

HEALTHSTAFFERS

A DIVISION OF MEDSTAFF

Our Annual Open Enrollment runs from now until February 26, 2010. This is the time to change medical plans; elect medical, if you had previously waived out; terminate coverage; or modify your family status. All eligible employees must complete the HEALTHSTAFFERS Employee Election Form and depending on your election either an HMSA Enrollment Form or HC-5 Waiver Form. Completed forms should be returned to the HR/Benefits Department at 3805 West Chester Pike Suite 200, Newtown Square, PA 19073. You may also fax your completed forms to HR/Benefits at 866-469-3359. You must complete and return the form(s) to be received no later than Friday, February 26, 2010.



****All changes will be effective March 1, 2010.**

We are pleased to announce that we will continue coverage through HMSA. However, **PLEASE NOTE** that the Health Plan Hawaii Basic HMO Plan will replace the CompMED B plan effective 3/1/10. The new plan requires selection of a Primary Care Physician and referrals for services. We are pleased to announce that employee contributions will remain the same for 2010. Remember, you pay no taxes on your contributions for medical coverage, which effectively reduces your benefit expense.

Benefit Highlights

- Deductible - None
- Physician Services - \$15 copay
- Outpatient Hospital Services – 20% of Eligible Charges
- Inpatient Hospital Services – 20% of Eligible Charges
- Emergency Room Services - \$75 copay (in-state & BlueCard provider) 20% (out-of-state)
- X-Ray and other Radiology – 20% of Eligible Charges
- Surgery - \$15 copay (outpatient professional charges)/ 20% (hospital operating room)
- Medical Equipment, Appliances, and Supplies – 50% of Eligible Charges
- Prescription Drug: Generic \$5/Preferred Brand \$20/Other Brand Name \$20 plus \$35 Other Brand Name cost share

Plan Summary available – Please contact recruiter or benefits team

What Action Must I Take?

- Complete and return the respective forms:
- ▶ **Elect/Change plan:** You must complete the Employee Election Form and the HMSA Medical Plan Enrollment Form.
 - ▶ **Add/Terminate dependents:** You must complete the Employee Election Form and the HMSA Medical Plan Enrollment Form.
 - ▶ **Decline enrollment in the medical plan:** You must complete the Employee Election Form and the Form HC-5
 - ▶ **If electing the medical plan,** go online to www.hmsa.com and select a Primary Care Physician by entering "Medical" under Plan Type, and "Health Plan Hawaii" under Plan Name then "Submit" to search. Be sure to designate your Island.
 - ▶ **If you are currently enrolled in the Medical Plan and do not return your enrollment form by February 26th** with your new medical plan election, you will automatically default into the Health Plan Hawaii Basic Plan. HMSA will select a PCP on your behalf if you do not return all forms.

Choose Your Benefits Carefully!

It is important to note that the choices you make regarding your medical benefits during the annual enrollment period will stay in effect for the entire plan year (3/1/2010- 2/28/2011), while you are eligible for benefits unless you have a change in status. HR must be notified of any changes within 30 days of the event date. Examples of a change in status are:

- Marriage or divorce;
- Birth or adoption;
- Death of a spouse or dependent;
- A change in your dependent's eligibility status because of age, marriage, or change in student status;
- A change in your or your spouse's employment status, work site, or work schedule that results in gain or loss of eligibility for benefits coverage (including a switch between part-time or full-time status);
- Entitlement to Medicare or Medicaid (applies to the person entitled to Medicare or Medicaid only);
- A change to comply with a state domestic relations order pertaining to medical coverage of a child or an employee.
- If an employee moves to a location where current benefits are no longer available.

Any benefit change must be consistent with the type of change you are making (i.e. you adopt a child – you may add your child to your existing plan).

For information on in-network Providers visit the HMSA website
www.HMSA.com

Monthly Contributions

Effective March 1, 2010, those who elect coverage will have the following deducted from their paycheck once a month on a pre-tax basis:

| HMSA Monthly Premiums | |
|--------------------------|----------|
| Employee only | \$84.00 |
| Employee & One dependent | \$302.08 |
| Family | \$453.12 |

This newsletter is intended to provide an overview of the benefit plan and is not the official plan document. If there is any dispute over plan provisions, the official plan documents will govern.



Employee Election Form

Effective 03/01/2010, the HMSA Health Plan Hawaii Basic HMO Plan is available to those eligible for benefits. All employees electing coverage are required to complete the HMSA Medical Plan Enrollment Form.

Please provide the Personal Information requested below and check the appropriate box for the plan you elect. Then, please sign and date the form where indicated at the bottom.

Personal Information: _____ Date of Hire: ____/____/____

| | | | | |
|--------------------|--|----------------|--|-----|
| Last Name | First Name | Middle Initial | Social Security Number | |
| Home Address: | Street | City | State | Zip |
| Date of Birth: / / | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married | |

Please elect one option (monthly payroll deduction):

- | | | | |
|---|----------------------------------|--|-----------------------------------|
| <u>HMSA – Health Plan Hawaii Basic plan</u> | <u>Employee Only</u> | <u>Employee & One Dependent</u> | <u>Family</u> |
| <ul style="list-style-type: none"> • PCP visits - \$15 copay then 100% of eligible charges • Outpatient Surgery (hospital operating room) 20% of eligible charges (outpatient professional charges) \$15 copay • Outpatient X-ray – 20% of eligible charges • Preventive Care - \$15 copay • Outpatient Mental Health - \$15 copay • RX - \$5/\$20/\$20 + \$35 cost share | <input type="checkbox"/> \$84.00 | <input type="checkbox"/> \$302.08 | <input type="checkbox"/> \$453.12 |

Waive Medical Coverage (Please complete the HC-5 waiver form).

Salary Redirection Agreement

I have read and understand the explanation I have received regarding my options under the MedStaff Health Care Plan. I understand I have the right to have the company redirect my salary on a pretax basis during the plan year and apply this amount toward the purchase of the medical coverage I have designated above. I understand that my share of the cost of this coverage may be adjusted from time to time to reflect the change in rates charged by the carriers. I acknowledge that my election is irrevocable unless there is a change in my family status. A change in family status includes: marriage; divorce; death of a spouse or dependent; birth or adoption of a child; or a change in you or your spouse’s employment status.

I hereby apply for the options listed above. If necessary, I authorize MedStaff to adjust my pay as required by my elections. I understand that the benefit options I have elected will remain in force from March 1, 2010– February 28, 2011 unless my family status changes or my benefit eligibility status changes.

Employee Signature

Date

Company Representative

Date



Blue Cross Blue Shield of Hawaii

An Independent Licensee of the State of Hawaii and the Special Administrator

HMSA MEDICAL PLAN ENROLLMENT FORM

PLEASE PRINT OR TYPE IN BLUE OR BLACK INK. REFER TO THE BACK FOR ENROLLMENT INSTRUCTIONS.

Group No. _____ Employer _____

FOR HMSA USE ONLY

A EMPLOYEE DATA:

| | | | | | | |
|---|-------------------------------|--|----------|-----------------|-------------------------|----------------|
| Last Name | First (Legal) | M. I. | Suffix | Gender M / F | Birthdate: (mm/dd/yyyy) | Work Phone No. |
| Mailing Address (Number & Street or P.O. Box Number) | City | State | Zip Code | Home Phone No. | | |
| Social Security No. (See Section A on reverse side for additional information on submission of SSN) | My Present or Former HMSA No. | If you are currently the subscriber of an HMSA Individual Plan and wish to cancel that membership, please submit a separate cancellation request in writing. | | | | |

B SELECTING YOUR COVERAGE: PLEASE CHECK WITH YOUR EMPLOYER REGARDING THE MEDICAL PLAN OPTION.

HMSA's Medical Plan
HMO Medical Plan
 Health Plan Hawaii
 **Indicate desired Health Center AND Personal Care Physician in Section C below

| | |
|---------------|------------|
| SUB ID NO. | GROUP NO. |
| EFF. DATE | DEPT. NO. |
| CONT. | PKG. |
| APP. RCV DATE | PROC. DATE |
| TRX | |

C ENROLLMENT DATA: PLEASE ENTER A HEALTH CENTER AND PERSONAL CARE PHYSICIAN FOR YOU AND YOUR DEPENDENTS.

| EMPLOYEE (Self) | LEGAL NAME | | M. I. | Suffix | Gender | BIRTHDATE mm dd yyyy | Full Time Student (over age 18) | SOCIAL SECURITY NO. See Sec C on reverse side | COMPLETE THIS SECTION IF YOU SELECTED AN HMO MEDICAL PLAN | |
|-----------------|------------|------------|-------|--------|--------|-------------------------|---------------------------------|--|---|------------------------------|
| | Last Name | First Name | | | | | | | Health Center | Personal Care Physician |
| Spouse | | | | | M / F | | | | - | <input type="checkbox"/> Yes |
| Child | | | | | M / F | | | | - | <input type="checkbox"/> Yes |
| Child | | | | | M / F | | | | - | <input type="checkbox"/> Yes |
| Child | | | | | M / F | | | | - | <input type="checkbox"/> Yes |
| Child | | | | | M / F | | | | - | <input type="checkbox"/> Yes |
| Child | | | | | M / F | | | | - | <input type="checkbox"/> Yes |

D OTHER INSURANCE: DO YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE (INCLUDING HMSA)? YES NO **IF YES, COMPLETE THE FOLLOWING:**

| | | | |
|-----------------------------|------------------------------|---------------------------|----------------------------------|
| Name of Other Policy Holder | Other Policy Holder's ID No. | Name of Other Health Plan | Other Health Plan's Phone Number |
|-----------------------------|------------------------------|---------------------------|----------------------------------|

E CONDITIONS OF ENROLLMENT: READ, SIGN AND DATE BELOW.

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. I further understand that as an HMSA member, I agree: (a) to abide by the HMSA's constitution and by-laws, and terms and conditions of the health plan; (b) to provide information to HMSA about my current or future medical treatment or condition; and (c) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health plan.

Signature _____ Date _____

ENROLLMENT INSTRUCTIONS

Complete all applicable fields to minimize delay in processing. You may not be entitled to all of the plans shown on this enrollment form. Only select plans that your employer states are available. See your employer if you have any questions.

SECTION A - EMPLOYEE DATA: complete your legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, work phone number, mailing address, home phone number, and social security number. Important Note: Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 (P.L. 110-173) and 42 U.S.C. 1395y(b)(7), requires HMSA to report social security numbers for anyone on this Plan age 55 and over or for anyone on this Plan who is otherwise eligible to receive Medicare benefits regardless of age. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over.

Enter your present or former HMSA number, if any. If you are currently enrolled in an HMSA Individual Plan (PPO Conversion Plan, Individual Business Plan, Individual Care Plan, Plan 6, Student Plan 19, HPH Conversion Plan or 65C Plus), and would like that coverage canceled, please submit a signed letter (include your Subscriber Number) stating you wish to cancel your individual plan coverage to: Hawaii Medical Service Association; P.O. Box 3500; Honolulu, HI 96811-3500. The cancellation will be effective on the first of the month following the receipt of the letter.

SECTION C - ENROLLMENT DATA: list the legal name (last name, first name, middle initial, generational suffix such as Jr, III), gender (M or F), birth date, and social security number for your spouse and each dependent child who you wish to cover under your selected plan. If a dependent child is a full-time student over the age of 18, circle "Y"; if not, circle "N". Important Note: Section 111 of MMSEA (P.L. 110-173) and 42 U.S.C. 1395y(b)(7), requires HMSA to report a social security number for anyone on this Plan age 55 and over or for anyone on the Plan who is eligible to receive Medicare benefits. Effective January 1, 2011, HMSA is required to include anyone on this Plan age 45 and over or anyone on this Plan who is otherwise eligible to receive Medicare benefits regardless of age.

Please enter a Health Center and the full name of a Personal Care Physician for yourself, your spouse, and each dependent child. In the Current Physician box, check "Yes" for you, your spouse, and each dependent child if the physician you selected is the current physician. Note: some Personal Care Physicians are not accepting new patients. For a current list, reference the current *Directory of Health Centers and Providers* or on the Internet at www.HMSA.com and click on "Find a Doctor".

SECTION D - OTHER INSURANCE: Check "Yes" to indicate if you, your spouse, or any of your dependents are also covered by any other group health plan (including HMSA or Medicare). If you check "Yes", enter the other policy holder's name, the other policy holder's ID number, the name of the other health plan, and a phone number for the other health plan.

SECTION E - CONDITIONS FOR ENROLLMENT: sign and date the enrollment form.