HMSA

PPP and CompMED Member Handbook

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

January 2016

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're 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 on the next page. 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 808-948-6372 • Kauai 808-245-3393 • Maui 808-871-6295
• Hilo 808-935-5441 • Kailua-Kona 808-329-5291
• Molokai & Lanai 1-800-639-4672

TTY 711 on Oahu

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QUALITY HEALTH CARE

Philosophy of Care

At HMSA, we maintain the highest levels of quality health care for our members.

We maintain a mutually respectful relationship with our members and health care practitioners to promote effective, quality health care and service.

We value our members' health and well-being. Prevention is a key component of our comprehensive care programs, resulting in lower risks of illness and better management of problems.

We hold the credentialed health care practitioners in our network to high standards of quality in the health care and services that they provide and in the satisfaction of their patients.

We inform our members about how their health plan works, how network physicians are compensated, and how utilization monitoring supports the delivery of quality health care.

We encourage health care decision-making that's based on appropriate care and service and existence of coverage. We reward appropriate decisions on care through financial incentives. We don't reward practitioners or other individuals for denying payment or coverage and actively discourage barriers to care.

We don't encourage decisions that result in underutilization and we don't provide financial incentives to utilization management decision makers.

We afford our members and physicians the right to voice complaints, appeal decisions, and receive timely responses from us.

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 Commendable status from NCQA for service and clinical quality that meets NCQA's rigorous requirements for consumer protection and continuous quality improvement. These HMSA plans include:

- Preferred Provider Plan.
- CompMED.
- Health Plan Hawaii.
- Federal Employee Health Benefit Program.
- State of Hawaii Employer-Union Health Benefit Trust Fund Plan.
- HMSA's Akamai Advantage local plan (Medicare PPO plan).
- HMSA'S QUEST Integration, a medical HMO.

NCQA is an independent, nonprofit national organization that evaluates managed care organizations. NCQA accreditation status is widely regarded as an evaluator of quality.

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. Many of these provisions have already been implemented.

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

No one will be denied coverage despite having a pre-existing condition.

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.

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

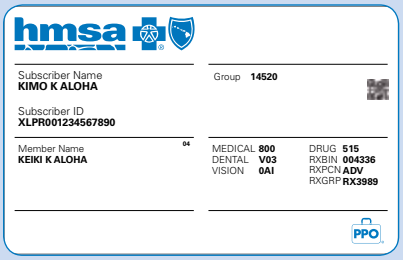
Membership Eligibility

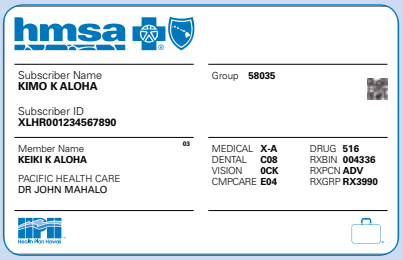
You're eligible for benefit payments from HMSA if you're a member of an HMSA plan and all membership premiums have been paid. If you're a current member in good standing, your claims for medical services are eligible for benefit payments. Verifying eligibility is the first step in reviewing a request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

HMSA Membership Card

INFORMATION FOR ALL HMSA MEMBERS

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.





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 Privacy Notice 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 don't 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 current subscribers 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'll 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.

Privacy Notice

This notice describes how your health data may be used and disclosed and how you can access your data. Please read it in detail.

We care about the privacy of your health data and protect your privacy in keeping with federal law. This notice describes our privacy rules, our legal duty, and your rights about your health data. This notice went into effect on September 22, 2013.

We must give you a copy of this notice and follow the terms of this notice. We have the right to change this notice at any time. If we make major changes to this notice, we'll post a revised notice on this website. We'll give you a copy of the revised notice or details about the changes and tell you how to get the revised notice.

Your Protected Health Information, or PHI

Your PHI includes data about you, the health care services you get, and payment for your care. HMSA gets and produces PHI. For example, after you visit the doctor, a claim is sent to HMSA. The claim may have details about your health, symptoms, injury or illness, exam, treatment, and more. Your PHI may be used in several ways, such as to pay your claim or to plan your care.

Your Rights

The law gives you rights about your PHI. As an HMSA member, you have the right to:

- Ask for and get a copy of this notice at any time.
- See or ask for a copy of your PHI on paper or in electronic form. There may be a fee for these copies.
- Ask us to limit how we use and share your PHI. There may be reasons why we can't agree to your request. Even if we agree, we may still share your records during emergencies or when the law says we have to.

- Ask for and get a list of third parties that we share your PHI with for certain reasons.
- Ask that your PHI be sent to you by a different way other than by mail or be sent to a different address. This can be done if you feel your life is in danger.
- Ask to add to your PHI. In some cases, we may not be able to grant your request, such as if we did not create the PHI. If we deny your request, we'll tell you why in writing. If you don't agree, you may send us a letter that says you do not agree.
- If there is a misuse of your PHI, we'll let you know about it if we feel it's needed or if the law says we have to.

You may contact us as noted at the end of this notice about your rights.

Our Duties

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

- Protect the privacy of your PHI.
- Give you a notice of our privacy practices.
- Follow the terms of this notice.
- Fulfill your request to send PHI in a different way or to a different address. This can be done if you feel you are in danger. Your request must be reasonable and state the other address or the other way you want us to contact you. Also, your request must let us pay claims, send you letters, and collect premiums for your health plan.*
- Use and share only the PHI we need to do our jobs.
- Make sure our business associates (BAs) agree to protect your PHI the same way we do.

We won't use or share your PHI except when the law says we have to or as described in this notice. Also, we won't ask you to give up your privacy rights to join an HMSA plan or to get care.

* Collecting premiums does not apply to HMSA QUEST Integration members.

How PHI is Used and Shared

There are three key areas where we need to use and share your PHI: to treat you, to pay your claims, and for other health care operations. We may also contract with other parties or BAs to do the work for us, as long as they promise to protect your PHI as we do. Each area is described below.

To treat you: This includes services to provide or manage your health care. As your health plan, we may need to share PHI with your doc¬tor or others so they can treat you.

To pay your claims: We need to pay claims from doctors, hospitals, and others for your care. We may also share PHI to collect premi¬ums, to see if you can get care, to set your level of coverage, and to work with other health plans to decide on benefits.

For health care operations: We want you to get quality health care services. To do that, we may get copies of your medical records and your lab test results for quality review, to review provider qualifications, and to track wellness and manage disease. We may also use PHI to set premiums, resolve complaints and appeals, manage our business, and other operations.

Other Ways We Use and Share PHI

At times, we'll need to use and share your PHI for your own good, to serve the public good, or when the law says we have to. In these cases, we'll use and share only the smallest amount of PHI needed. Examples are:

INFORMATION FOR ALL HMSA MEMBERS

To discuss treatment options or other products or services: HMSA or its BAs may use your PHI to send you details on care options or other products or services as allowed by law. This may include data on our provider network and new products or services that only HMSA members can get. It may also include options on other care, health care providers, or settings of care that may work for you. You may contact us if you don't want to get certain letters. We'll get your authorization to send you details about a third-party's products or services if we get financial payment from the third party for doing so or in other cases when the law says we have to.

To others involved in your health care: Unless you object, we may share your PHI with your family members or a friend who's involved in your health care.

For raising funds: HMSA doesn't ask its members to raise funds for its own use.

For underwriting: We may use your PHI to create, renew, or replace your health plan or health benefits. We won't use or share this PHI for any other reasons except when the law says we can or the law says we have to. We won't use or share genetic data for underwriting uses. If the contract for a health plan or health benefits is placed with us, we'll use and share your PHI only as described in this notice or as allowed by law.

With your written authorization: Most uses and sharing of psychotherapy notes, some uses and sharing for marketing, and sharing that involves the sale of your PHI will need your authorization. You may also give us authorization in writing to use or share your PHI with someone you name. You may end your authorization in writing at any time. We'll honor your request unless the PHI has already been shared. We won't use or share your PHI for reasons that are not allowed by law or not described in this notice unless we get your written authorization.

During an emergency or disaster: During a medical emergency or disaster, we may share your PHI to make sure you can get the care you need or to process payment for your care. We may also need to share your PHI during a disaster to help your family find out how you're doing and where you are. If you're not present or are not able to agree to these uses of your PHI, we may need to decide if sharing the PHI is best for you.

To plan sponsors: We may share your PHI with your group health plan sponsor or its legal representative to help them manage your group health plan. Only the smallest amount of PHI needed will be shared.

For health information exchanges (HIEs): We may take part in one or more HIEs. This means that your PHI may be available electronically to treat you, to pay your claim, or for health care operations. Other doctors and health plans that take part in the HIE may have access to this data.

To report to authorities: As required by law, we may share your PHI if we suspect abuse, neglect, or domestic violence.

For research: We may use or share your PHI with researchers when they agree to protect it.

To comply with privacy laws: We may use or share your PHI as required by privacy laws.

For workers' compensation: We may share your PHI to comply with laws on workers' compensation or similar programs.

For public health: We may share your PHI with public health or legal staff who work to prevent or control disease, injury, or disability.

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

For judicial and administrative matters: We may share your PHI in response to a court or administrative order, subpoena, or other law process, in some cases.

For law enforcement reasons: In a few cases, such as a court order, warrant, or grand jury subpoena, we may share your PHI with law enforcement officials.

For military or national security reasons: In some cases, we may share PHI of armed forces staff with military authorities. We may also share PHI with federal officials for national security reasons.

For More Information or to Report a Problem

For more details on HMSA's privacy practices, please contact us as noted at the end of this notice.

If you believe that your privacy rights have been breached, you may file a complaint with us as noted 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, we assure you that we won't retaliate in any way.

Thank you for taking the time to review this notice. As your health plan, we work hard to take care of your PHI. We know this is important to you and we take our duties very seriously.

Write to HMSA at:

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

Honolulu, Oahu

- Group/Individual Plans: 808-948-6111
- Federal/State/County Plans: 808-948-6499
- HMO Plans: 808-948-6372
- Blue Cross Blue Shield Service Benefit Plan (FEP): 808-948-6281
- HMSA QUEST Integration: 808-948-6486
- HMSA Akamai Advantage: 808-948-6000
- Text Telephone (TTY): 877-447-5990

Hilo, Hawaii Island: 808-935-5441

Kona, Hawaii Island: 808-329-5291

Lihue, Kauai: 808-245-3393

Kahului, Maui: 808-871-6295

INFORMATION FOR ALL HMSA MEMBERS

Write to the U.S. Department of Health and Human Services at:

Office for Civil Rights, DHHS
90 7th St., Suite 4-100
San Francisco, CA 94103

Phone: 1-800-368-1019 toll-free
TDD: 1-800-537-7697
Fax: 415-437-8329

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're 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, check your provider directory, or search for providers through our website at hmsa.com.

Well-Being Connect

We understand 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.

Our Well-Being Connect website is tailored to members' unique needs, desires, and motivations. Well-Being Connect starts by asking questions about your total health, and then develops a customized plan to help you achieve your goals. It's an effective, proven support system designed to help you change your behavior and improve your well-being.

Care After Hours

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

HMSA's Online Care

PREFERRED PROVIDER PLAN AND COMPMED 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 on your smartphone or tablet, 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 808-948-6013 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 don't need 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 don't need immediate care, make an appointment with your PCP. If you don't have a PCP, 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 bcbs.com or call 1-800-810-BLUE (2583) toll-free.

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 doesn't 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 COMPMED 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 won't be returned to you.

Once we receive and process your claim, we'll 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 need 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'll extend the time period for 15 days. We'll let you know within the initial 30-day period why we're extending the time and when you can expect our decision. If we need additional information, you'll 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 help. If you're 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're 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 COMPMED MEMBERS

Address written requests to:

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

Or send a fax to 808-952-7546 on Oahu.

Requests that don't comply with the requirements will not be recognized or treated as an appeal. If you have any questions, please call 808-948-5090 on Oahu or 1-800-462-2085 toll-free on the Neighbor Islands.

We'll 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'll 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 808-948-5090 on Oahu or 1-800-462-2085 toll-free on the Neighbor Islands. We'll 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 membership 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'd 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'll 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 808-948-5090 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 gives 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 808-948-6111 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

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 Immundeficency Virus (HIV)** screening and counseling for sexually active women.
- **Immunization** vaccines for adults. Doses, recommended ages, and recommended populations vary:
    - o Hepatitis A.
    - o Hepatitis B.
    - o Herpes Zoster.
    - o Human Papillomavirus.
    - o Influenza.
    - o Measles, Mumps, Rubella.
    - o Meningococcal.
    - o Pneumococcal.
    - o Tetanus, Diphtheria, Pertussis.
    - o 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

- **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

- **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:
    - o Diphtheria, Tetanus, Pertussis.
    - o *Haemophilus influenzae* type b.
    - o Hepatitis A.
    - o Hepatitis B.
    - o Human Papillomavirus.
    - o Inactivated Poliovirus.
    - o Influenza.
    - o Measles, Mumps, Rubella.
    - o Meningococcal.
    - o Pneumococcal.
    - o Rotavirus.
    - o 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.

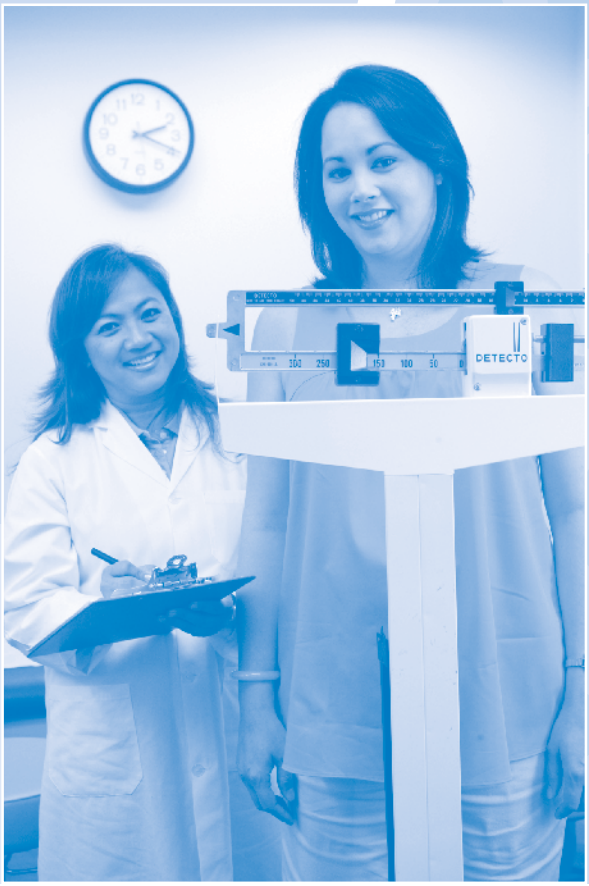
Screenings and Vaccinations

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 HMSA Well-Being Connection at 1-855-329-5461 toll-free.



Positively Pregnant

HMSA has partnered with Kapiolani Medical Center for Women & Children to offer a free Positively Pregnant class for you and your partner. The class includes information on the importance of prenatal care, including exercise and nutrition, and what to expect throughout your pregnancy.

Register today by calling 808-535-7474 on Oahu.

HEALTH EDUCATION

Health Education Workshops

Healthy lifestyle habits can help you live life to the fullest. HMSA uses fun, interactive methods to teach you about fitness, nutrition, stress management, and overall well-being. HMSA members can participate in these health education workshops at no charge.

- **Disease Awareness**: Review common and life-altering conditions such as heart disease, hypertension, diabetes, osteoporosis, and cancer.
- **General Health**: Increase your well-being in these workshops that focus on virus treatment and prevention, the importance of quality sleep, positive attitude, and goal-setting.
- **Healthy Aging**: Discover ways to keep your body and mind functioning at high levels throughout life in these engaging sessions.
- **Injury Prevention & Safety**: Practice healthy posture, proper lifting technique, and back stretches in this interactive workshop. Learn about the contributing factors for recurring back pain and reduce your risk.
- **Nutrition**: Explore our relationship with food - how to make smart choices "on the go," review current dietary guidelines, and choose healthier local foods.
- **Physical Activity & Exercise**: Tackle a hands-on approach in these interactive workshops that focus on cardiovascular exercise, strength training, outdoor fitness, and family-based activities.
- **Stress Management**: Relaxing and "finding the calm" in life are important for your home and work environment. Learn and practice techniques that will help you lower your stress levels.
- **Weight Awareness**: Gain an understanding of calories, lifestyle behaviors, and societal influences in relationship with weight management in these interactive workshops.

Workshops are available statewide for members ages 18 and older. To enroll, call HMSA Well-Being Connection at 1-855-329-5461 toll-free.

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 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.

Eligible HMSA members can enroll by calling HMSA Well-Being Connection at 1-855-329-5461 toll-free.

MANAGING YOUR HEALTH AND WELL-BEING

HMSA offers personalized plans to help you achieve optimal health.

Disease Management Services

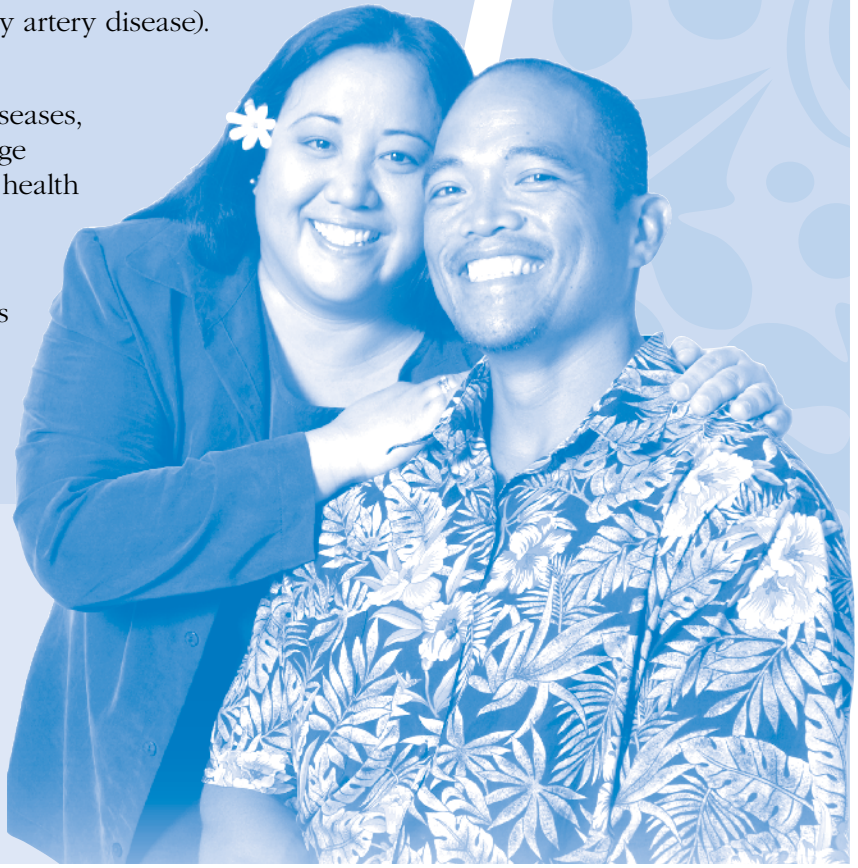
HMSA's disease management services provide you with a multidisciplinary team of nurses, dietitians, health coaches, and social workers to develop a personalized plan to reach your optimal health and well-being.

Disease management services help members who have:
- Asthma.
- Chronic obstructive pulmonary disease (COPD).
- Cardiac conditions (heart failure and coronary artery disease).
- Diabetes.

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 1-855-329-5461 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.

Managing Chronic Disease and Catastrophic Illness

Case management services are designed to supplement the relationship you have with your primary care provider. When you are in a medical crisis, such as dealing with a major chronic disease or experiencing a catastrophic illness that may require costly ongoing care, HMSA can help you with:

- Understanding your health care and coverage options.
- Finding care providers you need.
- Accessing additional community resources.
- Coordinating care, including palliative/comfort care services.

Specially trained care coordinators, social workers, and nurses use their clinical and benefits expertise to provide additional support and coordinate referrals as needed to help you make the best use of appropriate HMSA benefits and services.

If you qualify, case management is provided at no additional cost. For more information on care options, call 808-440-7057 on Oahu or 1-855-211-4527 toll-free.

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

The list of medications in your prescription drug plan is called a formulary. From time to time, we make changes to your formulary to ensure you're taking safe, effective medication at an affordable price. We'll work with you and your doctor through these changes to make sure you're taking the right medication at the right price.

HMSA Essential Prescription Formulary Plans

The HMSA Essential Prescription Formulary is a five-tiered managed formulary that limits the number of prescription medications covered and requires prior authorization for drugs that are non-formulary.

- The first tier contains mostly generic prescription drugs.
- The second tier contains some generic prescription drugs AND preferred brand prescription drugs with advantages (efficacy, safety, and/or overall value) over other options.
- The third tier contains non-preferred brand-name prescription drugs without advantages (efficacy, safety, and/or overall value) over other options, but with lower overall net costs compared to non-formulary drugs.
- The fourth tier contains preferred specialty drugs with advantages (efficacy, safety, and/or overall value) over other specialty drug options. Specialty drugs are typically high in cost and require specialized care. Specialty drugs are limited to a 30-day supply and must be filled at a participating specialty pharmacy.
- The fifth tier contains non-preferred specialty drugs without advantages (efficacy, safety, and/or overall value) over other specialty drug options. Specialty drugs are typically high in cost and require specialized care. Specialty drugs are limited to a 30-day supply and must be filled at a participating specialty pharmacy.
- Non-formulary drugs do not have advantages over other options or are new brand drugs to market.

Note: There may be drugs that are specifically excluded from coverage, such as over-the-counter medications, vitamins, drugs for cosmetic uses, and drugs for sexual dysfunction or infertility.

HMSA Select Formulary Plans

The HMSA Select Formulary is a four-tiered open formulary. An open formulary includes all prescription drugs except those prescription drugs that are excluded under the health plan benefit. Brand drugs that are not listed on the formulary are considered Tier 3 Other brand drugs and generics not listed are on Tier 1.

- The first tier contains generic prescription drugs.
- The second tier contains preferred brand prescription drugs with advantages (efficacy, safety, and/or overall value) over other brand options.
- The third tier contains other brand-name prescription drugs without advantages (efficacy, safety, and/or overall value) over other options or new brand drugs to market.
- The fourth tier contains specialty drugs that are typically high in cost and require specialized care. Specialty drugs are limited to a 30-day supply and must be filled at a participating specialty pharmacy.

Note: There may be drugs that are specifically excluded from coverage, such as over-the-counter medication, vitamins, drugs for cosmetic uses, and drugs for sexual dysfunction or infertility.

Here are some of the HMSA prescription drug plan changes that may affect you

	Essential	Select
Non-formulary When we take a drug off your formulary, it means we'll no longer pay for it because there are equally effective alternatives that cost less. Talk to your doctor about alternatives that you can take before your next refill. If you still want to continue taking these drugs, you'd have to pay the full cost.	X	
Tier changes Your plan's formulary uses a tier system. When we move a drug to a higher tier, although your drug plan will continue paying a portion of the cost, your share of the cost will increase. Talk to your doctor about taking an alternative that'll cost less.	X	X
Quantity limits We follow U.S. Food and Drug Administration (FDA) or manufacturer guidelines for medication quantity limits. The FDA says taking a higher-than-recommended dose could put your health and safety at risk.	X	X
Prior authorization Some medications require HMSA's authorization to ensure they're necessary for your condition.	X	X
Step therapy Some medications require step therapy. That means you'll be required to try certain drugs to treat your medical condition before we'll cover another drug for that condition.	X	X

If you're affected by one or more of these formulary changes, you'll receive a letter with details about the changes. Please read the information carefully and talk to your doctor or pharmacist about taking alternative medications that are right for you. In some cases, your doctor may request an exception to have you stay on your current medication or dosage.

Choose Generic

The high cost of prescription drugs is a critical factor in rising health care costs locally and nationally. HMSA 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.

Specialty pharmacy

Specialty drugs can help you stay healthy, but getting the most from them requires extra care. Our network specialty pharmacies make it easier for you to manage your condition and enjoy better quality of life with the experienced support of our clinician-led teams. For help with your specialty pharmacy needs, call 1-800-237-2767 toll-free.

Mail-Order and 90-day at Retail Prescription Drug Programs

HMSA's Mail-Order and 90-day at Retail Prescription Drug Programs are a cost-efficient, convenient way to receive your maintenance medications. Maintenance medications are drugs taken on a regular or long-term basis for conditions such as high blood pressure, arthritis, heart ailments, and diabetes.

Using these programs can reduce your prescription copayments. You can have your medication delivered to you or you can pick it up at one of the 90-day at Retail pharmacies near you.

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 and 90-day at Retail Prescription Drug Programs.

Choose from one of three easy ways to use mail service for your long-term medications:

- Fill out and send in a mail-service order form available through HMSA's My Account.
- In My Account, click on Prescription Tools and then on FastStart® to use the tool.
- Call FastStart at 1-800-875-0867 toll-free.

Mail-service medications will be delivered to the address of your choice.

To get refills automatically, enroll in ReadyFill at Mail® through My Account on hmsa.com. Or call 808-948-6111 on Oahu or 1-800-776-4672 toll-free on the Neighbor Islands.

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. This benefit provides hassle-free access to medications when visiting a provider while traveling. When planning a trip, however, we recommend that you take enough medication to last the duration of your trip.

Here are some of the participating national pharmacies in the HMSA and CVS/caremark network:

Albertson's Pharmacy
CVS Pharmacy
KMart Pharmacy
Rite Aid Pharmacy
Sams Pharmacy
Target Pharmacy
Walmart Pharmacy
Costco Pharmacy
Fred Meyer Pharmacy
Kroger Pharmacy
Safeway Pharmacy
Sav-On Drugs
Walgreens

20 percent in-store discounts

You can save money with the ExtraCare® Health Card when shopping at Longs Drugs, which is owned by CVS/caremark. You'll get a 20 percent discount on thousands of CVS/pharmacy Brand health-related items that are regularly priced at $1 or more. And you'll get the same savings if you shop online at cvs.com.

The 20 percent discount is restricted to items purchased for the health care of cardholder, spouse, or dependents. The discount excludes prescriptions, alcohol, tobacco, lottery, postage stamps, gift cards, money orders, pre-paid cards, and photo finishing, and aren't valid on other items reimbursed by a government programs.

Prescription tools

My Account on hmsa.com is your gateway to CVS/caremark's powerful online prescription tools that let you manage your health and wellness. Log on to HMSA's My Account and with a few clicks you can:

- Quickly order refills.
- Check drug costs.
- View your prescription history.
- Find a participating local pharmacy.
- Check drug interactions.
- Contact a pharmacist.
- Find health information.

To find a participating national pharmacy, visit hmsa.com, log in to My Account, and click on Find a Pharmacy. Or call CVS/caremark, HMSA's pharmacy benefits manager:

For commercial plans 1-855-298-2491 toll-free
For HMSA Akamai Advantage 1-855-479-3659 toll-free
For HMSA QUEST Integration 1-855-479-3656 toll-free
For TTY/TDD 1-800-863-5488

If you have any questions regarding your prescription call 1-855-298-2491 toll-free to talk to a medication specialist at CVS/caremark.

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 well-being products and services:

- Acupuncture.
- 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 1-855-329-5461 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

Visit our website at hmsa.com and read Well-Being Hawaii, our health and well-being blog, at wellbeinghi.com.

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 eonvenience, 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/CompMED 808-948-6111

Health Plan Hawaii/Health Plan Hawaii Plus....808-948-6372

65C Plus/Senior Connection 808-948-6000

Hawaii Island
Hilo 808-935-5441
Kona.....808-329-5291

Kauai 808-245-3393

Lanai 1-800-639-4672

Maui 808-871-6295

Molokai 1-800-639-4672

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 without discrimination.

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 treatment plans, instructions and care that they have agreed on with their practitioners and providers.

HMSA CENTERS

Convenient evening and Saturday hours:

HMSA Center @ Honolulu
818 Keeaumoku St.
Monday - Friday, 8 a.m. - 6 p.m. | Saturday, 9 a.m. - 2 p.m.

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday - Friday, 9 a.m. - 7 p.m. | Saturday, 9 a.m. - 2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday - Friday, 9 a.m. - 7 p.m. | Saturday, 9 a.m. - 2 p.m.

OFFICES

Visit your local HMSA office Monday through Friday, 8 a.m. - 4 p.m.:

Kailua-Kona, Hawaii Island | 75-1029 Henry St., Suite 301
Kahului, Maui | 33 Lono Ave., Suite 350
Lihue, Kauai | 4366 Kukui Grove St., Suite 103

PHONE

808-948-6111 on Oahu

If you're calling from the U.S. Mainland, please call 1-800-693-4672. If you need to call a local Hawaii telephone number from the Mainland, the area code is 808.

HMSA's mission is to provide the people of Hawaii access to a sustainable,quality health care system that improves the overall health and well-being of our state.

(00) 1000-4988 1:16 GO