HMSA periodically reviews your health plans to ensure that they provide your employees with quality health plan benefits in compliance with state and federal laws and are structured to best manage health care costs.

This notice contains a summary of the changes that will be made to your plan. Please use this document for general information only. It should not be used as the certificate for the plan. The 2017 Guide to Benefits or plan certificate will contain complete information on these changes as well as other benefits and applicable exclusions and limitations of your plan. In the case of a discrepancy between this summary and the language contained in the 2017 Guide to Benefits or plan certificate, the 2017 Guide to Benefits or plan certificate takes precedence.

**BENEFIT MODIFICATIONS**

- **Annual Preventive Health Evaluation.** Coverage for an Annual Preventive Health Evaluation benefit will be added. An Annual Preventive Health Evaluation is an annual health assessment visit to discuss the patient’s preventive service needs. The visit will be covered with no copayment cost to members who are 22 and older.

- **Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us.** For services received from participating providers, the copayment will change from $17 to $20.

- **Behavioral Health – Physician Services – Outpatient.** For services received from participating providers, the copayment will change from $17 after the annual deductible to $20 after the annual deductible.

- **Emergency Services – Physician Visits.** The copayment will change from $17 after the annual deductible to $20 after the annual deductible.

- **Gender Identity Services.** Gender identity services to treat gender dysphoria will be covered in accord with HMSA’s medical policy and Hawaii and Federal law. Benefits vary depending on the type of service or supply received. Services will be covered at the same benefit level as other similar covered services.

- **Laboratory and Pathology - Outpatient.** For services received from participating providers, the copayment will change from no copayment after the annual deductible to 20% after the annual deductible.

- **Mammography (screening).** The U.S. Preventive Services Task Force (USPSTF) no longer recommends one base line mammogram between the ages of 35 – 39. The frequency limit will change to cover one screening mammography per calendar year for women ages 40 and older. A woman of any age may receive the screening more often if she has a history of breast cancer or if her mother or sister has a history of breast cancer.

- **Maternity Care.** The maternity care benefit will change to include coverage for routine prenatal visits, delivery, and one postpartum visit. All other covered maternity related services will continue to be payable under other applicable benefit sections of the GTB or plan certificate (e.g. Physician Visits, Emergency Room, Radiology-Outpatient, Laboratory and Pathology-Outpatient).

- **Non-discrimination.** To comply with a new federal law, HMSA plans, benefits, and policies are currently being reviewed and will be modified where necessary to ensure that coverage for services do not discriminate on the basis of race, color, national origin, sex, age or disability.

- **Nutritional Counseling.** To comply with Hawaii law, nutritional counseling rendered by recognized licensed dietitians will be covered for the treatment of eating disorders. Services will be covered at the same benefit level as outpatient behavioral health physician services.

- **Pap Smears (screening).** The U.S. Preventive Services Task Force (USPSTF) no longer recommends that women receive one screening pap smear every calendar year. The frequency limit will change to cover one screening pap smear every three years for women ages 21 to 65.
• **Physician Services – Consultation Services and Physician Visits.** For services received from participating providers, the copayment will change from $17 after the annual deductible to $20 after the annual deductible.

• **Supportive Care.** Coverage for Supportive Care will be added. Benefits will be provided only for services received in the State of Hawaii and when a member is referred by his or her physician to a participating provider. Supportive Care is a comprehensive approach to care for members with a serious or advanced illness including Stage 3 or 4 cancer, advanced Congestive Heart Failure (CHF), advanced Chronic Obstructive Pulmonary Disease (COPD), or any advanced illness that meets the requirements of HMSA’s Supportive Care policy. Coverage is limited to 90 calendar days of service in a 12 month period and is provided with no copayment cost to members.

**LANGUAGE CLARIFICATION**

• **Cardiac Rehabilitation Disease Management Program.** The benefit for Dr. Ornish’s Program for Reversing Heart Disease™ will be revised to clarify the program requirements. Services are covered when received from a contracted provider and in the State of Hawaii at an accredited Ornish Reversal Program. The program consists of eighteen 4 hour sessions and coverage is limited to one program per lifetime.

**BENEFIT MODIFICATIONS FOR PRESCRIPTION DRUGS AND SUPPLIES**

• **Annual Copayment Maximum for Prescription Drugs and Supplies.** The annual copayment maximum will change from $3,850 per person/$4,700 per family to $4,150 per person/$5,300 per family.

• **Contraceptives.** To comply with Hawaii law, the dispensing limitation for contraceptives will change. The pharmacy will dispense contraceptives in the quantity amount specified on the prescription. Benefits are available for contraceptive supplies intended to last up to a twelve month period. A copayment may apply to each 30-day or 90-day supply.

• **Diabetic Supplies – Other Brand Name.** For other brand name diabetic supplies, the copayment will change from $50 after the annual deductible to $60 after the annual deductible.

• **Diabetic Supplies – Other Brand Name – 90-day at Retail Network or Mail Order (84 – 90 Days).** For other brand name diabetic supplies received from contracted providers, the copayment for will change from $125 after the annual deductible to $175 after the annual deductible.

• **Non-discrimination.** To comply with a new federal law, HMSA plans, benefits, and policies are currently being reviewed and will be modified where necessary to ensure that coverage for services do not discriminate on the basis of race, color, national origin, sex, age or disability.

• **Tier 2 and Contraceptive Tier 2.** For tier 2 drugs and supplies received from participating providers, the copayment will change from $50 after the annual deductible to $60 after the annual deductible. For nonparticipating providers, the copayment will change from $50 plus 20% of remaining eligible charges after the annual deductible to $60 plus 20% of remaining eligible charges after the annual deductible.

• **Tier 2 and Contraceptive Tier 2 – 90-day at Retail Network or Mail Order (84 – 90 Days).** For tier 2 drugs and supplies received from contracted providers, the copayment for will change from $125 after the annual deductible to $175 after the annual deductible.

• **Tier 3 and Contraceptive Tier 3.** For tier 3 drugs and supplies received from participating providers, the copayment will change from $50 plus $50 Tier 3 Cost Share after the annual deductible to $60 plus $60 Tier 3 Cost Share after the annual deductible. For nonparticipating providers, the copayment will change from $50 plus $50 Tier 3 Cost Share and 20% of remaining eligible charges after the annual deductible to $60 plus $60 Tier 3 Cost Share and 20% of remaining eligible charges after the annual deductible.

• **Tier 3 and Contraceptive Tier 3 – 90-day at Retail Network or Mail Order (84 – 90 Days).** For tier 3 drugs and supplies received from contracted providers, the copayment for will change from $125 plus $150 Tier 3 Cost Share after the annual deductible to $150 plus $180 Tier 3 Cost Share after the annual deductible.

• **Tier 4.** For tier 4 drugs and supplies received from participating providers, the copayment will change from $150 after the annual deductible to $200 after the annual deductible.

• **Tier 5.** For tier 5 drugs and supplies received from participating providers, the copayment will change from $300 after the annual deductible to $400 after the annual deductible.