

HMSA's Individual Care Plan

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 Individual Care Plan

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

HMSA's Individual Care Plan is one of the best investments you can make to protect your good health. HMSA developed the Individual Care Plan because everyone needs financial protection against unexpected health care costs.

HMSA's Individual Care Plan can help you meet expenses for office visits; surgical, hospital and maternity services; diagnostic tests; emergency room visits; and hospital care; as well as preventive services to keep you and your family healthy.

There are two options: High and Basic. You choose the option that best meets your financial and health care needs. Each option provides broad coverage for medical services as well as preventive services to keep you and your family healthy.

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

- ***Network of Providers***

HMSA's Individual Care Plan provides you with access to a large network of health care 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 to prevent them from becoming major health problems if left unattended. If enrolled in this plan, we encourage you to take advantage of the 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.

- ***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 (BK)

\$5,000 per person
\$15,000 (maximum) per family contract

Basic Option (BN)

\$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, all you have to do is call BlueCard Access toll-free at 1 (800) 810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder website at www.BCBS.com.

For trips to the Neighbor Islands, benefits are available by contacting the Customer Service office on the island you are visiting.

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.

- ***Integrated Case Management***

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 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 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

Services Not Covered (continued)

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 and supplies, oral chemotherapy).
- 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 or 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).

Services Not Covered (continued)

- Genetic testing and screening.
- 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 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.

Medical Underwriting Expenses Incurred

This plan is medically underwritten and not guaranteed issue. Once you submit your application, health history form, and authorization for medical records form, the medical underwriter will review your health statement and may contact you for additional medical information. This is a necessary step to determine whether you are an acceptable risk when measured against our acceptance guidelines for this plan. All information will be kept confidential during the medical underwriting process. Because acceptance is based on your health status, completion of these forms does not guarantee acceptance into this 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.

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.

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.

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.

Waiting Period for Transplants

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

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 on which your coverage under this plan begins). This waiting period applies

BENEFIT SUMMARY

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

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 Individual Care Plan

Your Copayment

BENEFIT DESCRIPTION

High Option (BK)

Basic Option (BN)

TYPE OF PLAN

These are health maintenance organization plans. They include benefits for emergency services, illness or injury, free physical exams and preventive care to keep members 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 services to help you maintain your optimal health.

ANNUAL DEDUCTIBLE

\$300 per person;
\$900 per family contract

\$500 per person;
\$1,500 per family contract

ANNUAL MAXIMUM COPAYMENT

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

\$7,500 per person;
\$22,500 per family contract

PHYSICIAN VISITS

ANNUAL DEDUCTIBLE APPLIES UNLESS OTHERWISE NOTED.

Office visit (including vision exam)

\$17

\$17

Home visit

\$25

\$35

Emergency room visit

\$25

\$35

Skilled nursing facility visit

\$17

\$17

Well-child care visit

\$17*

\$17*

Online Care visit

\$10 for up to 10 minutes*
\$5 for an additional
5-minute extension

\$10 for up to 10 minutes*
\$5 for an additional
5-minute extension

PHYSICAL EXAMINATIONS (Routine annual checkup)

\$17*

\$17*

SURGERY

Surgical procedure

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%

* Not subject to the annual deductible.

HMSA's Individual Care Plan

Your Copayment

BENEFIT DESCRIPTION

High Option (BK) Basic Option (BN)

IMMUNIZATIONS

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

HOSPITAL AND FACILITY SERVICES

Up to 365 days per calendar year

Room and board — Based on semiprivate room rates	10%	30%
Inpatient laboratory and pathology/X-ray and other radiology	10%	30%

MATERNITY CARE

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

EMERGENCY SERVICES

Emergency room facility services		
In state	\$50	\$50
BlueCard provider	\$50	\$50
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%
----------------	-----	-----

OUTPATIENT TESTS AND LABORATORY AND X-RAY SERVICES

Laboratory and pathology/Diagnostic tests	20% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room)	30% (office visit) 50% (hospital outpatient, ambulatory surgical center, or emergency room)
X-ray and other radiology	20% (office visit, hospital outpatient, ambulatory surgical center, or emergency room)	30% (office visit, hospital outpatient, ambulatory surgical center or emergency room)
Radiation therapy	50% (office visit/ hospital outpatient)	50% (office visit/ hospital outpatient)
Mammography (screening)	No copayment*	20%*
Allergy testing	\$17	\$25

HOSPICE CARE BENEFITS

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

* Not subject to the annual deductible.

HMSA's Individual Care Plan

Your Copayment

BENEFIT DESCRIPTION

High Option (BK) Basic Option (BN)

HOME HEALTH CARE BENEFITS

Limited to 150 visits per calendar year
from a qualified home health agency or health center

\$25 per visit

\$35 per visit

MENTAL HEALTH AND SUBSTANCE ABUSE

Physician Visits

Outpatient sessions (24 sessions per calendar year**)

20%

30%

Inpatient sessions (30 sessions per calendar year)

20%

30%

Hospital/Facility Charges

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

10%**

30%**

Psychological Testing

Outpatient

50%

50%

Inpatient

20%

30%

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

HMSA's Individual Care Plan

BENEFIT DESCRIPTION

Your Copayment

PRESCRIPTION DRUGS AND SUPPLIES

Chemotherapy – Oral Drugs

Chemotherapy – Oral

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

Diabetic drugs

Network Pharmacy*

20% of eligible charge (Generic)

20% of eligible charge (Preferred Brand Name)

30% of eligible charge (Other Brand Name)

Non-Network Pharmacy*

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 Pharmacy*

20% of eligible charge (Generic)

20% of eligible charge (Preferred Brand Name)

30% of eligible charge (Other Brand Name)

Diabetic supplies

Network Pharmacy*

50% of eligible charge

Non-Network Pharmacy*

You owe the entire charge and HMSA reimburses you 50% of the eligible charge

Contracted Mail Order Pharmacy*

50% of eligible charge

Insulin

Network Pharmacy*

20% of eligible charge (Preferred Brand Name)

30% of eligible charge (Other Brand Name)

Non-Network Pharmacy*

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 Pharmacy*

20% of eligible charge (Preferred Brand Name)

30% of eligible charge (Other Brand Name)

* Not subject to the annual deductible.

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 to apply, you must:

- Reside in the state of Hawaii for at least six consecutive months prior to applying to this plan.
- Be a legal resident and reside within the plan's service area.

Your application forms will be reviewed and acceptance is based on your health status. Completion of these forms does not guarantee acceptance into this plan.

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 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

Please complete and return the following items:

- Complete application form. 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 the health center.
- Health History Form for Subscriber and All Dependent(s)
- Completed and signed Individual Plan Authorization for Medical Records form for each applicant over 18 years of age.

Mail to: HMSA
6-AMS
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.

Although HMSA would like to be able to meet the special needs of each of Hawaii's citizens, completion of the application form does not guarantee acceptance into the Individual Care Plan. Your forms will be reviewed by medical underwriters and acceptance will be based on your health status. The medical underwriting process can take up to 60 days or more. Please give careful consideration before terminating any existing health coverage until acceptance in the Individual Care Plan is confirmed.

Rates

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

2010 Monthly Member Dues		
	HIGH OPTION	BASIC OPTION
Single	\$200.50	\$147.00
Two-Party	\$400.75	\$294.00
Family	\$601.50	\$441.25

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's sales department for more information.

Questions

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

Privacy Policies & Practices for Member Financial Information

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

- Maintain physical, electronic and procedural safeguards to protect the privacy, confidentiality and integrity of personal information.
- Ensure that those in our workforce who have access to or use your personal information

need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following our policies and practices.

- Require that third parties who access your personal information on our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

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

Effective July 1, 2002, HMSA is required by state law to provide annual notice of our privacy policies and practices for personal financial information to members who are enrolled in our individual health plans. This notice contains information regarding how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. Provisions of this notice apply to former as well as current HMSA members.

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

Collection of Personal Financial Information

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

Sharing Personal Financial Information

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

HMSA



HAWAII MEDICAL SERVICE ASSOCIATION
hmsa.com

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

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

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

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

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

If you are calling from the U.S. Mainland, please call 1 (800) 776-4672.

If you need to call a local Hawaii telephone number
from the Mainland, the area code is 808.

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