# Hawaii Teamsters PPO - FAQ's

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**Q: Who is HMA?**
**A:** Hawaii Mainland Administrators **(**HMA) is a Third-Party Claims Administrator (TPA) that provides claims administrative services for the Hawaii Teamsters Health and Welfare Trust Fund and helps eligible members get the most from their benefit plan.

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**Q: Where is HMA located?**
**A:** HMA is located on the corner of Kapiolani Boulevard and Keeaumoku Street in the Pacific Guardian Tower:

1440 Kapiolani Boulevard, Suite 1020
Honolulu, Hawaii 96814
Office Hours – Monday through Friday from 7:30 a.m. – 5:00 p.m.

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**Q: What is a TPA?**
**A:** A TPA is a company that the Board of Trustees hired to handle the many tasks associated with managing a health benefit plan. HMA processes your medical claims, making sure they are handled quickly and accurately. We even have medical professionals on staff who can help coordinate your care if you are in the hospital or are dealing with a chronic health condition. HMA also answers questions from providers and members who call our Customer Service Department at (808) 951-4694 or toll free at (866) 331-5913.

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**Q: What is a PPO?**
**A:** A Preferred Provider Organization (PPO) is a large network of health care providers who have agreed to discount (reduce) what they charge for services when treating members of a benefit plan. When you choose to see an in-network PPO health care provider, you will pay less for their services than if you had chosen an out-of-network (non-PPO) health care provider. You can see a PPO specialist without a referral. You have the option to see non-PPO providers, but you will pay more out-of-pocket for their services. Your member ID card contains important information regarding your plan. Visit **www.teamsterstrustbenefits.com** to check on a health care provider's participation with the Hawaii Teamsters Health & Welfare Trust Fund.

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**Q: How do I request a new ID card?**
**A**.: You may request for a new ID card by contacting our Customer Service Department at (808) 951-4694 or toll free (866) 331-5913. There is no charge and it will be mailed to you within 3-5 business days.

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**Q: How do I update my Coordination of Benefits (COB)?**
**A:** To update your Coordination of Benefits please call our Customer Service Department at (808) 951-4694 or toll free (866) 331-5913 and provide your other insurance information over the phone to a representative. A COB questionnaire can be mailed to you to complete and return. The COB questionnaire and other forms can also be found in the Forms and Documents tab on HMA's website:

**www.hma-hi.com/Teamsters-PPO**

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**Q: Who can I call for questions regarding my claims, benefits and provider participation?**
**A:** Contact our Customer Service Department at (808) 951-4694 or toll free (866) 331-5913.

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**Q: What is the difference between participating and non-participating providers?**
**A:** A Non-Participating provider is a provider who has not agreed to participate in the plan's network. Claims submitted by a non-participating provider will be paid directly to the covered person. The covered person is responsible for checking benefits, submission of claims and payment for all non-eligible charges including the balance bill. Participating providers have signed a contract to participate in the plan's network and agree to provide the needed healthcare services at the agreed upon fee. Members are encouraged to use participating providers for convenience and to maximize savings.

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**Q: What should I do in case of an emergency?**
**A**: For immediate medical attention or an emergency, please call 911. After your treatment, you may need to contact our Customer Service Department at (808) 951-4694 or toll free (866) 331-5913. Check the back of your ID card for additional information.

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**Q: Who is responsible for notifying HMA regarding PPO hospital outpatient or inpatient services?**
**A:** For Inpatient admittance, Emergency Room admittance, & Same Day Surgery admittance to a Hospital, it is the Hospital's responsibility to notify HMA.

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**Q: Who is responsible to submit a request for PPO prior authorization for services from a non-participating provider?**
**A:** Member should check benefits by calling the Customer Service Department at (808) 951-4694 or toll free (866) 331-5913. If a prior authorization request is required then it can be submitted by either the referring/ordering Physician or the treating Physician/Facility.

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**Q: How can I obtain an Explanation of Benefits (EOB)?**
**A:** An Explanation of Benefits is not a bill. It is a statement that is sent to HMA members and/or dependents each time a claim is processed. An EOB explains what medical services were paid or denied for on their behalf with their appeal rights. For questions or assistance with your EOBs, you may contact our Customer Service Department at (808) 951-4694 or toll free (866) 331-5913.

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**Q: My physician has referred me to a provider on the mainland. Do I have coverage for these services on the mainland?**
**A:** All non-emergency out-of-state services require prior authorization. The member or his/her referring physician must call the HMA Health Services Department at (808) 951-4621 or toll free (866) 377-3977.

For covered services rendered outside the State of Hawaii, the Plan's reimbursement will be made as though such services had been rendered in Hawaii; however, the Eligible Charge (E.C.) for out-of-state inpatient and emergency services shall not exceed 170% of the Hawaii Eligible Charge for the same or comparable services, and the Eligible Charge for all other out-of-state services shall not exceed 150% of the Hawaii Eligible Charge for the same or comparable service. This benefit limitation applies to both participating and non-participating providers.

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**Q: How do I get reimbursed for services received from a non-participating PPO provider?**
**A:** Submit copies of claims and receipts to:

HMA – Claims Department
PO Box 135005
Honolulu, HI 96801-52005

Claims and receipts must include: Patient Name, Address and ID#, Provider Name, Address and TAX ID#, Date of Service, Diagnosis and Procedures rendered. If information is missing claim may be rejected or denied for lack of information provided.

*Note:* Submissions received more than one year after the date of service will be denied and no reimbursement will be made.

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**Q: Am I covered while traveling Out of State?**
**A:** Yes. Prior authorization is required prior to receiving non-emergency services outside the State of Hawaii. Benefit payments will be based on the type of service and provider status.

For covered services rendered outside the State of Hawaii, the Plan's reimbursement will be made as though such services had been rendered in Hawaii; however, the Eligible Charge (E.C.) for out-of-state inpatient and emergency services shall not exceed 170% of the Hawaii Eligible Charge for the same or comparable services, and the Eligible Charge for all other out-of-state services shall not exceed 150% of the Hawaii Eligible Charge for the same or comparable service. This benefit limitation applies to both participating and non-participating providers.

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**Q: How do I get reimbursed for emergency services received in a foreign country?**
**A:** You will be reimbursed at the non-participating benefit level for covered services. You must do the following:

1. Pay for the services up front;
2. Provide copies of the medical records/notes, including your diagnosis (translated into English); and
3. Provide copies of the receipt showing how much you paid (translated into English and converted into US dollars).

* For assistance with translating your documents into English and currency into U.S. dollars an option available is to visit: www.oanda.com (currency) and translate.google.com (documents).

Send your translated receipts and medical records/notes to:

HMA – Claims Department
P O Box 135005
Honolulu, HI 96801-5005

Please be sure all items are clear and readable, if not, this may delay your reimbursement. Also, be sure to include a daytime contact number so that HMA can contact you should they have questions or need additional information. Please allow up to 4-6 weeks for processing. *Note:* Submissions received more than one year after the date of service will be denied and no reimbursement will be made.

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