

HMSA's Individual Business Plan

HMSA's Health Plan for Individual Business Owners

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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 Individual Business Owners

As an individual business owner, you face many challenges. But finding the right health plan shouldn't be one of them.

That's why HMSA has developed the Individual Business Plan — a plan designed specifically for you, so you can take care of business while we take care of you.



Individual Business 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 health plan for individual business owners strikes a balance between the coverage you need and a cost you can afford.

HMSA's Individual Business Plan offers broad coverage for medical services, prescription drugs, vision and dental care. It helps protect you against the catastrophic costs of a major illness or injury. Additionally, HMSA has arranged a \$15,000 group-term life and accidental death and dismemberment benefits policy for plan subscribers through Benefit Services of Hawaii, Inc. We think you'll agree that the Individual Business Plan is the best value to meet your needs.

There are more good reasons to select HMSA's Individual Business Plan:

- **Freedom to Choose**

You have the freedom to choose your own personal physician, dentist, pharmacist and vision provider with the Preferred Provider Plan option. Or, you may select a personal care physician from the health center of your choice with the HMO option.

- **You Have Access to HealthPass**

This program offers preventive services designed to help you identify potential health problems and develop ways to reduce your health risks.

- **You Save Money With the Plan's Managed Care Program**

This plan has cost-management features to assure you get the most appropriate and efficient method and place of treatment for your specific illness or injury. Prior review must be obtained from HMSA for certain types of medical services.

- **The BlueCard Program**

When you're away from home, the last thing you want to worry about is your health. This plan provides nationwide coverage for urgent care services through BlueCard, a Blue Cross and Blue Shield national network that will provide you access to urgent care benefits with designated urgent care providers across the nation.

One phone call is all it takes to access a representative who can provide you with the name, telephone number and address of several providers in your area. Our members also benefit from worldwide emergency coverage through HMSA's Away From Home Program.

HMSA's Individual Business Plan Can Save You Money

With HMSA's Individual Business Plan, you can choose either our Preferred Provider Plan or HMO Hawaii option. These options provide financial protection for you and your family against health care costs and include coverage for dental, drug and vision services.

The Preferred Provider Plan gives you the freedom to choose any licensed physician. However, we suggest that you choose a participating provider to receive maximum benefits of this plan. HMSA has agreements with more than 3,000 of Hawaii's health care providers to assure that our members receive the maximum benefits of their plan.

HMSA participating providers agree to accept not more than a specified amount which, for most services, is the eligible charge for the service. Participating providers also agree, in most cases, to collect from you only the copayment specified in your plan's *Guide to Benefits* for the covered services you receive.

HMO Hawaii provides you with access to a large network of medical providers throughout Hawaii. You select a health center from which to receive all your medical services and then select a personal care physician within the health center. Your personal care physician will coordinate all your health care needs. With HMO Hawaii, you'll receive benefits such as first office visit coverage; low office visit copayments; preventive care services at no extra charge, including annual physical exams and well-baby care; and ongoing programs to assure you of quality care and services.

For a list of providers, please go to hmsa.com or call your local HMSA office.

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 provider, benefit payments are based on the negotiated contract between the out-of-state Blue Cross and/or Blue Shield plans and their participating providers. For services from other out-of-state providers, benefits are based on the eligible charges for the same or similar services in Hawaii.

Precertification

Your HMSA plan has been designed to help control expenses. It includes special features to help members get appropriate health care in the proper setting.

Precertification is a special approval process to ensure that certain medical treatments, procedures, or devices meet payment determination criteria prior to services being rendered.

When you visit HMSA participating providers, the participating providers are responsible for contacting HMSA to obtain approval for you. When you visit nonparticipating providers, you are responsible for obtaining approvals.

If you select the HMO option, your personal care physician is aware of the guidelines to follow and will submit the information and papers that are needed for consideration.

In addition, these features of your plan save you money:

- **Participating Pharmacies**

HMSA's agreement with participating pharmacies guarantee that you will not pay more than the

amounts shown on pages 10 through 12 of this brochure.

If prescriptions are filled at nonparticipating pharmacies, you pay for the total cost of the drug. HMSA will then reimburse you for the remaining eligible charges after deducting the copayment amount. You can avoid unexpected out-of-pocket costs by filling all of your prescriptions at HMSA participating pharmacies.

- **Generic Drugs**

Generic drugs are drugs prescribed or dispensed under their commonly used generic (chemical) name rather than a brand name and that are not protected by patent, or drugs identified by HMSA as "generic."

- **Preferred Brand Drugs**

HMSA has worked with physicians statewide to develop a select formulary of drugs that offers members lower out-of-pocket costs. Ask your physician or pharmacist about preferred brand drugs.

- **HMSA Prescription Delivery Program**

Prescribed maintenance medications that are covered under this plan are available for delivery to your home when obtained from an HMSA contracted pharmacy.

- **Drug Benefit Management**

HMSA has arranged with participating pharmacies to assist in managing the use of certain drugs, including drugs listed in the HMSA Select Prescription Drug Formulary. A list of drugs that require preauthorization of HMSA has been distributed to all participating pharmacies.

Participating pharmacies may dispense up to a 30-day supply for first-time prescriptions of maintenance drugs. For subsequent refills, the participating pharmacy may dispense up to a 90-day supply after confirming that you have tolerated the drug without adverse side effects that could cause the drug to be discontinued and your physician has determined that the drug is effective. (You pay one copayment for each 30-day supply or fraction thereof.)

Group Term Life Benefits

HMSA has arranged to provide Individual Business Plan subscribers a \$15,000 group term life and accidental death and dismemberment policy as part of your benefit package. When you reach age 70, the benefit will reduce to \$7,500. Benefits terminate when you are no longer a member of the Individual Business Plan.

The policy will pay the face value to your beneficiary(ies) when you die. If your death is accidental, an additional amount equal to the face value of the policy will be paid. This is called the principal sum. In case of an accidental injury resulting in the loss of two members (hands, feet or eyes), the principal sum will be paid to you. Half the principal sum will be paid for an accidental injury resulting in the loss of one member.

Should you be declared terminally ill with less than 12 months to live, you may apply for one-half of the benefit to be paid to you immediately to be used as you wish. The remaining amount will be paid to your beneficiary(ies) after your death.

This is a brief description of the benefits of the policy. Upon joining, you will receive a certificate fully describing the benefits, limitations and exclusions of the policy. The group term life is underwritten, and all benefits are provided through USABLE Life. Benefit Services of Hawaii, Inc., is the local agent.

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.

- The care is 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 which 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.

BENEFIT SUMMARY

This brochure is for general information only. It is intended to give you a summary of HMSA's Individual Business Plan benefits and is not to be used as the certificate for the plan. Upon joining, members will receive an *Individual Business Plan Guide to Benefits* that gives further information on benefits, limitations and exclusions. Services rendered within a waiting period will not be payable until the plan waiting periods have been met. 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 3. You may request a copy of the plan's *Guide to Benefits* prior to enrolling by calling your local HMSA office.

Individual Business Plan	YOUR COPAYMENT	AMOUNT OF ELIGIBLE CHARGE YOU PAY WHEN YOU USE:	
	HMO Hawaii	Preferred Provider Plan Participating Providers	Nonparticipating Providers
BENEFIT DESCRIPTION			You owe the amount indicated below plus the difference between eligible charge and actual charge.
ANNUAL DEDUCTIBLE	None	\$100 per person; \$300 per family	
ANNUAL COPAYMENT MAXIMUM	\$5,000 per person; \$15,000 per family	\$5,000 per person; \$15,000 per family	\$5,000 per person; \$15,000 per family
All percentages listed below are based on eligible charges as described on page 3.		Annual deductible applies unless otherwise noted.	
PHYSICIAN SERVICES			
Physician Visits			
Office visit	\$17 copayment per visit	20%	30%
Home or emergency room visit	\$25 copayment per visit	20% ER visit	20% ER visit
Hospital, skilled nursing facility visit	No charge after \$17 copayment per visit	20%	30%
Well-child care visit	No charge	20% No deductible	30% No deductible
Physical Examinations	No charge	Not a benefit	Not a benefit
Surgery			
In or out of the hospital	20%	20%	30%
Anesthesiology	20%	20%	30%
Immunizations			
Well-child	No charge	No charge	No charge
Routine	No charge	No charge	50% No deductible

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

**Individual
Business Plan**

YOUR COPAYMENT

**HMO
Hawaii**

AMOUNT OF ELIGIBLE CHARGE YOU PAY WHEN YOU USE:

**Preferred Provider Plan
Participating
Providers** **Nonparticipating
Providers**

You owe the amount indicated below plus the difference between eligible charge and actual charge.

BENEFIT DESCRIPTION

HOSPITAL SERVICES

You may owe amounts in addition to your copayment. Please refer to the plan certificate for more information. Annual deductible applies unless otherwise noted.

Room and Care Based on semiprivate room rate	20%	20%	30%
Isolation Unit or Intermediate Care Unit	20%	20%	30%
Intensive Care or Coronary Care Unit	20%	20%	30%
Inpatient Services	20%	20%	30%
Inpatient Laboratory and X-ray Services	20%	20%	50%

MATERNITY SERVICES

Routine pre/post natal care and delivery	20%	20%	30%
Hospital services Based on semiprivate room rate	20%	20%	30%

EMERGENCY SERVICES

Use of emergency room (for illness or injury not related to a pre-existing condition or condition not subject to waiting periods)	No charge after \$25 copayment per visit – statewide \$25 copayment per visit - BlueCard provider 20% worldwide	20%	20%
Automobile and Air Ambulance	20%	20%	30%

SKILLED NURSING FACILITY SERVICES

Room and Care and other inpatient services Up to 100 days per calendar year based on daily minimum semiprivate room rate	20%	20%	30%
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AMBULATORY SURGICAL CENTER SERVICES

	20%	20%	30%
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OUTPATIENT LABORATORY AND X-RAY SERVICES

Laboratory services, diagnostic tests, radiation therapy	Outpatient hospital services: 50%	50%	50%
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Note: This is a summary of plan benefits. Please refer to the Guide to Benefits for plan details. 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.

**Individual
Business Plan**

YOUR COPAYMENT

**HMO
Hawaii**

AMOUNT OF ELIGIBLE CHARGE YOU PAY WHEN YOU USE:

**Preferred Provider Plan
Participating
Providers Nonparticipating
Providers**

You owe the amount indicated below plus the difference between eligible charge and actual charge.

BENEFIT DESCRIPTION

Annual deductible applies unless otherwise noted.

Other outpatient laboratory services, diagnostic tests: No charge

50%

50%

X-ray films

20%

50%

50%

Screening by low-dose mammography

No charge

50% No deductible

50% No deductible

Allergy testing and treatment materials

No charge after \$17 copayment

50%

50%

HOSPICE CARE SERVICES

Care for a terminal illness from a hospice that is currently under contract with HMSA. Payment based on an all-inclusive daily rate.

No charge

No charge

Not a benefit

HOME HEALTH CARE SERVICES

Up to 150 days per illness or injury from a qualified home health care agency for part-time skilled medical services.

\$25 copayment per visit

20%

30%

MENTAL HEALTH

Provider Services

Outpatient sessions, (24 sessions per calendar year)

20%

20%

30%

Inpatient session (30 sessions per calendar year)

20%

20%

30%

Room and Care and Inpatient Services

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

20%

20%

30%

Psychological Testing

Outpatient

50%

50%

50%

Inpatient

20%

20%

50%

CARE CONNECTION PROGRAM

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.

* For alcohol and drug dependence services, only the program providers who have been specifically contracted by HMSA to provide alcohol and drug dependence services will qualify as participating providers. Nonparticipating provider benefits shall be paid for services rendered by other providers.

Note: This is a summary of plan benefits. Please refer to the Guide to Benefits for plan details. 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.

Dental Benefits

Individual Business Plan gives you HMSA's CHOICE Dental Plan to suit your needs. You can select HMSA's Preferred Provider Program or HMSA's Dental Network Program. With HMSA's Dental Network Program, your comprehensive dental care is provided at one of many convenient locations. There is no maximum annual allowance for this option.

HMSA's Preferred Provider Program allows you the freedom to visit the dentist of your choice. Benefits are based on a percentage of eligible charges. The maximum annual allowance for this option is \$600.

Dental services must be performed by a doctor of dentistry (D.M.D.) or dental surgeon (D.D.S.).

SERVICE	YOU PAY	
	Dental Network Program	Preferred Provider Program*
EXAMINATIONS	Nothing	Nothing
CLEANINGS	Nothing	Nothing
PALLIATIVE SERVICES	Nothing	Nothing
X-RAYS	Nothing	Nothing
AMALGAM FILLINGS	\$10 per tooth	30%
ROOT CANAL THERAPY	\$50 per tooth	30%
DENTAL SURGERY	\$10-\$75 per tooth	30%
CROWNS	\$25-\$200 per tooth	30%
COMPLETE DENTURES (After a 12-month waiting period)	\$300 per denture	30%
OCCLUSAL SPLINT THERAPY (After a 12-month waiting period)	\$100 per treatment	30% and all charges over the plan's maximum payment of \$250
ORTHODONTICS	Special member rates	All charges

* Benefits shown are for covered services rendered by a participating provider. For covered services rendered by a nonparticipating provider, you owe the difference between actual and eligible charges in addition to the percentage of eligible charges shown above.

Vision Care Benefits

	HMSA Vision Plan Pays	
	Participating Provider	Nonparticipating Provider
Vision Exam	100% after \$10 deductible	Up to \$40
Single Vision Lenses	100% after \$10 deductible	Up to \$16
Multifocal Lenses	100% after \$10 deductible	Up to \$25
Polycarbonate Lenses for children <18 years old	100%	Up to \$18
Contact Lenses	Up to \$130 after \$25 deductible	Up to \$50
Frames	100% after \$15 deductible	Up to \$12
Contact Lens Fitting	Up to \$45	Up to \$20

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.

Prescription Drugs

Copayments for prescription drugs are listed below. Benefits for prescription drugs vary depending on whether the drug is a generic drug, a preferred drug,

or other brand-name drug. Benefit levels also vary depending on whether you use a participating or nonparticipating provider.

Your Copayment Amount Is:

(COPAYMENTS ARE BASED ON ELIGIBLE CHARGES)

	Participating	Nonparticipating
GENERIC DRUGS		
Including oral contraceptives and other contraceptive methods		
Generic	\$5	\$5 plus 20%
DIAPHRAGMS		
	\$10	\$10 plus 20%
ALL OTHER COVERED BRAND-NAME DRUGS		
Preferred	\$20	\$20 plus 20%
Other Brand Name*	\$20*	\$20 plus 20%*
MAIL ORDER DRUGS		
Including oral contraceptives and other contraceptive methods		
Generic Mail Order	\$10	Not Covered
Preferred Mail Order (except insulin and diabetic supplies)	\$45	Not Covered
Insulin -- Preferred	\$10	Not Covered
Diabetic Supplies -- Preferred	None	Not Covered

* Additional amount required (\$35 other brand name cost share)

Diabetic Drugs, Supplies and Insulin

YOUR COPAYMENT

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 toll-free at 1 (800) 499-5036 for more information about this program.

DIABETIC DRUGS

NETWORK PHARMACY

\$5 (generic)
\$20 (preferred brand name)
\$20* (other brand name)

NON-NETWORK PHARMACY

\$5 plus any charges exceeding our payment of 80% of the eligible charge (generic);
\$20 plus any charges exceeding our payment of 80% of the eligible charge (preferred brand name);
\$20* plus 20% of the remaining eligible charge (other brand name)

MAIL-ORDER PHARMACY

\$10 (generic)
\$45 (preferred brand name)
*Additional amount required (\$35 other brand name cost share)

DIABETIC SUPPLIES

Syringes, needles, test strips and auto-lancet devices
Preferred diabetic supplies
Other brand diabetic supplies

NETWORK PHARMACY

None (preferred brand name)
\$20 (other brand name)

MAIL ORDER SERVICE

This service is administered by PrecisionRx. For information on the type of insulin and supplies available through this mail order service, please call PrecisionRx toll-free at 1 (800) 905-9820. Once you are enrolled in this plan, you may order insulin and diabetic supplies via the mail, conveniently delivered to your home.

NON-NETWORK PHARMACY

None (preferred brand name)
\$20 (other brand name)

MAIL-ORDER PHARMACY

None (preferred brand name)

Note: This is a summary of plan benefits. Please refer to the Guide to Benefits for plan details. 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.

Diabetic Drugs, Supplies and Insulin continued...

YOUR COPAYMENT

INSULIN

NETWORK PHARMACY

\$5 (preferred brand name)

\$20 (other brand name)

NON-NETWORK PHARMACY

\$5 plus any charges exceeding our payment of 80% of the eligible charge (preferred brand name)

\$20 plus any charges exceeding our payment of 80% of the eligible charge (other brand name)

MAIL-ORDER PHARMACY

\$10 (preferred brand name)

Note: This is a summary of plan benefits. Please refer to the Guide to Benefits for plan details. 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.

Care Consistent with HMSA's Medical Policies

To be covered, the care you receive must be consistent with HMSA's medical policies. These are policies drafted by HMSA medical directors, many of whom are practicing physicians, in conjunction with community physicians and nationally recognized authorities. Each policy provides detailed coverage criteria for when a specific service, drug or supply meets payment determination criteria. If you have questions about the policies or would like to obtain a copy of a policy related to your care, please call us at one of the telephone numbers on the back cover of this brochure.

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.

Fertility and Infertility

- Contraceptives or contraceptive services including implanted, oral or injected contraceptives and contraceptive devices.
- Infertility diagnosis, supplies or services related to the diagnosis or infertility (PPP).
- 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*) (PPP).
- Physical examinations (including for employment, insurance, school, travel, and other non-medical reasons) (PPP).
- Routine circumcision (PPP).
- Routine foot care (PPP).

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.

Services Not Covered (continued):

- 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.
- 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.
- Topical hyperbaric oxygen therapy.
- Travel or lodging costs.
- Vertebral Axial Decompression (VAX-D).
- Vitamins, minerals and food supplements.
- Weight reduction programs.
- Wigs.

Exclusions Under the Prescription Drug Plan

- Immunization agents.
- Agents used in skin tests to determine allergic sensitivity.
- All drugs to treat infertility.
- All drugs to treat sexual dysfunction, except suppositories listed in the HMSA Prescription Drug Formulary and used to treat sexual dysfunction due to an organic cause as defined by HMSA.
- Smoking cessation agents or devices except as specified in the plan's *Guide to Benefits*.
- Appliances and other non-drug items.
- Injectable drugs except Imitrex, Glucagon and Epinephrine.
- Drugs furnished to hospital inpatients.
- Convenience packaged drugs.
- Unit dose drugs.
- Lifestyle drugs.
- Drugs that may be purchased without a prescription.
- Replacement of lost or stolen prescriptions.

Exclusions Under the Vision Care Plan

- Sunglasses.
- Prescription inserts for diving masks and any protective eyewear.
- Non-prescriptive industrial safety goggles.
- Nonstandard items for lenses, including tinting and blending, oversized lenses, and invisible bifocals or trifocals.
- Repair and replacement of frame parts and accessories.
- Replacements of lost, stolen or broken lenses, contact lenses or frames.
- Refractive eye surgery to correct visual acuity problems.
- Vision training.
- Aniseikonic studies and prescriptions.
- Reading problem studies or other procedures determined to be special or unusual.

Exclusions Under the Dental Plan

- Services that exceed limits for number of services or frequency of services covered during a specific period of time based on our dental policies.
- Any services in connection with temporomandibular disorders or malocclusion (misalignment of teeth or jaws) except as provided under occlusal splint therapy.
- Any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion.
- Temporary crowns, except for fractures, bridges or temporary dentures.
- Indirect pulp caps.
- Prosthetic precision attachments.
- Cosmetic services.
- Treatment of any complications because of previous cosmetic, experimental or investigative services, or other services not covered under this plan.

- Augmentation of the gum ridge and osseointegration and all related services.
- Any service not rendered, supervised or directed by a dentist.
- Orthodontics (treatment and appliances for straightening irregularly placed teeth).
- Services that exceed limits for the number or frequency of services covered during a specific time period, based on our dental policies.
- Maxillary and mandibular implant (osseointegration) and related services.
- Any dental service not rendered, supervised or directed by a dentist.
- Localized delivery of chemotherapeutic agents in periodontal therapy.
- Denture adjustments after six months of initial delivery.
- Maxillofacial prosthetics.

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 certain conditions or services. Please refer to the *Guide to Benefits* for specific information regarding these conditions or services.

Prior continuous coverage cannot be applied toward the waiting periods under this plan for you and each of your dependents. If you or your dependents were covered by another HMSA plan immediately prior to joining this plan, your waiting period will not be reduced by the amount of time spent in that plan. 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 periods 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

periods provided you enroll the child as a dependent within 31 days after the date of initial eligibility.

You must meet all waiting periods for that particular illness or injury before we will cover any related services.

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 on which 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. The discharge date is the day you can leave the hospital or skilled nursing facility because the attending physician has determined that continuous skilled medical care is no longer necessary.

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.

When you apply for this plan, you will fill out a Health History form that tells us about previous medical treatment or advice. The Health History and information from providers who treated you help us determine your eligibility for coverage (Medically Underwritten).

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.

Benefit Summary

This brochure is for general information only. It is intended to give you a summary of HMSA's Individual Business Plan benefits and is not to be used as the certificate for the plan. Upon joining, members will receive an *Individual Business Plan Guide to Benefits*, which gives further information and detail 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. You may request a copy of the *Individual Business Plan's Guide to Benefits* before enrolling by calling your local HMSA office. We have listed our telephone numbers on the back cover of this brochure for your convenience.

Please see pages 15-17 regarding plan waiting periods.

Who Can Apply

You are eligible to apply for HMSA's Individual Business Plan if you are self-employed and engaged in a full-time business in the state of Hawaii as a sole proprietor, partner or corporation for a minimum of six months prior to applying.

You must have the following current federal and state of Hawaii taxpayer's identification numbers and the following information and licenses:

- General excise tax license number.
- Federal tax payer number.
- Current federal and state tax filings for your business (i.e., Form 1040, with Schedule C, Profit and Loss).
- Other professional licenses (contractor, pocket license, broker, etc.) required to do business by the state of Hawaii.

Employees are not eligible for this plan. If you have employees, you should consider another HMSA plan for them. HMSA group coverage is available for employers who must comply with the Hawaii Prepaid Health Care Act. If you have employees who are exempt from the Hawaii Prepaid Health Care Act and do not have any health care coverage, they may be eligible for HMSA's Individual (non-group) Care Plan. Please contact the Hawaii Department of Labor if you have questions about your need to comply with the Hawaii Prepaid Health Care Act.

Once you no longer work at your business on a full-time basis, move out of state, or retire, you are no longer eligible for this plan. Please call HMSA to learn about alternative plan options.

If you qualify for COBRA coverage through a former employer, we strongly recommend that you elect and exhaust all COBRA coverage prior to enrolling in this plan.

You must submit an application and HMSA health statement for this plan. Your application and HMSA health statement will be reviewed and acceptance is based on your health status. Completion of these forms does not guarantee acceptance into this plan.

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 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.

How to Join

To apply for Individual Business Plan, please complete and return the following items:

- Application.
- US Able life insurance form.
- Eligibility questionnaire.
- Health History form for subscriber.
- Copy of your current general excise tax license (if your license is older than two years, please enclose a copy of your current G.E.T. booklet cover).
- Copy of your federal tax payer number (if applicable).
- Articles of incorporation or proof of partnership (if applicable).
- Copy of your most current federal tax filings for your business (Schedule C, Profit/Loss statement).
- Copy of your professional license required within the state of Hawaii to perform your business (e.g., contractor's or pocket license, broker or real estate license, medical license).
- Individual Plan Authorization for Medical Records form for each applicant over 18 years of age.

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

Please do not send any money at this time. Upon approval of your application, HMSA will send you a bill.

HMSA would like to meet the special needs of each of Hawaii's citizens. However, completion of the application and health statement does not guarantee acceptance into Individual Business Plan. Please give careful consideration before ending any existing health coverage until you are notified of your acceptance into Individual Business Plan.

Rates

These benefits and the following rates are effective from Jan. 1, 2008.

2008 Monthly Member Dues		
	HMO	PPP
Single Membership	\$257.50	\$322.75
Two-Party Membership	\$505.75	\$633.25
Family Membership	\$699.00	\$875.50

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 for more information.

Questions

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

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.

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

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

The Hawaii Medical Service Association is a nonprofit, mutual benefit association founded in Hawaii in 1938. It is the most experienced provider of health care coverage in the state. HMSA is a member of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

HMSA is dedicated to providing Hawaii's families with access to quality, affordable health care. We are also committed to improving the health and well-being of all HMSA members and the community at large through a variety of health education, promotion and prevention programs and other community services.