIC DRUGS, SUPPLIES AND INSULIN

#### Diabetes management

Diabetes self-management training and educational services focusing on self-managing diabetes care are available only through HMSA's Care Connection. There is no copayment for services rendered by a provider contracted through Care Connection. Call 1 (800) 499-5036 for more information about this program.

#### Diabetic drugs

Network pharmacy	
Generic	20%
Preferred brand name	20%
Other brand-name	30%

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

Generic	20%
Preferred brand name	20%
Other brand name	30%

#### Contracted mail-order pharmacy

Generic	20%
Preferred brand name	20%
Other brand name	30%

#### Diabetic supplies

##### Syringes, needles, test strips and auto-lancet devices

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

#### Contracted mail-order pharmacy

50%

#### Insulin

Network pharmacy	
Preferred brand name	20%
Other brand name	30%

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

Preferred brand name	20%
Other brand name	30%

#### Contracted mail-order pharmacy

Preferred brand name	20%
Other brand name	30%

## *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 Join*

Please submit the following within 31 days of your last day of coverage:

- Completed application.
- Check or money order for your first two month's dues.

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

You must enroll your spouse or child(ren) by naming them on the application form and submitting it within 31 days of the date the spouse or child becomes eligible. If you do not enroll within this time frame, their enrollment is subject to the next open enrollment period. Open enrollment takes place once a year.

## *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 Law***

Effective July 1, 2002, HMSA is required by state law to provide an 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.

### ***Collection of Personal Financial Information***

HMSA collects personal financial information about you that is necessary to administer your health plan. We 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 of 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 or organizations controlled by HMSA. We do not otherwise share your personal financial information with anyone without your permission.

## ***Rates***

These benefits and rates are good through June 2010.

<b>Monthly Member Dues</b>	
Single	\$ 293.88
Two-Party	\$ 587.76
Family	\$ 881.64

### ***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 for more information.

Thank you again for your interest in HMSA's HPH Conversion Plan. If you have any questions, please call 948-5555 to speak with an HMSA representative on Oahu. Neighbor Island residents may call toll-free 1 (800) 620-4672.



# HMSA



**HAWAII MEDICAL SERVICE ASSOCIATION**  
**[hmsa.com](http://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 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.