

HMSA PPP and CompMED Member Handbook

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association



WELCOME

Welcome and thank you for choosing HMSA. We appreciate your membership with HMSA and are confident that you'll be pleased with the products and services HMSA has to offer.

As a nonprofit organization founded in 1938, HMSA is the most experienced health plan in Hawaii. HMSA is committed to ensuring access to quality health care. We are also dedicated to helping you stay healthy by offering health education, prevention, and disease management services.

Your HMSA Member Handbook highlights what you should know about HMSA and your benefit plan. If you have questions or need additional information, please refer to the "Keeping You Connected" section on page 34. For information on your specific plan benefits, please refer to your *Guide to Benefits* brochure.

Thank you for choosing HMSA's Preferred Provider Plan. This is your Preferred Provider Plan Member Handbook. If you need help understanding this book, please call one of the HMSA offices listed herein. HMSA offers interpreter services at no charge. If you need an interpreter, please tell our representative when you contact us.

Salamat sa pagpili mo sa Preferred Provider Plan ng HMSA. Ito ang iyong kopya ng Aklat ng Miyembro ng Preferred Provider Plan. Kung kailangan mo ng tulong upang maunawaan ang aklat na ito, pakitawagan ang isa sa mga opisina ng HMSA na nakalista dito. Iniaalok ng HMSA ang mga serbisyo ng tagapagsalin nang walang bayad. Kung kailangan mo ng tagapagsalin, pakisabi sa aming kinatawan kapag makikipag-ugnayan ka sa amin.

Agyaman kami ta pinilim ti Preferred Provider Plan ti HMSA. Daytoy ti kopyam ti Libro ti Miyembro ti Preferred Provider Plan. No kasapulam ti tulong tapno maawatam daytoy a libro, tawagam koma ti maysa kadagiti opisina ti HMSA a nakalista ditoy. Idiaya ti HMSA dagiti serbisyo ti mangiyulog ti pagsasao nga awan bayadna. No kasapulam ti mangiyulog ti pagsasao, ibagam koma iti mangibagi kadakami no makiumanka kadakami.

感謝您選擇 HMSA 首選提供者計劃。這是您的首選提供者計劃成員手冊。如果您在理解本手冊方面需要協助，請致電本手冊中列出的 HMSA 辦公室。HMSA 免費提供翻譯服務。如需翻譯服務，請在與我們聯絡時告訴我們的客戶服務人員。

この度は、HMSAのPreferred Provider Plan (プリファード・プロバイダー・プラン) をお選びいただき誠にありがとうございます。Preferred Provider Plan (プリファード・プロバイダー・プラン) のメンバーズ・ハンドブックをお送りいたしましたのでご査収ください。このハンドブックの使い方についてご質問がある場合は、一覧に示すHMSAのオフィスにお電話でお問い合わせください。HMSAでは、無料にて通訳のサービスをお付けいたします。通訳が必要な場合は、お問い合わせの際にその旨をお申し出ください。

HMSA 의 선호 제공자 플랜(Preferred Provider Plan)을 선택해 주셔서 감사합니다. 이것은 귀하의 선호 제공자 플랜 회원 편람입니다. 이 편람을 이해하는데 도움이 필요하시면 여기 열거된 HMSA 사무소 중 한 곳에 문의하십시오. HMSA 는 통역 서비스를 무료로 제공합니다. 통역이 필요하시면 저희에게 연락하실 때 우리 직원에게 말씀해 주십시오.

Oahu 948-6111 • Kauai 245-3393 • Maui 871-6295 • Hilo 935-5441
Kailua-Kona 329-5291 • Molokai & Lanai 1 (800) 639-4672
TTY 948-6222 on Oahu

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QUALITY HEALTH CARE

HMSA strives to maintain the highest levels of quality health care for our members.

Philosophy of Care

HMSA is committed to maintaining a mutually respectful relationship with our members and health care physicians, thus promoting effective, quality health care and service.



HMSA believes in the value of keeping our members healthy and making them well. Prevention is a key component of HMSA's comprehensive care programs, resulting in lowered risks of illness and better management of problems.

HMSA believes that the credentialed health care practitioners in its network are held to high standards of quality in the health care and services that they provide and in the satisfaction of their patients.

HMSA is committed to informing our members about how their health plan works, how network physicians are compensated, and how utilization monitoring supports the delivery of quality health care.

HMSA rewards health care decision-making that is based on appropriate care and service and actively discourages barriers to such care and service. Financial incentives are in place to encourage appropriate decisions on care.

HMSA does not specifically reward practitioners or other individuals for denying payment or coverage.

HMSA does not encourage decisions that result in underutilization by providing financial incentives to utilization management decision makers.

HMSA affords our members and physicians the right to voice complaints, appeal decisions, and receive timely responses from HMSA.

NCQA Accreditation

HMSA's commitment to quality health care in Hawaii includes a voluntary and thorough evaluation by the National Committee for Quality Assurance (NCQA). NCQA's elevated accreditation standards encourage health plans to continually improve their quality.

HMSA's PPO and HMO plans have earned "Excellent" Accreditation status from NCQA. "Excellent" is the highest level of accreditation for health plans, granted for service and clinical qualities that meet or exceed NCQA's rigorous requirements for consumer protection and continuous quality improvement. These HMSA plans include:

- Preferred Provider Plan.
- CompMED.
- Federal Employee Health Benefit Program.
- State of Hawaii Employer-Union Health Benefit Trust Fund Plan.
- 65C Plus.
- Health Plan Hawaii.



INFORMATION FOR ALL HMSA MEMBERS

Health Care Reform

The following provisions will affect your HMSA health plan under the Affordable Care Act (ACA), federal health care reform legislation that was signed into law by President Obama in March 2010. Some of these provisions have already been implemented and others will be implemented in the first plan year after Sept. 23, 2010.



Appeals

Members have available to them an internal and external appeals process that is consistent with health care reform rules. For more on appeals, please see page 20.

Dependent Age

Dependents can stay on their parents' health plan until age 26, regardless of the child's marital status, financial dependency, or residency. "Child" for these purposes is defined as:

- An individual who is the son, daughter, stepson, or stepdaughter of the employee.
- A legally adopted individual.
- An individual who is placed with the employee for legal adoption by the employee.
- A child for whom the employee is the court-appointed guardian.
- An eligible foster child who is placed with the employee by an authorized placement agency or by judgment, decree, or other court order.

Emergency Care

HMSA members can receive coverage for emergency care without prior authorization. Copayments and coinsurance for out-of-network providers are no more than that for in-network providers. However, members may be required to pay the difference between what the out-of-network provider charges and what HMSA is required to pay under federal regulations. For more on emergency care, please see page 16.

Lifetime Maximum

HMSA health plans will not have annual or lifetime dollar limits for essential benefits.

Pre-existing Conditions

Children under age 26 will be allowed coverage despite having a pre-existing condition. This requirement will extend to adults beginning in 2014.

Preventive Services

HMSA members will have coverage without cost-sharing for the following services obtained from participating providers:

- Select services recommended by the U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Preventive care and screenings for women and children supported by the Health Resources and Services Administration.

For more on preventive services, please see pages 22-25.

Rescissions

HMSA members will not be dropped from coverage retroactively except in cases of fraud, intentional misrepresentation, or failure to pay member dues on time.

Urgent Care Claims

You may submit a request for an expedited pre-certification review of an urgent care claim. A decision will be made within 24 hours of receiving the requested information. Refer to your *Guide to Benefits* for a definition of “urgent care.” For more on filing claims, please see page 18.

This information is based on HMSA’s review of the national health care reform legislation. This overview is intended for educational purposes and should not be used as tax, legal, or compliance advice. Interpretations of the legislation vary and some reform regulations differ for particular members enrolled in certain groups. HMSA will continue to present and update information related to national health care reform as additional guidance becomes available.

Report to Member

Report to Member (RTM) statements are provided for medical, vision, and pharmacy services. RTMs identify applicable copayments that members are responsible for paying providers. RTMs are available through My Account on hmsa.com. You can download electronic RTMs, share them electronically, or print them.

Members of group health centers may not receive RTMs for services rendered within their health center. Also, RTMs will be mailed to members who visit a nonparticipating provider or if a service is denied. If you have questions about your RTM statement or if you would rather have them mailed to you, contact an HMSA office listed at the end of this handbook.

Enrollment Guidelines



Membership Eligibility



You are eligible for benefit payments from HMSA if you are a member of an HMSA plan and all membership dues have been paid. If you are a current member in good standing, your claims for medical services are eligible for benefit payments. Verifying eligibility is the first step in reviewing a request for payment of a member's health care bill.

HMSA Membership Card

New subscribers receive two copies of their HMSA membership card. Below are examples of HMSA membership cards for the Preferred Provider Plan and Health Plan Hawaii.

INFORMATION
FOR ALL
HMSA
MEMBERS

HMSA 	
Subscriber Name KIMO K ALOHA	
Subscriber ID XLPR001234567890	
Group 88755	
Medical 643	Drug 374
Dental 053	BN 600428
Vision AT	PCN 00510000
Chiro 00E	
	

HMSA 	
Subscriber Name FIRSTNAME M LASTNAME-PLACEMENT	
Subscriber ID XLHR001234567890	
Group 27	
Medical YI	Drug 358
	BN 600428
	PCN 00510000
Dependent 1 Health Center1 Physician1	
Dependent 2 Health Center2 Physician2	
	

Coverage Under an HMSA Plan

The employee or the person who fills out the enrollment form is covered by the plan and is called the subscriber. The subscriber is the HMSA policyholder and is responsible for notifying HMSA and/or their employer of any changes to the account. The subscriber may also ask for and receive claims or billing information.

However, under the Privacy Act, there are limitations that may apply. For additional information, please refer to the "Notice to HMSA Members" on page 10.

Everyone covered by a subscriber's plan is an HMSA beneficiary or member.

The subscriber may add these eligible dependents to their coverage, within limits:

- Spouse: HMSA medical plans comply with state of Hawaii laws. A couple who has qualified for a marriage license according to government statutes is legally married. The state does not recognize "common law" or live-in relationships.
- Children under age 26. Some plans have limitations.

Children with Special Needs

You may enroll your child if they are disabled by providing us with written documentation acceptable to us demonstrating that:

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of their disability.
- Your child is enrolled with us under this coverage or another HMSA coverage and has had continuous health care coverage with us since before the child's 26th birthday.

You must provide this documentation to us within 31 days of the child's 26th birthday and subsequently at our request but not more frequently than annually.

This benefit varies by plan. Contact HMSA's Customer Relations department to determine if this is a benefit of your plan.

If your child no longer meets the eligibility requirements, you must notify HMSA in writing on or before the first day of the month following the month the child no longer meets the requirements. For example, if your child turns 26 on June 1, you would need to notify us by July 1.

Open Enrollment Periods

An initial enrollment period is a specific time when an individual is first eligible, according to your employer's rules for eligibility. If you do not apply for coverage when you first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, your enrollment form will not be accepted until the next open enrollment period.

Open enrollment is a specific time each year when a current subscriber can make changes to their coverage. The annual open enrollment period for employer groups varies, and the number of days allotted for open enrollment may also differ between groups. Employees should check with their Human Resources department to find out their company's open enrollment period.

Situation	When is the earliest enrollment period?
Enrollment for a new employee, union member, or other group-sponsored enrollee (and qualified dependents).	Must apply when first offered the opportunity by the group (initial enrollment period), or subscriber will have to wait for the next open enrollment period.
Group or individual plan subscriber wants to add a new qualified dependent.	Must be added within 31 days of the qualifying event (e.g., marriage, birth, adoption, etc.) or subscriber will have to wait until the next open enrollment period.

**INFORMATION
FOR ALL
HMSA
MEMBERS**

Your HMSA Membership Card

After you enroll in an HMSA plan, you will receive your HMSA membership card. Check your card to make sure that the information printed is correct. If you need to make changes, please contact your local HMSA office as listed at the end of this handbook.



Your HMSA membership card identifies you as an HMSA member and gives you access to medical services. Always carry your card with you and present it whenever you receive services. This will help ensure that your claims are processed properly.

If you lose your card, report the loss to your local HMSA office and a new one will be sent to you. You can also request a new card by logging in to My Account through our website at [hmsa.com](https://www.hmsa.com).

Notice to HMSA Members

Privacy of Your Confidential Member Information

This notice describes how information about you may be used and disclosed and how you can access this information. Please review it carefully.

As your health plan, we care about the privacy of your personal information. Federal law requires us to maintain this privacy. This notice describes our privacy practices, our legal obligations, and your rights regarding your personal information. We will not make any changes to our privacy practices without letting you know in advance. If it becomes necessary for us to revise or update our privacy practices, we will inform you before the changes go into effect.

Your Protected Health Information

Each member generates Protected Health Information. For example, when you visit a doctor, a record of your visit is made. This record may have details about your symptoms, injury or illness, exam, treatment, test results, and more. Claims sent to HMSA may have some of these details. Information about you and the services that you received is called your Protected Health Information. This information is used in a number of ways. For example, it may be shared among your health care providers to plan or coordinate your care. Or it may be used to process claims, pay for your health care services, or review services.

Your Rights

The law gives you certain rights that pertain to your Protected Health Information. As an HMSA member, you have the right to:

- Request and receive a copy of this privacy notice at any time.
- View or request a copy of your Protected Health Information.

- Ask for added limits on permitted uses of your Protected Health Information. There may be reasons we cannot agree to this request. If we agree to your request, we will keep our agreement except to make records available to a provider when necessary for your treatment in a medical emergency or disaster.
- Request and receive a list of third parties we disclose your information to for certain, permitted reasons described in this notice.
- Ask that your Protected Health Information be sent by reasonable means other than mail or be sent to a different address to avoid putting your life in danger.
- Request to change or add to your Protected Health Information. We may deny your request if we did not create the information or for certain other reasons. If we deny your request, we will explain why in writing. If you do not agree with our denial, you may send us a written statement of disagreement that will be added to your record.

Our Duties

The law clearly spells out the duties of health plans. HMSA must:

- Protect the privacy of your Protected Health Information.
- Give you a notice of our privacy practices.
- Follow the terms of this privacy notice.
- Fulfill your request to send information by other means or to another address to avoid putting your life in danger. Your request must be reasonable and must state the other address or the means you wish us to use. The alternate address or means must allow us to pay claims and collect dues under your health plan.
- Use and share only the information needed for treatment, payment, and health care operations.
- Make sure our business partners agree to protect your information the same way that we do.

We will not use or share your Protected Health Information except as required by law or described in this notice. Also, we will not ask you to waive your privacy rights to enroll in an HMSA plan or to receive services.

How Protected Health Information is Used

There are three key purposes for which we need to use your Protected Health Information: treatment, payment, and other health care operations. We may also contract with other parties to do the work for us as long as they promise to protect your information the same way we do. Each area is described below.

Treatment: This includes services needed to provide, coordinate, or manage your health care. As your health plan, we may need to share Protected Health Information with your doctor or other health care providers for treatment reasons.

Payment: We need to pay claims from doctors, hospitals, and other providers for the care you receive. This includes our efforts to collect dues, see if you are eligible for care, determine the level of coverage, work with other plans to determine benefits, and pay claims.

Health care operations: We want all HMSA members to receive quality health care services. This may include our quality review and improvement activities, case management, care coordination, review of provider credentials, establishment of dues, resolution of complaints and appeals, management of our business, and other operations. We may also use your information to send you communications to describe a health-related product or service. This may include information on our participating providers, new health-related products or services available only to HMSA members, or recommendations of other treatments, health care providers, or settings of care that may be of interest to you.

Other Uses of the Information

There may be a time when the use of your Protected Health Information is needed because it benefits you, serves the public interest, or is required by law. In these cases, we will use and share only the Protected Health Information needed or as required by law. Please read all of these other uses carefully.

For underwriting: We may receive your Protected Health Information to create, renew, or replace a contract of health insurance or health benefits. We will not use or further disclose this information for any other reasons except as required by law. If the contract of health insurance or health benefits is placed with us, then we will use and share your Protected Health Information only as described in this notice.

With your written permission: You may give us written permission to use your information or share it with someone you name for any purpose. You may withdraw your permission in writing at any time. We will honor your request unless the timing is such that the information has already been shared.

During an emergency or disaster: We may disclose the information if we believe it is in your best interest during a medical emergency or disaster to make sure you have access to the services you need or to process payment for those services.

To plan sponsors: We may disclose your Protected Health Information--and the information of others enrolled in your group health plan--to your plan sponsor or its authorized representative. Employers are often plan sponsors; this disclosure helps them administer your group health plan. Plan sponsors may use your Protected Health Information only as permitted or required by law.

To report to authorities: We may need to share Protected Health Information if we suspect abuse, neglect, or domestic violence. As required by law, we may need to make such a report to the authorities.

For research purposes: We may use or share information with researchers when their work has been approved by an institutional review board that has gone over the research project and set rules to make sure that your Protected Health Information is kept private.

To comply with the privacy law: We may use or share information as required by the privacy law. For example, to see if we are complying with the law, the U.S.

Department of Health and Human Services may review our practices and ask us for some Protected Health Information.

For workers' compensation: We may disclose information to comply with laws on workers' compensation or other similar programs.

For public health: We may share your Protected Health Information with public health or legal authorities who work to prevent or control disease, injury, or disability in the community. For example, we may share information about problems related to food, drugs, supplements, and product defects with the U.S. Food and Drug Administration (FDA).

For health oversight: We may share information with authorities for activities to prevent fraud and abuse, audits, investigations, inspections, licenses, and other government activities to monitor health care.

For judicial and administrative proceedings: We may share your information in response to a court or administrative order, subpoena, or other lawful process under certain circumstances.

For law enforcement: Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your information to law enforcement officials.

For military or national security: Under certain conditions, we may share the Protected Health Information of armed forces staff with military authorities. We may also share your information with federal officials for intelligence, counterintelligence, and other national security activities.

For More Information or to Report a Problem

If you have questions or would like more information on HMSA's privacy practices, you may contact us using the information at the end of this notice.

If you believe your privacy rights have been violated, you may file a complaint with us using the contact information at the end of this notice. You may also send a written complaint to the U.S. Department of Health and Human Services. If you choose to file a complaint, you have our assurance we will not retaliate in any way.

Thank you for taking the time to review this Notice to HMSA Members. As your health plan, we work hard to protect your Protected Health Information. We know the privacy of this information is important to you and we take our duties very seriously.

Send HMSA correspondence to:

HMSA Privacy Office
Attention: Privacy Official, 8th Floor
P.O. Box 860
Honolulu, HI 96808-0860

**INFORMATION
FOR ALL
HMSA
MEMBERS**

Honolulu, Oahu	
Group/Individual Plans	948-6111
Federal/State/County Plans	948-6499
HMO Plans	948-6372
Blue Cross and Blue Shield Service Benefit Plan.....	948-6280
QUEST.....	948-6486
Medicare Programs - Akamai Advantage and 65C Plus	948-6000
TTY.....	948-6222
Hilo, Hawaii	
Hilo, Hawaii.....	935-5441
Kona, Hawaii.....	329-5291
Lihue, Kauai	245-3393
Kahului, Maui.....	871-6295

Send U.S. Department of Health and Human Services correspondence to:

**U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201**

1 (877) 696-6775 toll-free

Coordination of Benefits



If you have other insurance coverage that provides benefits that are the same or similar to your HMSA plan, we will coordinate your HMSA benefits with your other coverage. This is called coordination of benefits, or COB. Generally, this includes other group or non-group insurance coverage and Medicare benefits.

Coordinating benefits with automobile insurance (fault or no-fault), workers' compensation insurance, and third-party liability coverage are subject to guidelines stated in your *Guide to Benefits*. To request a copy, please contact your local HMSA office.

PREFERRED PROVIDER PLAN AND COMPMED MEMBERS

HMSA offers PPP and CompMED members benefits specially designed to meet their health care needs.

Participating Providers

HMSA members have convenient access to health care through the largest provider network in the state. We encourage Preferred Provider Plan and CompMED members to choose participating providers to help keep their out-of-pocket expenses down.

A participating provider is a physician or other health care provider who has completed our credentialing process and has a contract with HMSA. These participating providers have agreed to limit what they charge our members for services. Participating providers also file claims and related paperwork with HMSA for you.

You can always obtain services from a nonparticipating provider. However, nonparticipating providers do not have a contract with HMSA and are free to set their rates at any amount they choose. With a nonparticipating provider, you are responsible for paying the total charge at the time of service and for submitting the necessary claims and other paperwork to HMSA.

To find out if a provider participates with HMSA, ask the provider's office directly, call your local HMSA office, consult your provider directory, or search for providers through our website at hmsa.com.



Well-Being Connect

HMSA is introducing a new, powerful website for members called **Well-Being Connect™**. It recognizes that there's no such thing as a one-size-fits-all solution to maintain a healthy weight, eat right, manage stress, and everything else that goes along with being healthy.

Well-Being Connect is tailored to members' unique needs, desires, and motivations. Well-Being Connect starts by asking questions about several aspects of members' total health, and then develops a customized plan to help members achieve their goals. It's an effective, proven support system designed to help members change their behavior and improve their health. Well-Being Connect will be available at no cost in early 2012 from My Account on hmsa.com.

Care After Hours

Your personal physician is responsible for your care 24 hours a day. When your doctor's office is closed, they will have information available regarding after hours and weekend coverage. Check with your personal physician for instructions. Some common methods your physician may use to make information available include an answering service, pager, or answering machine.

HMSA's Online Care

PREFERRED
PROVIDER
PLAN AND
COMPAMED
MEMBERS

HMSA's Online Care connects you with an HMSA participating provider online or by phone from the comfort and privacy of your home. It is available when you need to talk to a doctor right away and can't wait for an appointment. Online Care gives you immediate access to providers from HMSA's PPO networks online or by phone, any time of the day or night. It also gives you access to your HMSA health summary, a personalized health assessment, and resources on a variety of health and medical topics.

To access Online Care, you must register for My Account through our website at hmsa.com. For more information or help with registration, call 948-6013 on Oahu or 1 (866) 939-6013 toll-free on the Neighbor Islands.

Emergency Care

While most health problems are best treated by your physician, accidents and other unexpected situations can occur that require immediate attention. In such cases, please call 911 or go to the emergency room.

Examples of emergencies include:

- Chest pain or other heart attack signs.
- Poisoning.
- Loss of consciousness.
- Convulsions or seizures.
- Broken bones, including back or neck injuries.
- Heavy bleeding.
- Sudden weakness on one side.
- Severe pain.
- Breathing problems.
- Drug overdose.
- Severe allergic reaction.
- Severe burns.

Do not go to the emergency room if you do not require immediate care. Going to the emergency room for non-emergencies delays treatment for those with true emergencies. It also drives up the overall cost of health care; a visit to the ER costs more than a doctor's office visit.

If you do not require immediate care, make an appointment with your doctor. If you do not have a primary care provider, choose a doctor you feel you can form a long-term relationship with. Look for someone you feel comfortable with and can speak openly to about your health care issues. A doctor who knows your medical history can often give you better care than an emergency room.

Examples of non-emergencies are:

- Colds.
- Flu.
- Earaches.
- Sore throats.

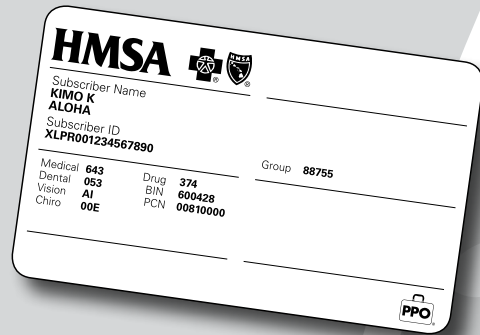
Receiving Care While Away from Home

Your health care is the last thing you want to worry about when you're traveling abroad. Fortunately, HMSA members have a level of protection no other health plan in Hawaii can match.

HMSA participates with other Blue Cross and Blue Shield plans in the BlueCard Program. This program offers members of any Blue Cross and Blue Shield plan advantages when they receive health care outside their plan's service area. Benefit payments for covered services received out of state are based on contracts negotiated between the out-of-state Blue Cross and Blue Shield plans and preferred and participating BlueCard providers.

The Blue Cross and Blue Shield plan in the area where you need services can provide you with information regarding preferred or participating providers in the area. You can also use the BlueCard Find a Doctor or Hospital feature at www.bcbs.com or call 1 (800) 810-BLUE (2583).

Always carry your HMSA membership card with you. Your membership card tells preferred and participating BlueCard providers which Blue plan you belong to and includes information the provider needs to file your claim properly.



Filing Claims

When to File Claims: All participating and most nonparticipating providers in Hawaii will file claims for you. If your nonparticipating provider does not file claims for you, please submit an itemized bill or receipt within 90 days of the last day on which you received services. No payment will be made on any claim received by us more than one year after the last day on which you received services. If you have any questions, please contact your Human Resources department or your local HMSA office as listed at the end of this handbook.

PREFERRED
PROVIDER
PLAN AND
COMPAMED
MEMBERS

How to File a Claim: File a separate claim for each covered family member and each provider. You should follow the same procedure for filing a claim for services received in Hawaii, out of state, or outside the U.S.

Information You Must Submit:

- The subscriber number that appears on your HMSA membership card.
- The bill or statement from your provider itemizing all services provided. Statements you prepare yourself, cash register receipts, receipt of payment notices, and balance due notices cannot be accepted. Without the provider statement, claims are not eligible for benefits.

The provider statement must include:

- Provider's full name and address.
- Patient's name.
- Date(s) you received service(s).
- Date of the injury or beginning of illness.
- Charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of illness or injury.
- Where you received the service (office, outpatient, hospital, etc.).
- If applicable, information about other health coverage you may have.

It is helpful if the provider statement is on the provider's stationery and is in English or accompanied by the English translation.

Please include a daytime phone number where you can be reached. Make sure you sign the claim and enclose proof of payment.

Send your claim to:

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

You should keep a copy of the information provided to us for your records. Information provided to us will not be returned to you.

Once we receive and process your claim, we will send you a report explaining your benefits no later than 30 days after we receive the claim. Your Report to Member will tell you how we processed the claim, including services performed, the actual charge, any adjustments to the actual charge, our eligible charge, the amount we paid, and the amount you owe.

Although we have 30 days to issue your report, we may require additional information to make a decision about your claim or be unable to make a decision due to circumstances beyond our control. In those cases, we will extend the time period for 15 days. We will let you know within the initial 30-day period why we are extending the time and when you can expect our decision. If we require additional information, you will have at least 45 days to provide us with the information requested.

If your claim is denied, our report will provide an explanation for the denial. If you believe we wrongly denied a claim or coverage request, please call HMSA's Customer Relations department for assistance. If you are not satisfied with the information you receive and wish to pursue a claim for coverage, you may request an appeal.

Your Request for an Appeal

You must request an appeal if you 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. Your request must be in writing unless you are requesting an expedited appeal. We must receive it within one year from the date of the action or decision you are contesting. For coverage or reimbursement disputes, this is 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.

PREFERRED
PROVIDER
PLAN AND
COMPAMED
MEMBERS

Address written requests to:

HMSA Appeals Unit
Attn: Appeals Coordinator
P.O. Box 1958
Honolulu, HI 96805-1958

Or send a fax to 952-7546 on Oahu.

Requests that do not comply with the requirements will not be recognized or treated as an appeal. If you have any questions, please call 948-5090 on Oahu or 1 (800) 462-2085 toll-free on the Neighbor Islands.

We will respond to your appeal regarding our decision as soon as possible given the medical circumstances of your case, but not later than 30 days after we receive your appeal. We will respond to your appeal regarding any other decision or action within 60 calendar days of receiving your appeal.

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

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

You may request an expedited appeal by calling 948-5090 on Oahu or 1 (800) 462-2085 toll-free on the Neighbor Islands. We will respond to your request for an expedited appeal as soon as possible, taking into account your medical condition, but not later than 72 hours after receiving your request.

To be recognized as an appeal, your request must include:

- The request date.
- Your name.
- The date of the service we denied or date of the contested action or decision (or in the case of pre-certification for a service or supply, the date of our denial of coverage for such service or supply).
- The subscriber number from your HMSA card.
- The provider's 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 your appeal relates to a claim for benefits or request for pre-certification, we will provide (upon your request and free of charge) reasonable access to and copies of all documents, records, and other information relevant to your claim as defined by the Employee Retirement Income Security Act.

If you have questions regarding appeals, please call HMSA at 948-5090 on Oahu or 1 (800) 462-2085 toll-free on the Neighbor Islands.



Voicing Complaints

HMSA wants you to be satisfied with your health plan and your health care. HMSA affords you the right to voice complaints and receive timely responses regarding quality of care, access to care, provider service, plan service, or plan administration. You can contact HMSA at 948-6111 on Oahu or your local HMSA office.

PREVENTIVE CARE

HMSA believes in the importance of helping members stay healthy. Healthier lifestyles, immunizations, and early detection and treatment can prevent many serious diseases. That is why HMSA offers preventive care services to help keep you and your family healthy.



Preventive Care Guidelines

An ounce of prevention is worth a pound of cure. HMSA encourages you to receive the appropriate immunizations and screenings to help lower your risk of chronic diseases.

Covered Preventive Services for Adults

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked.
- **Alcohol misuse** screening and counseling.
- **Aspirin** use for men and women of certain ages.
- **Blood pressure** screening for all adults.
- **Cholesterol** screening for adults of certain ages or at higher risk.
- **Colorectal cancer** screening for adults over 50.
- **Depression** screening for adults.
- **Type 2 diabetes** screening for adults with high blood pressure.
- **Diet** counseling for adults at higher risk for chronic disease.
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*.
- **Immunization** vaccines for adults. Doses, recommended ages, and recommended populations vary:
 - Hepatitis A.
 - Hepatitis B.
 - Herpes Zoster.
 - Human Papillomavirus.
 - Influenza.
 - Measles, Mumps, Rubella.
 - Meningococcal.
 - Pneumococcal.
 - Tetanus, Diphtheria, Pertussis.
 - Varicella.
- **Obesity** screening and counseling for all adults.
- **STI** prevention counseling for adults at higher risk.
- **Tobacco use** screening for all adults and cessation interventions for tobacco users.
- **Syphilis** screening for all adults at higher risk.

Covered Preventive Services for Women, Including Pregnant Women

Note: Services marked with an asterisk (*) must be covered with no cost-sharing in plan years starting on or after August 1, 2012.

- **Anemia** screening on a routine basis for pregnant women.
- **Bacteriuria** urinary tract or other infection screening for pregnant women.
- **BRCA** counseling about genetic testing for women at higher risk.
- **Breast cancer mammography** screenings every 1 to 2 years for women over 40.
- **Breast cancer chemoprevention** counseling for women at higher risk.
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*.
- **Cervical cancer** screening for sexually active women.
- **Chlamydia infection** screening for younger women and other women at higher risk.
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*.
- **Domestic and interpersonal violence** screening and counseling for all women*.
- **Folic acid** supplements for women who may become pregnant.
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*.
- **Gonorrhea** screening for all women at higher risk.
- **Hepatitis B** screening for pregnant women at their first prenatal visit.
- **HIV** screening for all adults at higher risk.
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*.
- **Osteoporosis** screening for women over age 60 depending on risk factors.
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk.
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- **STI** counseling for sexually active women*.
- **Syphilis** screening for all pregnant women or other women at increased risk.
- **Well-woman visits** to obtain recommended preventive services for women under 65*.

Covered Preventive Services for Children

PREVENTIVE CARE

- **Alcohol and drug use** assessments for adolescents.
- **Autism** screening for children at 18 and 24 months.
- **Behavioral** assessments for children of all ages.
- **Blood pressure** screening for children.
- **Cervical dysplasia** screening for sexually active females.
- **Congenital hypothyroidism** screening for newborns.
- **Depression** screening for adolescents.
- **Developmental** screening for children under age 3, and surveillance throughout childhood.
- **Dyslipidemia** screening for children at higher risk of lipid disorders.
- **Fluoride chemoprevention** supplements for children without fluoride in their water source.
- **Gonorrhea** preventive medication for the eyes of all newborns.
- **Hearing** screening for all newborns.
- **Height, Weight, and Body Mass Index** measurements for children.
- **Hematocrit or Hemoglobin** screening for children.
- **Hemoglobinopathies** or sickle cell screening for newborns.
- **HIV** screening for adolescents at higher risk.
- **Immunization** vaccines for children from birth to age 18. Doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis.
 - *Haemophilus influenzae* type b.
 - Hepatitis A.
 - Hepatitis B.
 - Human Papillomavirus.
 - Inactivated Poliovirus.
 - Influenza.
 - Measles, Mumps, Rubella.
 - Meningococcal.
 - Pneumococcal.
 - Rotavirus.
 - Varicella.
- **Iron** supplements for children ages 6 to 12 months at risk for anemia.
- **Lead** screening for children at risk of exposure.
- **Medical history** for all children throughout development.
- **Obesity** screening and counseling.
- **Oral health** risk assessment for young children.
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns.
- **STI** prevention counseling and screening for adolescents at higher risk.
- **Tuberculin** testing for children at higher risk of tuberculosis.
- **Vision** screening for all children.



Note: For immunizations for children, please ask your doctor or refer to the CDC schedule. If your child stays up-to-date on their well-baby visits, it will help ensure they remain up-to-date on their immunizations.

Screenings and Vaccinations

We know that life can get busy and things like preventive care can slip your mind. But preventive care services like immunizations and screenings are too important to forget. Health screenings help to catch potentially serious diseases and offer the best opportunity for early detection and successful treatment.

Prenatal Care Services

Having a baby is an exciting experience. HMSA's prenatal care services help ensure a healthy experience for mother and child. Prenatal care can address your questions and support you and your ob-gyn through your pregnancy with a variety of educational and clinical services. You will be contacted during your pregnancy and given personalized information and guidance to assist you in getting the appropriate care. HMSA will send you information specific to your needs, link you to other resources in the community, and be available to answer questions you have regarding your pregnancy.

Most pregnant HMSA members are eligible for prenatal care at no cost. Your ob-gyn can enroll you or you can enroll by calling 1 (888) 400-2776 toll-free.

Positively Pregnant is a partnership between HMSA and Kapiolani Medical Center for Women & Children. The program offers monthly workshops at various locations on Oahu for pregnant women at no cost. Prenatal care information is provided, including how to look for signs of preterm labor and what to do if it occurs. Participants also learn that treatment and medication used to stop preterm labor work best when started early.

For workshop information, call 535-7474 on Oahu.



HEALTH EDUCATION

Health Education Classes

Healthy lifestyle habits can help you live life to the fullest and manage chronic conditions. HMSA uses fun, interactive methods to teach you about fitness, nutrition, stress management, and overall wellness. HMSA members can participate in these health education classes at no charge.



Healthy Eating. This class teaches the basic principles of nutrition and how to incorporate strategies for healthier eating into your lifestyle.

Fitness Basics. This beginner-level, interactive class can help you get started on your way to a more fit and healthy lifestyle.

Stress Management. Learn to manage stress by understanding the mind/body connection and practicing various breathing and relaxation techniques.

Meditation. Transform your life with simple meditation techniques.

Exercise for Older Adults. What is aging really all about? Discover the changes that will occur in your body as you get older.

Strength and Balance. Falls are a major risk for older adults. This class teaches you how to prevent falls.

Classes are available for members ages 18 and older. To enroll, call 948-6398 on Oahu or 1 (800) 525-6548 toll-free on the Neighbor Islands.

Stop Smoking Services

Smoking is a hard habit to break. But you can become tobacco-free with the help of HMSA's stop smoking services, which are designed to provide you the support you need to quit and stay smoke-free. The services focus on your individual needs and are designed to be convenient, flexible, and personalized.

Participants will receive:

- Phone counseling for 18 months at no cost.
- Help to set and prepare for your quit date.
- Strategies to deal with cravings, avoid weight gain, and stay smoke-free.
- Information on nicotine replacement therapy and stop-smoking aids.
- Referrals for community resources, including classes, support groups, websites, and alternative therapies.
- Stop-smoking classes from recognized community providers and medical facilities at no cost or at a discount.

Eligible HMSA members can enroll by calling 952-4400 on Oahu or 1 (888) 225-4122 toll-free on the Neighbor Islands.

MANAGING YOUR HEALTH AND WELL-BEING

HMSA offers personalized plans to help you achieve optimal health.

Disease Management Services

HMSA's disease management services provide you with a multidisciplinary team of nurses, dietitians, health coaches, and social workers to develop a personalized plan to reach your optimal health and well-being.

Disease management services help members who have:

- Asthma.
- Chronic obstructive pulmonary disease (COPD).
- Cardiac conditions (heart failure and coronary artery disease).
- Diabetes.
- Chronic kidney disease.

In addition to helping manage these chronic diseases, behavioral health services help members manage depression, substance abuse, and other mental health conditions.

More than 100,000 members with chronic conditions work with local nurses and dietitians trained in disease management and behavior therapy. Members receive information and support through regular phone calls, mailings, and state-of-the-art computer support systems. Some patients receive equipment needed to monitor themselves from home.

For more information, call HMSA's disease management services at 1 (800) 499-5036 toll-free.



BENEFITS MANAGEMENT

Medical Management

Smart management of the use of health care services is another way HMSA ensures appropriate, quality care and efficient use of members' dues. HMSA's Utilization Management (UM) program is an innovative system of integrated processes that seeks to ensure members receive the right care, at the right time, in the right setting.

HMSA's Medical Management department administers the UM program. Examples of UM activities include:

Pre-certification review: Prospective and concurrent evaluation of health care services (e.g., medical procedures, treatments, pharmaceuticals, and devices) for appropriateness, medical necessity, and health plan benefit applicability. (Refer to your plan *Guide to Benefits* for a list of services that require pre-certification.)

Focused medical review: Reviews between nurse reviewers, physicians, and case managers to ensure timely, appropriate care is conducted to maintain patient safety, continuity, and quality of care. These reviews can include referrals for case management if needed.

Claims analysis: Reviews of claims are performed by clinical reviewers and certified coders. Established criteria, relevant clinical information, resources, and clinical or coding knowledge are used to validate variances in provider practices and billing and coding patterns, as well as to review provider compliance with best practices and evidence-based medicine.

Appeals review: A process to resolve HMSA member appeals of denied pre-certification requests. Patients and/or their representatives are provided information on the appeal process via an attachment to their denial notification, entitled *Member Appeal Rights and Process*.

With HMSA's large membership, the most efficient and equitable way to determine which services are appropriate for patients and their conditions is through established medical policy. We use nationally published guidelines and established criteria to help our members receive quality health care services and positive clinical outcomes. HMSA's Medical Management department also uses other types of guidelines, such as claims and administrative policies.

Evaluation of new technology: HMSA has a comprehensive process to evaluate any new or experimental technology and/or the new application of existing technologies to determine if the technology is eligible for benefit coverage. The Technology Evaluation Committee, composed of providers and professional analysts, evaluates new technology for possible benefit inclusion.



All decisions are based on research from sources such as professional medical journals, government agencies, national resources, and findings from the Blue Cross and Blue Shield Association's Technology Evaluation Center.

If your physician is considering the use of new technology in your treatment, you must first receive pre-certification from HMSA. Your physician must contact HMSA before beginning such treatment. Please refer to your *Guide to Benefits* for complete information. To request a copy, please contact an HMSA office listed at the end of this handbook.

Integrated Case Management Services

When members and their families experience a medical crisis, such as a serious illness or injury, we want to make sure they get the care they need. In these cases, an HMSA case manager can work with physicians and hospitals to help coordinate patient services and benefits. When necessary, the case manager can help patients access services not usually covered under their health plan by identifying community resources or other options. By coordinating services and providing individualized case management services, we help ensure that members receive the highest possible quality care.

Integrated Case Management Services include:

- Helping members explore medical benefit options.
- Finding providers that members need.
- Accessing additional community resources.
- Assisting with self-management of chronic disease.
- Helping members and their families obtain caregiver support and education.
- Assisting with communication between different service providers.
- Assisting with members' overall coordination of care.



Please call HMSA's Integrated Case Management Services unit at 440-7057 on Oahu or 1 (855) 211-4527 toll-free on the Neighbor Islands for more information.

PRESCRIPTION DRUGS

Your drug therapy is an important part of your health care. HMSA promotes proper use of your prescription drugs and works to help keep your share of drug costs down.

Drug Formulary



Your HMSA drug plan is designed to give you a choice of prescription drugs for which you share the cost through copayments:

- **First tier:** Generic drugs – lowest copayment. Generic drugs are sold under their common generic or chemical name. Generics have the same active ingredients as their brand-name equivalents and have been determined to be safe and effective by the U.S. Food and Drug Administration (FDA). We encourage the use of generics because their low cost results in the lowest copayment for you.
- **Second tier:** Preferred brand drugs – higher fixed copayment. Some brand-name drugs are designated as preferred brand drugs when generic alternatives are not available or do not adequately represent a therapeutic class. For preferred brand drugs, you pay a higher, fixed copayment than for generics.
- **Third tier:** Other brand drugs – higher fixed copayment plus differential. Other brand drugs have a higher member copayment.

For most members, the out-of-pocket cost for other brand drugs is the second-tier copayment plus the differential. The differential is the difference between the average cost for other brand drugs and the average cost for generic and preferred brand drugs.



Choose Generic

The high cost of prescription drugs is a critical factor in rising health care costs locally and nationally. HMSA's Choose Generic campaign encourages the use of generic drugs to help our members manage their prescription drug costs. Talk to your doctor or pharmacist about obtaining a generic drug if it's appropriate for your condition.

Mail Order Prescription Drug Program

HMSA's Mail Order Prescription Drug Program is a cost-efficient, convenient way to receive your maintenance medications. Maintenance medications are drugs taken on a regular or long-term basis for such conditions as high blood pressure, arthritis, heart ailments, and diabetes.

Administered by Medco, this program can reduce your prescription copayments and have your medications delivered directly to you. You will also receive important reminders to help you maintain your medication regimen. Ask your doctor to prescribe a 90-day supply of medication plus appropriate refills to receive the greatest cost savings.

Most HMSA members on maintenance medications are eligible for the Mail Order Prescription Drug Program. For a program brochure, call Medco at 1 (866) 544-6765 toll-free. TTY users may call 1 (800) 759-1089 toll-free. Order forms are also available by logging on to My Account at [hmsa.com](https://www.hmsa.com).

National Pharmacy Network

You can pick up prescriptions when you travel the same way you do in Hawaii – you pay your usual copayment and the pharmacist files the claim. You no longer have to prepay the entire amount and file for reimbursement. This benefit provides hassle-free access to medications when visiting a provider while traveling. However, when planning a trip, we recommend that you take enough medication to last for the duration of your trip. HMSA's participating national pharmacies include:

- Albertsons
- Costco Pharmacy
- CVS
- Kmart
- Rite Aid
- Safeway
- Supervalu
- Target
- Walgreens
- Walmart

This list is subject to change. Please visit [hmsa.com](https://www.hmsa.com) or call HMSA's Customer Relations department for updates.

DISCOUNT PROGRAM

HMSA365

HMSA believes good health should be affordable 365 days a year. With HMSA365, you receive discounts on many health and wellness services throughout the state, including the YMCA, Curves, Jazzercise, Jenny Craig, and more.

The program is convenient and easy to use. There are no forms to fill out or receipts to submit. Simply show your HMSA card at a participating company to save money.

HMSA365 includes discounts on these health and wellness products and services:

- Acupuncture.
- Behavioral health services.
- Biofeedback.
- Energy healing.
- Fitness centers.
- Hearing aids.
- LASIK.
- Massage therapy.
- Pilates.
- Qi gong.
- Tai chi.
- Vision services.
- Yoga.

For a complete list of businesses participating with HMSA365, go to hmsa.com/hmsa365 or call 1 (866) 510-6362 toll-free.

HMSA365 is administered by Healthways Whole Health Network. Please note that not all discounts are available on all islands. Current HMSA members only.



MANAGING HEALTH CARE COSTS

Unhealthy lifestyle habits put you at high risk for chronic diseases and other serious health conditions that drive up the overall cost of health care. In many cases, diseases and other illnesses can be prevented by taking personal responsibility for your health.

Take an Active Role in Your Care

- **Know your health risk:** Take preventive steps to minimize the risk of diseases that run in your family.
- **Work with your doctor:** Speak openly about your medical problems with your doctor. Don't be afraid to ask questions.
- **Manage your prescription drugs:** Take your medication as directed. Follow the directions on the bottle and from your doctor or pharmacist.

Use Your Health Plan Wisely

- **Understand your plan benefits:** Know what medical procedures and prescription drugs are covered under your health plan and what alternatives are available.
- **Use the ER wisely:** Going to the emergency room for non-emergencies drives up the overall cost of health care and delays care for people with true emergencies.
- **Be aware of fraud and abuse:** Review your HMSA Report to Member statements carefully to make sure you're not paying for procedures you didn't receive.

Make Healthy Lifestyle Choices

- **Keep active:** Get at least 30 minutes of moderate activity on most days of the week.
- **Make healthy eating choices:** Choose foods that are low in fat and sugar and high in fiber, vitamins, and other nutrients.
- **Avoid substance abuse:** Talk to your doctor or contact HMSA's behavioral health services if you're addicted to tobacco, alcohol, or drugs.

Practice Preventive Care

- **Receive appropriate health screenings:** Regular preventive exams and screenings can detect chronic diseases early and lead to faster treatment.
- **Take safety precautions:** Wear your seat belt or helmet while on the road. Protect your skin from the sun.



KEEPING YOU CONNECTED

We want our members to have access to information regarding HMSA services and other health and wellness information. We have several options that are easy to access and help you stay connected to HMSA.

Island Scene Magazine



HMSA's quarterly magazine provides an entertaining and informative mix of health information and HMSA news. This award-winning member magazine includes a variety of feature stories on health and fitness, healthy recipes, HMSA member news, and other topics.

On the Web

You can visit us online at hmsa.com. Member news and health information can also be found at Island Scene Online (www.islandscene.com), our online companion to *Island Scene* magazine.

HMSA Now

HMSA's YouTube channel features HMSA videos on a wide variety of topics:

- Customer service information and frequently asked questions.
- HMSA commercials.
- Akamai Living segments and shows.
- HMSA community events and programs, such as the HMSA Teen Video Awards and the HMSA Kaimana Awards & Scholarship Program.



Visit www.youtube.com/HMSANow.

YouTube videos are also linked to information on hmsa.com.

CUSTOMER RELATIONS

For your convenience, we have offices available to serve you on Oahu, Maui, Kauai, and in Hilo and Kona on Hawaii Island. HMSA wants you to be satisfied with your health plan and your health care. If you have any questions or complaints, please call HMSA's Customer Relations department:

Oahu

- Preferred Provider Plan/CompMED948-6111
- Health Plan Hawaii/Health Plan Hawaii Plus....948-6372
- 65C Plus/Senior Connection948-6000

Hawaii Island

- Hilo935-5441
- Kona.....329-5291

Kauai245-3393

Lanai1 (800) 639-4672

Maui871-6295

Molokai1 (800) 639-4672



MEMBER RIGHTS AND RESPONSIBILITIES

Members have the right to make recommendations regarding their health plan's members' rights and responsibilities policies.

Members have the right to receive information about their health plan, benefits, services, practitioners and providers, and members' rights and responsibilities.

Members have the right to be treated with respect by all members of the health care system and the right to have the confidentiality of their protected health information maintained.

Members have the right to participate with practitioners and providers in all decisions regarding their health care.

Members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Members have the right to a choice of health care practitioners and providers that is sufficient to ensure access to appropriate high-quality care and services.

Members have the right to voice complaints or appeal decisions about their health plan or care provided.

Members have the responsibility to provide, to the extent possible, information that their health plan, practitioners, and providers need in order to provide care.

Members have the responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Members have the responsibility to follow plans and instructions for care that they have agreed on with their practitioners and providers.



HMSA



HAWAI'I MEDICAL SERVICE ASSOCIATION
hmsa.com

HONOLULU • 818 Keeaumoku St. • 96814
Phone: 948-6372 for HMO Plans
948-6111 for PPO Plans

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. TTY: 948-6222 on Oahu.

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.