

# HMSA's HPH CONVERSION PLAN

This plan is a health maintenance organization (HMO) medical plan that provides access to health care for you and your eligible dependents after you leave HPH or HMO Hawaii group coverage. Membership is guaranteed and includes limited prescription drug benefits and an annual vision exam.

Joining HPH Conversion Plan:	To Apply:	2012 Monthly Rates:						
<p>To be eligible to enroll in HPH Conversion Plan, you must meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Prior HPH or HMO group plan coverage.</li> <li>• Legal resident of the state of Hawai'i.</li> </ul>	<p>Please submit completed application and check or money order for the first two month's dues within 31 days of your last day of coverage.</p> <p>Mail to: HMSA/6-AMS P.O. Box 860 Honolulu, HI 96808-0860</p>	<p style="text-align: center;"><b>(7/1/11 – 6/30/12)</b></p> <table> <tr> <td>Individual</td> <td style="text-align: right;">\$359.20</td> </tr> <tr> <td>Two party</td> <td style="text-align: right;">\$718.40</td> </tr> <tr> <td>Family</td> <td style="text-align: right;">\$1,077.60</td> </tr> </table>	Individual	\$359.20	Two party	\$718.40	Family	\$1,077.60
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## Three convenient ways to contact HMSA today for details on how to secure your enrollment:

- Call us at 948-5555, option 2, on Oahu
  - 1 (800) 620-4672 toll free on the Neighbor Islands
  - 1 (877) 298-4672 TTY/TDD users
- Go to [hmsa.com](http://hmsa.com) and click on Health Plans/On Your Own/HPH Conversion Plan
- Visit your local HMSA office nearest you:
  - Honolulu, Oahu..... 818 Keeaumoku St
  - Hilo, Hawai'i..... 670 Ponahawai St, Ste 121
  - Kailua-Kona, Hawai'i ..... 75-1029 Henry St, Ste 301
  - Kahului, Maui ..... 33 Lono Ave, Ste 350
  - Lihue, Kauai..... 4366 Kukui Grove St, Ste 103

We reserve the right to request documentation at any time which demonstrates, in our sole discretion and to our satisfaction, that you meet the residency requirement.

This is a pre-paid health plan. If accepted on this plan, you must pay your dues in advance every month to be eligible for coverage. Initial payment must be enough to cover from your date of cancellation up to the current month. Additional dues may be required if applying after the 10<sup>th</sup> of the current month.

This is intended to provide a condensed explanation of the plan. Certain limitations, restrictions and exclusions may apply. Please refer to the plan Guide to Benefits or certificate for complete information on benefits and provisions. In the case of a discrepancy between this summary and the language within the Guide to Benefits or certificate, the latter will take precedence.

# HPH Conversion Plan

BENEFIT DESCRIPTION	Your Copayment In-Network
<b>PLAN PROVISIONS</b>	
Lifetime Maximum	Unlimited
Annual Copayment Maximum	\$2,500 per person Maximum: \$7,500 per family
Annual Deductible	None
<b>HOSPITAL AND FACILITY SERVICES</b>	
Hospital Room and Board (based on semiprivate room rates) and ancillary services.	20% <sup>1</sup>
Skilled Nursing Facility / Ambulatory Surgical Center	20% / None (ASC)
<b>EMERGENCY SERVICES</b>	
Emergency Room	\$75
Physician Visits	None
<b>ONLINE CARE</b>	
Online Care	\$10 <sup>2</sup>
<b>PHYSICIAN SERVICES</b>	
Anesthesia	\$15 (outpatient) None (inpatient)
Office Visit / Home Visit / Facility Visit <sup>4</sup>	\$15
<b>SURGICAL SERVICES</b>	
Surgery (cutting / non-cutting)	None (outpatient surgical center) \$15 (outpatient professional charges) 20% (hospital operating room) None (inpatient professional charges)
<b>TESTING, LABORATORY AND RADIOLOGY</b>	
Diagnostic Testing / Radiology	
Office Visit	20%
Inpatient	20%
Outpatient	20%
Laboratory / Pathology	
Office Visit	20%
Inpatient	20%
Outpatient	20%
<b>OTHER MEDICAL SERVICES AND SUPPLIES</b>	
Ambulance (ground)	20%
<b>REHABILITATION THERAPY</b>	
Physical Therapy / Occupational Therapy	
Office Visit	\$15
Inpatient	20%
Outpatient	\$15
Speech Therapy Services	
Inpatient	20%
Outpatient	\$15
<b>SPECIAL BENEFITS FOR CHILDREN</b>	
Well Child Care Physician Office Visits <sup>3</sup>	None
Well Child Care Immunizations <sup>3</sup>	None

(1) You may owe amounts in addition to your copayment. Please refer to the *Guide to Benefits* for more information.

(2) For up to 10 minutes and \$5 for an additional five-minute extension.

(3) Covered up through age 21. Please refer to the *Guide to Benefits* for more information.

(4) There is no copayment for skilled nursing physician visits.

# HPH Conversion Plan

BENEFIT DESCRIPTION	Your Copayment In-Network
<b>SPECIAL BENEFITS FOR MEN</b>	
Prostate Specific Antigen (PSA) Test (screening)	20%
Vasectomy	Refer to Surgical Services
<b>SPECIAL BENEFITS FOR WOMEN</b>	
Mammography (screening)	None
Pap Smears (screening)	None
Maternity Care	None
Well Woman Exam	None
<b>BEHAVIORAL HEALTH – MENTAL HEALTH AND SUBSTANCE ABUSE</b>	
Physician Visits <sup>5, 6</sup>	20%
Psychological Testing <sup>5</sup>	
Inpatient <sup>5</sup>	20%
Outpatient <sup>5</sup>	20%
Facility Services <sup>5</sup>	20%
<b>CHEMOTHERAPY – ORAL DRUGS</b>	
Chemotherapy – Oral	None
Mail Order Chemotherapy – Oral	None
<b>DIABETIC DRUGS, SUPPLIES AND INSULIN</b>	
Diabetic Drugs	
Retail – Generic / Preferred Brand Name	20%
Retail – Other Brand Name	30%
Mail Order – Generic / Preferred Brand Name	20%
Mail Order – Other Brand Name	30%
Insulin	
Retail – Preferred Brand Name	20%
Retail – Other Brand Name	30%
Mail Order – Preferred Brand Name	20%
Mail Order – Other Brand Name	30%
Diabetic Supplies (e.g. syringes, needles, test strips and lancet devices)	
Retail – Preferred Brand Name	50%
Retail – Other Brand Name	50%
Mail Order – Preferred Brand Name	50%
Mail Order – Other Brand Name	50%
<b>U.S. PREVENTIVE SERVICES TASK FORCE (USPSTF) RECOMMENDED DRUGS</b>	
Retail – USPSTF recommended drugs	None
Mail Order – USPSTF recommended drugs	None

(5) Services provided by licensed physician, psychiatrist, psychologist, clinical social worker, marriage and family therapist, mental health counselor, or advanced practice registered nurses.

(6) For serious mental illness as defined by Hawaii law, see Guide to Benefits.

# SERVICES NOT COVERED

The following is an overview of some of the services not covered by this plan. Upon joining, you will receive a *Guide to Benefits* that provides detailed information on benefits, limitations, and exclusions that are not described in this summary. You may also request a *Guide to Benefits* before enrolling by calling your local HMSA office or you may access the information online at [hmsa.com](http://hmsa.com).

## Provider Type

- Chiropractor, complementary and alternative medicine provider, physician assistant (unless P.A. is employed by a medical group, M.D., or D.O.), or social worker (except for mental health or substance abuse services).
- Services provided by an immediate family member.

## Counseling Services

- Bereavement.
- Marriage or family.
- Sexual identification.
- Genetic.\*
- Nutritional.\*

## Coverage Under Other Programs or Laws

- For treatment of an illness or injury related to military service.
- When someone else has the legal obligation to pay.
- For services or supplies for an illness or injury caused or alleged to be caused by a third party.

## Dental, Drug and Vision

(not applicable to 50 Plus)

- Dental care (including orthodontics).
- Drugs (except as specified on benefit summary).\*
- Eyeglasses, contacts, and appliances.
- Vision services (except for annual eye exam under HMO plans).\*\*

## Fertility and Infertility

- Contraceptive services or contraceptives including implanted, oral, injected, and devices.
- Infertility treatment.\*
- Sterilization reversal.

## Transplants

- Living organ donor services if you are the organ donor.
- Living donor transport.
- Mechanical or non-human organs.
- Organ purchase.
- Transplant services or supplies.\*
- Transportation related to organ and tissue transplants.

## Miscellaneous Exclusions

- Act of war – injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists.
- Acupuncture.
- Airline oxygen.
- Biofeedback.
- Bionic devices.
- Blood.\*
- Carcinoembryonic antigen (CEA) screening.
- Cardiac rehabilitation.
- Chemotherapy, high dose.\*
- Complications of a non-covered procedure.
- Convenience treatments, services, or supplies.
- Custodial care.
- Cosmetic services, surgery, or supplies.
- Developmental delay.
- Ductal lavage.
- Electron Beam Computed Tomography (EBCT) or Ultrafast CT.

- Environmental control equipment and supplies.
- Enzyme-potentiated Desensitization.
- Erectile dysfunction.
- Extracorporeal shock wave therapy.
- Foot orthotics (except for specific diabetic conditions).
- Genetic testing and screening.\*
- Growth hormone therapy.\*
- Hair loss/wigs.
- Hypnotherapy.
- Intradiscal Electro Thermal therapy (IDET).
- Motor vehicle related.
- Personal convenience items and supplies.
- Physical examinations or health exams and any associated screening procedures.\*
- Radiation, nonionizing/high dose.\*
- Self-help or self-cure programs or equipment.
- Services or supplies gained by reason of a false statement or other misrepresentations.
- Services prior to plan effective date. You are not covered for services or supplies that you received before the effective date of this coverage.
- Sexual transformation.
- Supplies billed separately by your provider when the supplies are integral to services being performed by your provider or take-home supplies.
- Thoracic Electric Bioimpedance (outpatient/office).
- Topical hyperbaric oxygen therapy.
- Travel or lodging costs.
- Vertebral axial decompression (VAX-D).
- Vitamins, minerals, medical foods, and food supplements.\*
- Weight-reduction programs.

\*Except as described in the plan's *Guide to Benefits*.

\*\*HMO Plans are: 50 Plus Plan, Conversion Plan 10, HPH Conversion Plan and Individual Care Plan.