

SENIOR Connection



Plan B
Certificate
2012



An Independent Licensee of the Blue Cross and Blue Shield Association

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30-Day Right to Cancel

You have the right to return this certificate within 30 days of its delivery and to have the dues refunded if, after examination of the certificate, you are not satisfied for any reason.

Notice to Buyer

This certificate may not cover all of your medical expenses. This is an individual plan certificate and does not provide coverage for a family.

Introduction

Welcome to HMSA's **Senior Connection Plan B**. This certificate contains important information about your plan, and how to use it. If you need additional information or assistance, you may contact an HMSA representative by phone. Your local HMSA office number is listed on the back of this brochure.

Notifying You of Any Change

HMSA reserves the right to change the terms, conditions and benefits under this certificate or to increase the monthly dues which you must pay for coverage. HMSA will always provide you with at least 30-days notice of any change.

We will send all our letters to you at the last address we have on file for you.

If you change your address, please contact your local HMSA office. On Oahu, please call 948-6140. Members on Molokai and Lanai may call toll-free 1 (800) 639-4672. Hearing-impaired members can call our text telephone (TTY) at 948-6222 on Oahu or toll-free on the Neighbor Islands and U.S. Mainland at 1 (877) 298-4672.

Continuing Your Coverage

Plan coverage is guaranteed renewable unless:

- You fail to pay your dues, or
- You materially misrepresent information to HMSA.

If at any time you fail to meet either of these requirements, your **Senior Connection Plan B** coverage will end automatically. Even though your **Senior Connection Plan B** coverage has ended, your Medicare coverage has not automatically ended.

Your Contract With HMSA

You will know that we have accepted you as a **Senior Connection Plan B** member when you receive a membership card telling you on which day your coverage starts.

Upon application to and acceptance into an HMSA plan, you are enrolled as a member of

HMSA and you have all the rights and obligations described in this certificate and in the constitution and bylaws of HMSA. The constitution and bylaws of HMSA are available for your review at your local HMSA office.

As an HMSA member, you agree to abide by the constitution and bylaws of HMSA.

You hereby expressly acknowledge your understanding that this agreement constitutes a contract solely between you and HMSA, which is an independent plan operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans (the "Association"), permitting HMSA to use the Blue Cross and Blue Shield service marks in the state of Hawaii, and that HMSA is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this agreement based upon representations by any person, entity or organization other than HMSA and that no person, entity or organization other than HMSA shall be held accountable or liable to you for any of HMSA's obligations to you created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMSA other than those obligations created under other provisions of this agreement.

This certificate, together with your application and membership card, constitutes the entire legal contract between you and HMSA. Please read this certificate carefully because it describes the benefits of **Senior Connection Plan B**, limitations and exclusions to your coverage, your rights and obligations, and those of HMSA.

Wherever we use the words "you" or "your" in this certificate, we mean the member, whose application for coverage under this plan has been accepted by HMSA. The words "we," "us" and "our" refer to HMSA.

To help you in your reading, we have defined several of the special words used in this certificate (see pages 13-15).

Paying Your Dues on Time

You must pay your **Senior Connection Plan B** dues on time. Your monthly dues beginning Jan. 1, 2012, are \$152.00. We will send you a

billing statement every month showing you the dues you owe and the date by which we must receive them. Dues must be received within 10 days of the due date shown on the billing statement. If we do not receive your dues on a timely basis, your membership in **Senior Connection Plan B** will terminate at the end of the last month for which we received your dues.

For your convenience, **Senior Connection Plan B** has an automatic dues payment service available. You determine how often you would like to make payments on your account (monthly, quarterly, semiannually, annually), and we can help you arrange to have the correct amount transferred from your bank account directly to **Senior Connection Plan B**.

If you are an inpatient or certified by your physician to be totally disabled while your **Senior Connection Plan B** is still in effect, benefits under **Senior Connection Plan B** will be paid for the period of continuous total disability if you continue to pay your dues.

When Coverage Ends

By paying your dues on time, you elect to renew your coverage and the contract between us for an additional month. You can cancel your coverage at any time by sending us advance notice. Your last day of coverage will be the last day of the month in which we receive your notice, provided you have paid your dues for that month. Any dues received for periods of coverage after your last day of coverage will be refunded to you.

Automatic Adjustments

Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Dues may be modified to correspond with these changes.

How to Use Your Plan

When Coverage Begins

Coverage begins on the date shown on your **Senior Connection Plan B** membership card.

HMSA will pay benefits only starting from that date. HMSA will not pay for services received before your effective date. Effective Jan. 1, 2001, **Senior Connection Plan B** is no longer available to new enrollments.

Your Customer Service Representatives

Senior Connection Plan B has Customer Service representatives to help you in all matters related to your health plan. Your Customer Service representatives are available to help you promptly with any questions or problems. Your Customer Service representative is an active part of your health care team and is available to serve you in offices on Oahu, Maui, Kauai, and in Hilo and Kona.

Your Membership Card

Your membership card is your key to all medical services. It identifies you as a **Senior Connection Plan B** member. Always carry your membership card. **Important: Your HMSA membership number is very important in filing claims. If you lose your card, please call HMSA's Membership representatives at 948-6140 for a new card.**

Reducing Your Expenses – Steps You Can Take

You can control how much you pay for covered services through your choice of a physician. Under this plan, you are free to go to any licensed physician or hospital of your choice and receive coverage.

However, we suggest that you choose a Medicare participating provider to receive the maximum benefits of this plan.

Scheduling Appointments

Always call your physician in advance for an appointment when you need health care. Appointments help make the most effective use of time for everyone. If you cannot keep your appointment or will be late, please notify your physician so that other arrangements may be made.

Suspension of Coverage While You are Covered by Medicaid

You may suspend your HMSA Medicare Supplement **Senior Connection Plan B** coverage

for up to 24 months if you become eligible for Medicaid assistance under Title XIX of the Social Security Act (42 U.S.C. § 1395 et seq.), but only if you notify HMSA in writing within 90 days of becoming eligible for this assistance. Upon receipt of timely notice, HMSA will return to you that portion of the dues attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If you later become ineligible for Medicaid assistance, HMSA will reinstate your **Senior Connection Plan B** if you notify HMSA within 90 days of losing your Medicaid eligibility, and if you pay dues from the date of termination from Medicaid. HMSA will then reinstate your **Senior Connection Plan B** effective as of the date of your termination from Medicaid and no waiting periods will be imposed. Upon reinstatement, your dues will be the same as those members under **Senior Connection Plan B** and will be the amount that would have applied had you not suspended your **Senior Connection Plan B** coverage.

If **Senior Connection Plan B** is no longer available, you will be reinstated into a plan substantially equivalent to the **Senior Connection Plan B** coverage you had in effect before the date of suspension. Upon reinstatement, the dues will be at least as favorable as the dues that would have applied had your coverage not been suspended.

Knowing Your Benefits

You get the best protection from this plan by knowing what services are covered and by using these services only when necessary. In this way, you can help control the cost of your plan.

All covered services you receive must be Medically Necessary.

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 is Medically Necessary, even if it is listed as a covered service.

Participating providers may not bill or collect charges for services or supplies that are not Medically Necessary 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 write to us for a determination regarding the medical necessity of a procedure, service or supply before you receive the care.

The benefits charts on pages 16-18 show you:

- Services covered by Medicare,
- Benefits paid by Medicare, and
- Any amount you owe for covered services.

The charts on pages 16-18 shows **Senior Connection Plan B** regular benefits. These benefits give you additional coverage for those services only partially paid for by Medicare.

Senior Connection Plan B will not pay its regular benefits for services you receive unless Medicare has paid for them first. For example, if you have not met your Medicare Part B (medical) deductible and you visit your physician for care, Medicare and **Senior Connection Plan B** will not pay benefits for that visit. After you have met your deductible, Medicare must pay 80 percent of its approved charges for covered services before **Senior Connection Plan B** will pay the remaining 20 percent.

In all cases, Medicare will pay its benefits first and **Senior Connection Plan B** will then pay benefits for approved charges in excess of Medicare benefit payments. You will still have to pay all charges for services that are not covered at all by Medicare and that are not included in **Senior Connection Plan B** as regular benefits.

Besides knowing what services are covered, you should also know the limitations and exclusions of this plan. You will find the exclusions section on pages 9-10.

Medicare Participating Providers

Health care providers who are participating providers sign Medicare participation agreements and accept the Medicare-approved amount on Medicare claims. If you are not sure whether your health care provider is a Medicare participating provider, you should ask them.

When you use Medicare participating providers, Medicare will pay its benefits first. HMSA will then pay the **Senior Connection Plan B** benefits directly to the Medicare participating provider. You are responsible for the payment of any services or charges not covered by Medicare or **Senior Connection Plan B**.

Medicare Nonparticipating Providers

If you use a health care provider who is not a participating provider, you pay the health care provider directly, and HMSA will send the **Senior Connection Plan B** benefit payment directly to you. You will owe the nonparticipating provider the Medicare deductible and co-insurance amounts, including any difference between the Medicare-approved amount and the Medicare-limiting amount.

Member's Rights & Responsibilities

HMSA's **Senior Connection Plan B** is committed to treating members in a manner that respects their rights and has written policies addressing the members' responsibility for cooperating with those providing health care services.

HMSA's **Senior Connection Plan B** recognizes the following members' rights:

- Members have the right to be provided with information about **Senior Connection Plan B**, its services, the practitioners providing care, and members' rights and responsibilities in clear, understandable language.
- Members have the right to receive Medically Necessary care covered under the members' benefit package.
- Members have the right to be informed about their diagnosis, treatment options and prognosis in clear, understandable language.
- Members have the right to participate in decision making regarding their health care.

- Members have the right to be treated with respect and recognition of their dignity and privacy.
- Members have the right to confidentiality of information concerning their medical treatment.
- Members have the right to voice dissatisfaction about their health plan or the medical care they receive.
- Members have a right to a candid discussion of all appropriate or Medically Necessary options for their condition.
- Members have the right to know how their physician and other health care professionals are compensated by their plan.

Senior Connection Plan B members also have the following responsibilities:

- Members are responsible for reading and understanding all materials concerning their health benefits.
- Members are responsible for complying with all terms of their membership with their plan.
- Members are responsible for notifying their plan of any other health care plan they are a member of and for cooperating with their plan in coordinating benefits.
- Members are encouraged to develop and maintain a satisfactory physician-patient relationship.
- Members are responsible for providing, to the extent possible, necessary information that the professional staff needs for the members' care.
- Members are responsible for making, keeping or canceling appointments.
- Members are responsible for following instructions and guidelines given to them by their health care providers.
- Members are responsible for copayments to the health care provider.
- Members are responsible for engaging in a healthy and safe lifestyle.

Filing Claims

Here are some instructions to help you file a claim. A claim is a form requesting payment of benefits for services covered by Medicare.

For Regular Benefits of Senior Connection Plan B That are Covered by Medicare

In Hawaii

When you receive covered services in Hawaii:

- Present your HMSA membership card to the provider.
- Be sure the provider and HMSA have your correct mailing address, and
- Ask the provider to file a Medicare claim for you. Please make sure that the provider indicates on the claim form that you have HMSA coverage and includes your HMSA membership number.

Most providers will file claims with Medicare for you. However, you are responsible for making sure that the claim is sent to Medicare. We can pay our benefits only after you file your claim.

When a provider does not file claims for you, you must file your own claims with Medicare. Please see *The Medicare Handbook* for instructions. Be sure to write on the claim form that you have **Senior Connection Plan B** coverage and include your HMSA membership number.

Whether you or your provider files the claim for services received in Hawaii, Medicare will send you and HMSA a notice called Medicare Summary Notice to explain Medicare's payment decision on your claim. With the information we receive from Medicare, we can then pay **Senior Connection Plan B** benefits. You do not have to send us your Medicare Summary Notice.

Any claim sent or brought to us more than one year after the date you received the services will not be eligible for payment.

Anywhere Else in the United States

For covered hospital and medical services you receive while traveling anywhere else in the United States, you must file your Medicare claim in the state where you received your care. When you receive the Medicare Summary Notice after Medicare pays its benefits, send a copy of the notice to us.

Be sure to write the following on the Medicare Summary Notice:

- Your physician's full name.
- Your HMSA membership number.

- Your current address on the Medicare Summary Notice next to your name.

Then send the Medicare Summary Notice to:

HMSA Medical Claims
P.O. Box 860
Honolulu, HI 96808-0860

Incorrect or Material Misrepresentation

We will not pay any benefits to the extent that such benefits are payable by reason of any material misrepresentation made in an application for membership or in any claims for benefits. If we pay such benefits before learning of any material misrepresentation, you agree to reimburse HMSA for such payment. You also may no longer be eligible to continue as a member of **Senior Connection Plan B**.

Regular Benefits

Regular Benefits — Part A Hospitalization

Subject to the provisions of this certificate, the hospital benefits to which you are entitled are as follows:

Inpatient Hospital Benefits

Your **Senior Connection Plan B** pays your Part A Medicare-eligible deductible for hospitalization during the first 60 days per Medicare benefit period. This includes semiprivate room and board and miscellaneous hospital services and supplies, such as drugs, X-rays, lab tests and operating room.

Senior Connection Plan B pays the portion of Medicare-approved amounts for Medicare Part A expenses not paid by Medicare from the 61st day through the 90th day in any Medicare benefit period.

Senior Connection Plan B pays the portion of Medicare Part A approved amounts not paid by Medicare during the 91st day through the 150th day. These are your lifetime reserve days.

Once these lifetime reserve days are exhausted, **Senior Connection Plan B** will pay 100 percent of Medicare-eligible expenses, paid at the diagnostic related group (DRG), day outlier, per diem, or other appropriate standard of payment, up to a lifetime maximum benefit of an additional 365 days. **Senior**

Connection Plan B pays nothing beyond the 365 additional days.

Blood — Inpatient

Senior Connection Plan B pays Medicare-approved amounts for the first three unreplaced pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) used in a year and its administration.

Regular Benefits — Part B Medical

Inpatient or Outpatient Physician Services

You are responsible for the first \$140 (Part B deductible) of Medicare-approved amounts. If there are Medicare-approved charges remaining after the \$140 Part B deductible is met, the plan will pay 20 percent of those remaining charges. Thereafter, Senior Connection Plan B will pay 20 percent of Medicare-approved amounts. You will be responsible for all costs exceeding Medicare-approved amounts.

Blood — Outpatient

Senior Connection Plan B pays Medicare-approved amounts for the first three unreplaced pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) used in a year unless you have already paid for them as part of a hospital stay, plus 20 percent of the Medicare-approved amount for blood after you have met the Medicare Part B annual deductible.

Regular Benefits - Part A and Part B

Home Health Care

Under home health care, you pay nothing for Medically Necessary skilled care service and medical supplies.

For durable medical equipment, you pay the Part B annual Medicare-eligible deductible. If there are Medicare-approved charges remaining after the \$140 Part B deductible is met, the plan will pay 20 percent of those remaining charges. Thereafter, Senior Connection Plan B will pay 20 percent of Medicare-approved amounts. You will be responsible for all costs exceeding Medicare-approved amounts.

Online Care

Covered, when provided by HMSA's Online Care at hmsa.com. You must be at least 18 years old. Care is available for 10-minute sessions, which may be extended up to 5 additional minutes. Each session is limited to a total of 15 minutes (except for Behavioral Health providers).

Third-Party Liability Rules

If You Have Coverage Under Workers' Compensation or Motor Vehicle Insurance

If you have or may have coverage under workers' compensation or motor vehicle insurance for the illness or injury, please note the following:

- **Workers' Compensation Insurance**

If you have or may have coverage under workers' compensation insurance, such coverage will apply instead of the coverage under this plan. Medical expenses arising from injuries or illness covered under workers' compensation insurance are excluded from coverage under this plan.

- **Motor Vehicle Insurance**

If you are or may be entitled to medical benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us. Please refer to the section entitled "Motor Vehicle Insurance Rules" for a detailed explanation of the rules applicable to your automobile coverage.

What Third-Party Liability Means

Third-party liability is when you are injured or become ill and:

- The injury or illness is caused or alleged to have been caused by someone else and you have or may have a right to recover damages or receive payment in connection with the injury or illness; or
- You have or may have a right to recover damages or receive payment without regard to fault.

In such situations, any payment made by us on your behalf in connection with such injury or illness will only be in accord with the following rules.

What You Need to Do

Your cooperation is necessary for us to determine our liability for coverage and to protect our rights to recover our payments. We will provide benefits in connection with the injury or illness in accordance with the terms of this plan only if you cooperate with us by doing all of the following:

- **Give Us Timely Notice**

You must give us timely notice in writing for each of the following: (1) your knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness; (2) any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the injury or illness; and (3) any recovery of damages (including any settlement, judgment, award, insurance proceeds or other payment) against any third party or other source of recovery in connection with the injury or illness. To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above.

- **Sign Requested Documents**

You must promptly sign and deliver to us all liens, assignments and other documents we deem necessary to secure our rights to recover payments, and you hereby authorize and direct any person or entity making or receiving any payment on account of such injury or illness to pay to us so much of such payment as necessary to discharge your reimbursement obligations described above.

- **Provide Us Information**

You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us medical records and other relevant information.

- **Do Not Release Claims Without Our Consent**

You must not release, extinguish or otherwise impair our rights to recover our payments, without our express written consent.

- **Cooperate With Us**

You must cooperate in protecting our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.

Any written notice required by these rules must be sent to:

HMSA
Attn: 8CA/Other-Party Liability
P.O. Box 860
Honolulu, HI 96808-0860

If you do not cooperate with us as described above, your claims may be delayed or denied, and we shall be entitled to reimbursement of payments made on your behalf to the extent that your failure to cooperate has resulted in erroneous payment of benefits or has prejudiced our rights to recover our payments.

Payment of Benefits Subject to Our Right to Recover Our Payments

If you have complied with the rules above, we will pay benefits in connection with the injury or illness to the extent that the medical treatment would otherwise be a covered benefit payable under this plan. However, we shall have a right to be reimbursed for any benefits we provide, from any recovery received from or on behalf of any third party or other source of recovery in connection with the injury or illness, including, but not limited to, proceeds from any:

- Settlement, judgment or award;
- Motor vehicle insurance including liability insurance or your underinsured or uninsured motorist coverage;
- Workplace liability insurance;
- Property and casualty insurance;
- Medical malpractice coverage; or
- Other insurance.

We shall have a first lien on such recovery proceeds, up to the amount of total benefits we pay or have paid related to the injury or illness. You must reimburse us for any benefits paid, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment):

- Do not specifically include medical expenses;
- Are stated to be for general damages only;
- Are for less than the actual loss or alleged loss suffered by you due to the injury or illness;
- Are obtained on your behalf by any person or entity, including your estate, legal representative, parent or attorney;
- Are without any admission of liability, fault or causation by the third party or payor.

Our lien will attach to and follow such recovery proceeds even if you distribute or allow the proceeds to be distributed to another person or entity. Our lien may be filed with the court, any third party or other source of recovery money, or any entity or person receiving payment regarding the illness or injury.

If we are entitled to reimbursement of payments made on your behalf under these rules, and we do not promptly receive full reimbursement pursuant to our request, we shall have a right of set-off from any future payments payable on your behalf under this plan.

To the extent that we are not reimbursed for the total benefits we pay or have paid related to your illness or injury, we have a right of subrogation (substituting us to your rights of recovery) for all causes of action and all rights of recovery you have against any third party or other source of recovery in connection with the illness or injury.

Our rights of reimbursement, lien and subrogation described above are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien we may have for reimbursement of these payments, all of which rights are preserved and may be pursued at our option against you or any other appropriate person or entity.

For any payment made by us under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this plan.

Nothing in these third-party liability rules shall limit our ability to coordinate benefits in accord with HMSA's policies.

Motor Vehicle Insurance Rules

Automobile Coverage

If your injuries or illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes, Chapter 431, Article 10C, then that motor vehicle coverage will pay before this coverage.

You are responsible for any cost-sharing payments required under such motor vehicle insurance coverage. We do not cover such cost-sharing payments.

Before we pay benefits under this coverage for an injury covered by motor vehicle insurance, you must give us a list of medical expenses paid by the motor vehicle insurance. The list must show the date the expenses were incurred, the provider of service, and the amount paid by motor vehicle insurance.

We will review the list of expenses to make sure that the motor vehicle insurance coverage under Hawaii law is exhausted. After we check this, you can receive covered services in accord with your health plan certificate.

Please note that in the following two situations, you are also subject to the third-party liability rules stated above:

(1) If your injury or illness is caused or may have been caused by someone else and you have or may have a right to recover damages or receive payment for the illness or injury, or

(2) If you have or may have a right to recover damages or receive payment without regard to fault (other than coverage available under Hawaii Revised Statutes Chapter 431, Article 10C).

Any benefits paid by us under this section or the third-party liability rules are subject to the provisions described above under third-party liability rules.

Exclusions

Senior Connection Plan B has the same exclusions as Medicare, which include the following:

- Any services or charges not covered under Medicare Part A and Part B.

- Cosmetic surgery, unless it is needed for the prompt repair of accidental injury or to improve the functioning of a malformed part of the body.
- Drugs except for inpatient drugs covered under Medicare Part A and Part B.
- Environmental control equipment and supplies such as air conditioners, humidifiers, dehumidifiers, air purifiers, or sterilizers, water purifiers, vacuum cleaners, or supplies such as filters, vacuum cleaner bags and dust mite covers.
- Eye examinations for prescribing, fitting or changing eyeglasses.
- Eyeglasses or contact lenses, except as covered by Medicare.
- Hearing aids and hearing examinations.
- Interisland transportation, except air ambulance.
- Personal comfort items such as telephone, TV and personal grooming services.
- Preventive immunizations except:
 - Pneumococcol vaccine.
 - Hepatitis B vaccine.
 - Flu shots (limited to one per calendar year).
- Rest cures, custodial or domiciliary care or homemaker services.
- Routine dental care.
- Routine foot care, except as covered by Medicare to treat medical conditions affecting the lower limbs.
- Routine physical examinations.
- Services required in the treatment of an injury or illness that results from an act of war.
- Services for which no charge or collection would be made if you had no health plan coverage.
- Services not covered by Medicare or not described as covered in this plan.
- Services not Medically Necessary.
- Services or supplies not required in accordance with accepted standards of medical, dental or psychiatric practice.
- Services provided by members of your immediate family, household or yourself.
- Services related to sex transformations and sexual dysfunctions or inadequacies.
- Treatments, services and supplies that are primarily for your convenience or the convenience of your provider.

Additional Information

Health Information

As part of your plan, HMSA makes health information available to you through the media, the mail and community-wide programs. Information about exercise, high blood pressure, stress, and other health-related topics is available to help you maintain better health.

Information to Pay Your Claim

There may be times when we need more information to pay your claim. You therefore agree to complete forms or provide us with certain documents or papers when necessary.

Confidential Information

Your medical records and information about your care is confidential. HMSA does not use or disclose your medical information except as permitted or required by law. In accordance with law, we may use or disclose your medical information (including providing this information to third parties) for purposes such as payment activities and health care operations including but not limited to quality assurance, disease management, provider credentialing, administering the plan, complying with government requirements, and research or education.

Unclaimed or Uncashed Benefit Checks

A service charge will be assessed on a benefit check that has not been cashed, deposited or otherwise negotiated by the member prior to the check's expiration date. A schedule of current service charges is available upon request.

Benefit Payment Notices

After benefits have been paid, Medicare and HMSA will send you a benefit payment notice. For **Senior Connection Plan B**, you will receive a Report to Member showing you the date and the amount of our payments.

If you do not receive a Medicare Summary Notice after you receive covered services, call your local Medicare office and ask if your claim was received. If you do not receive a Report to Member from **Senior Connection Plan B**, call your local HMSA office.

To be sure you receive **Senior Connection Plan B** benefit payments and notices, please write or call us to let us know whenever you have a new mailing address.

Transfer Into Another HMSA Plan

If you cannot continue as a member of **Senior Connection Plan B** because you do not have both Medicare Part A and Part B, you may transfer into another HMSA plan. You must, of course, meet the other plan's requirements for becoming a member.

Questions About Payments

Review

There may be a time when you disagree with our payment of your claim. If this happens, you may ask for a review of that claim.

For Benefits Covered by Medicare

Since our regular benefits are based on what Medicare covers, you must ask Medicare for a review. Please see *The Medicare Handbook* for details. After this review, we will follow Medicare's decision to pay or not pay a claim.

Your Request for an Appeal

For Additional Benefits that Medicare Does Not Cover

If you have a question about our payments for additional benefits that Medicare does not cover, please contact your local HMSA office for assistance.

If you are not satisfied with the information you receive and wish to dispute a determination made by HMSA related to coverage, reimbursement, any other decision or action by HMSA, or any other matter related to this agreement, you may request an appeal.

Writing Us to Request an Appeal

Your request must be in writing unless you are requesting an expedited appeal. We must receive it within one year from the date we first informed you of the denial or limitation of your claim, or of the denial of coverage for any requested service or supply.

Address written requests to:

HMSA

Attn: Appeals Coordinator

P.O. Box 1958

Honolulu, HI 96805-1958

Or, send us a fax at 952-7546 on Oahu. Provide the information described in the section below labeled "What Your Request Must Include." Requests that do not comply with the requirements of this chapter will not be recognized or treated as an appeal by us.

If you have any questions regarding appeals, you can call us at 948-5090 on Oahu, or toll-free at 1 (800) 462-2085. We will respond to your appeal within 60 calendar days of our receipt of your appeal.

Expedited Appeal

You may request expedited appeal if application of the time periods for appeals above may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

You may request an expedited appeal by calling us at 948-5090 on Oahu, or toll-free at 1 (800) 462-2085.

We will respond to your request for expedited appeal as soon as possible, taking into account your medical condition, but not later than 72 hours of our receipt of your request.

Who Can Request an Appeal

Either you or your authorized representative may request an appeal. Authorized representatives include:

- Any person you authorize to act on your behalf provided you follow our procedures which include filing a form with us. To obtain a form to authorize a person to act on your behalf, call us at 948-5090 on Oahu, or toll-free at 1 (800) 462-2085. (Requests for appeal from an authorized representative who is a physician or practitioner must be in writing unless requesting expedited appeal.)

- A court-appointed guardian or an agent under a health care proxy.

What Your Request Must Include

To be recognized as an appeal, your request must include all of the following information:

- The date of your request.
- Your name.
- The date of the service we denied or date of the contested action or decision (or in the case of precertification for a service or supply, the date of our denial of coverage for such service or supply).
- The subscriber number from your member card.
- The provider name.
- A description of facts related to your request and why you believe our action or decision was in error.
- Any other information relating to your appeal including written comments, documents and records you would like us to review.

You should keep a copy of the request for your records. It will not be returned to you.

If You Disagree With Our Appeal Decision

If you disagree with HMSA's appeal decision, you must either 1) request arbitration before a mutually selected arbitrator, or 2) request review by a panel appointed by the Hawaii state insurance commissioner.

Request for Arbitration

If you select arbitration, you must submit a written request for arbitration to HMSA, Legal Services, P.O. Box 860, Honolulu, HI 96808-0860.

Your request for arbitration will not affect your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and we must receive your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the disagreement. No other parties may be joined in the arbitration. The arbitration is binding and the parties waive their right to a court trial and jury.

Before arbitration actually starts, both parties (you and we) must agree on the person to be the arbitrator. If we both cannot agree within 30 days of your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The rules of the arbitration shall be those of the Dispute Prevention and Resolution, Inc. to the extent not inconsistent with this plan's dispute resolution. The arbitration shall be conducted in accord with the Hawaii Uniform Arbitration Act, Chapter 658A, H.R.S., and such other arbitration rules as both parties agree upon.

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding and no further appeal or court action can be taken except as provided under the Hawaii Uniform Arbitration Act.

Both parties will pay an equal share of the arbitrator's fee. You must pay your attorney's or witness's fees, if you have any, and we must pay ours. The arbitrator will decide who will pay all other costs of the arbitration.

Request for Review by Insurance Commissioner

You may request review by a panel selected by the Hawaii State Insurance Commissioner by submitting a request for review within 60 days of the date of HMSA's appeal decision to the insurance commissioner at:

Hawaii Insurance Division
 ATTN: Health Insurance Branch
 External Appeals
 335 Merchant St., Room 213
 Honolulu, HI 96813
 Telephone: 586-2804

If your request for review is accepted by the commissioner, the commissioner will appoint a three-member panel composed of a representative from another health plan, a provider not involved in your care, and a representative from the commissioner's office. A hearing will be conducted within 60 days and the panel will issue a decision within 30 days of the hearing. If the amount in controversy is less than \$500, the commissioner may conduct a review hearing without a review panel.

You may request expedited review by the insurance commissioner if application of the above time frames may:

- Seriously jeopardize your life or health,
- Seriously jeopardize your ability to gain maximum functioning, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Privacy Policies and Practices for Member Financial Information

HMSA and our affiliated organizations have always respected your privacy and are committed to protecting your personal health and financial information. HMSA values your business and the trust you have placed in choosing us as your health plan. We work to recognize and respect your expectations for the treatment of your personal information and have the following policies and practices:

- Maintain physical, electronic and procedural safeguards to protect the privacy, confidentiality and integrity of personal data.
- Make sure that those in our workforce who have access to your personal data need it to do their jobs and have been trained to properly handle personal data. Our employees must follow our privacy and security policies and practices.
- Require that third parties who access your personal data on our behalf follow applicable laws and agree to our strict standards of confidentiality and security.

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

As of July 1, 2002, state law requires HMSA to provide an annual notice of our privacy policies and practices for personal financial information to members of our health plans. This notice contains information on how we collect and disclose personal financial information about our members to our affiliates and to nonaffiliated third parties. This notice applies 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 needed to administer your health plan. We use 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 any of the personal financial information that is needed to administer your health plan with our affiliates and nonaffiliated third parties, as allowed by law. Nonaffiliated third parties are entities that are not part of the family of organizations controlled by HMSA. We do not otherwise share your personal financial data with anyone without your permission.

Contact Information

For more information or questions on our privacy policy, please call 948-6820 on Oahu.

Definitions

This section gives you the meanings of important words used in this certificate.

Approved Amount

The amount Medicare determines to be reasonable for a covered charge. It may be less than the actual charge.

Approved Charges

See Medicare-approved amount.

Assignment

Assignment refers to a method of submitting claims and receiving payment for Part B (medical) services. A provider (physician or supplier) that accepts assignment agrees to charge Medicare patients no more than Medicare-approved charges for covered services. In turn, Medicare sends payment directly to the provider. Providers who do not accept assignment of Medicare claims can charge more than the Medicare-approved amount and are paid directly by the Medicare beneficiary. Medicare then reimburses the beneficiary its share of the approved amount.

Benefit

A benefit is the amount HMSA, Medicare or any insurance policy pays for a covered service.

Benefit Period

A benefit period begins the first day a member receives Medicare-covered inpatient hospital services. It ends when the member has been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if the member remains in a skilled nursing facility but does not receive skilled care there for 60 days in a row. A new benefit period starts when inpatient hospital services are again required. The number of benefit periods is unlimited.

Claim

This is a form requesting payment of benefits for services covered by Medicare or **Senior Connection Plan B**. You or the provider who performed the service must fill out and send this form to Medicare or HMSA to receive payment for covered services. You or the provider must also use the forms that Medicare or HMSA has approved.

Copayment

A copayment is a percentage or part of the Medicare-approved charge that you owe the provider, where applicable, when you receive certain services covered by Medicare Part A or Part B.

Cover, Coverage

When Medicare, **Senior Connection Plan B**, or any insurance policy covers or provides your coverage for a service, it will pay either all or a portion of the charge for that service.

Deductible

This is the fixed amount you must pay before Medicare pays for any of its covered services. There is one deductible for Medicare Part A (hospital) and another one for Medicare Part B (medical). Medicare keeps track of your deductibles and uses the Medicare Summary Notice to tell you which services and charges make up your deductible.

Effective Date

The effective date is the date on which you are first eligible to receive **Senior Connection Plan B** benefits. You can find your effective date on your HMSA **Senior Connection Plan B** membership card.

HMSA

HMSA, the Hawai'i Medical Service Association, is a nonprofit organization that provides prepaid health plans for its members.

Hospital

By law, a hospital must be licensed to provide surgical or medical care on an inpatient basis and must meet federal standards set up for Medicare. (Nursing homes, rest homes, and intermediate care and skilled nursing facilities are not hospitals.)

Injury

This refers to an injury resulting from an external force (such as a blow, collision or impact) that is of sufficient magnitude to require the services of a physician within 48 hours. Subjective symptoms that occur spontaneously or from trivial movement or exercise and that are of physiological, pathological, toxic or infective origin are not to be considered the result of external force and therefore shall not be considered an injury.

Inpatient

An inpatient is a person who is admitted by a physician to a hospital or skilled nursing facility and requires at least an overnight stay because that person needs the continuous skilled care given there.

Lifetime Reserve Days

The reserve days are limited by Medicare to 60 days during your lifetime. Once these 60 days are used, they are not renewed and Medicare will provide no hospital coverage after 90 days of a benefit period.

Medically Necessary

Where Medicare makes a determination as to whether services covered by **Senior Connection Plan B** as regular benefits are Medically Necessary, **Senior Connection Plan B** will follow Medicare's decision. For additional benefits not covered by Medicare, the following criteria (also known as Payment Determination Criteria) must be met for coverage to be "Medically Necessary":

- 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; and
- Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

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

Definitions of terms and additional information regarding application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Requests should be submitted to HMSA's Customer Service department.

Medicare

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended, Chapter 7, Title 42, Section 426, 1395C, U.S. Code.

Medicare-Approved Amount

The Medicare-approved amount means the amount Medicare determines to be reasonable for a covered charge. It may be less than the amount a physician or supplier actually bills for a particular medical service or supply.

Medicare-Eligible Expenses

Medicare-eligible expenses are the expenses of the kinds covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare-Limiting Amount

For health care providers who do not participate in the Medicare program and who do not accept assignment, the maximum they may charge in 2012 is generally limited to 115 percent of the nonparticipating Medicare fee schedule amount. The nonparticipating fee schedule amount is 95 percent of the Medicare fee schedule amount.

Member

Member refers to the person who executes the application card that is accepted in writing by HMSA.

Nonparticipating Provider

A health care provider (physician or supplier) who is not a participating provider.

Participating Provider

A health care provider, who is a participating provider, signs a Medicare participation agreement and accepts the Medicare-approved amount on Medicare claims.

Physician

For coverage under this plan, a physician must be a properly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).

Provider

A provider is a physician or any other person, facility or supplier whose services are covered by this plan, as specified in this certificate. A provider must be appropriately licensed by law and provide you medical care within the scope of that license.

Regular Benefits

Refers to **Senior Connection Plan B** benefits that provide the member additional coverage for those services only partially paid for by Medicare.

Skilled Nursing Facility

This is a facility where licensed registered nurses provide or supervise the care your physician orders for you. The facility must be licensed by law to give you this care on an inpatient basis. It must also meet Medicare standards.

Senior Connection Plan B

MEDICARE (PART A) — REGULAR BENEFITS • HOSPITAL SERVICES — PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--|--|------------------------------------|----------------------|
| HOSPITALIZATION * | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but \$1,156 | \$1,156 (Part A deductible) | \$0 |
| 61st through 90th days | All but \$289 a day | \$289 a day | \$0 |
| 91st day and after: | | | |
| – While using 60 lifetime reserve days | All but \$578 a day | \$578 a day | \$0 |
| – Once lifetime reserve days are used: | | | |
| – Additional 365 days | \$0 | 100% of Medicare-eligible expenses | \$0** |
| – Beyond the additional 365-days | \$0 | \$0 | All costs |
| ** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid. | | | |
| SKILLED NURSING FACILITY CARE * | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21st through 100th days | All but \$144.50 a day | \$0 | Up to \$144.50 a day |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First 3 pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

Senior Connection Plan B

MEDICARE (PART B) — REGULAR BENEFITS • MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$140 of Medicare-approved amounts for covered services noted with an asterisk, your Part B deductible has been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--|---------------|---------------|---------------------------|
| MEDICAL EXPENSES — | | | |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.* | | | |
| First \$140 of Medicare-approved amounts | \$0 | \$0 | \$140 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | \$0 |
| Part B excess charges (above Medicare-approved amounts) | \$0 | \$0 | All costs |
| BLOOD | | | |
| First 3 pints | \$0 | All costs | \$0 |
| Next \$140 of Medicare-approved amounts* | \$0 | \$0 | \$140 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — BLOOD TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

Senior Connection Plan B

MEDICARE (PART A AND B) — PER CALENDAR YEAR

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--|---------------|-----------|---------------------------|
| HOME HEALTH CARE | | | |
| MEDICARE-APPROVED SERVICES | | | |
| – Medically Necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| – Durable medical equipment | | | |
| First \$140 of Medicare-approved amounts* | \$0 | \$0 | \$140 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

OTHER BENEFITS — NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|--------------------|---------------|---|--|
| ONLINE CARE | \$0 | All but \$10 for up to 10 minutes and \$5 for additional 5 minutes. Note: For Behavioral Health providers, all but \$10 for up to 20 minutes and \$5 for an additional 25 minutes. | When using HMSA participating providers, you pay \$10 for up to 10 minutes. \$5 for an additional 5-minute extension. There is no benefit if using nonparticipating providers. Note: For Behavioral Health providers, you pay \$10 for up to 20 minutes and \$5 for an extension of up to an additional 25 minutes. |

NOTES

NOTES

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. For more information, visit hmsa.com.

HMSA



HAWAI'I MEDICAL SERVICE ASSOCIATION

hmsa.com

HONOLULU • 818 Keeaumoku St. • 96814
Phone: 948-6000 for benefit and claims information
Phone: 948-6140 for address changes

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

LANAI AND MOLOKAI • Toll-free 1 (800) 639-4672

For the hearing and speech impaired: TTY/TDD 948-6222 on Oahu; 1 (877) 298-4672 toll-free