HAWAIʻI MEDICAL SERVICE ASSOCIATION
BLUE CROSS BLUE SHIELD OF HAWAII

SILVER PPO 2500

SUMMARY OF CHANGES EFFECTIVE JANUARY 1, 2018

HMSA periodically reviews your health plans to ensure that they are 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 2018 *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 2018 *Guide to Benefits* or plan certificate, the 2018 *Guide to Benefits* or plan certificate takes precedence.

BENEFIT MODIFICATIONS

- **Annual Copayment Maximum.** The annual copayment maximum will change from $7,150 per person/$14,300 per family to $7,350 per person/$14,700 per family.
- **Emergency Services – Emergency Room.** For services received from participating and nonparticipating providers, the copayment will change from 20% of eligible charge after annual deductible to 25% of eligible charge after annual deductible.
- **Medical Services.** For services received from a participating provider, the copayment will change from 20% of eligible charge after annual deductible to 25% of eligible charge after annual deductible. For services received from a nonparticipating provider, the copayment will change from 40% of eligible charge after annual deductible to 45% of eligible charge after annual deductible. The copayments will change for the following services:
  - Anesthesia.
  - Behavioral Health – Mental Health and Substance Abuse.
  - Chemotherapy and Radiation Therapy.
  - Home Health Care.
  - Hospital and Facility Services.
  - Maternity Care.
  - Organ Donor Services.
  - Other Medical Services and Supplies.
  - Physical and Occupational Therapy and Speech Therapy Services.
  - Special Benefits for Men.
  - Surgical Services.
  - Testing, Laboratory, and Radiology.
- **Physician Visits - Emergency Room.** For services received from participating and nonparticipating providers, the copayment will change from $30 to $35.
- **Preventive Services – Nonparticipating Providers.** For services received from a nonparticipating provider, the copayment will change from 40% of eligible charge after annual deductible to 45% of eligible charge after annual deductible. The copayment will change for the following services:
  - Annual Preventive Health Evaluation.
  - Immunizations – Standard and Travel.
  - Screening Services, Preventive Counseling, and Preventive Services.

- Well Child Care Office Visits and Laboratory Tests. The annual deductible does not apply to these services.
- Women's Preventive Services.

- **Professional Services.** For services received from a participating provider, the copayment will change from $30 to $35. For services received from a nonparticipating provider, the copayment will change from 40% of eligible charge after annual deductible to 45% of eligible charge after annual deductible. The copayments will change for the following services:
  - Applied Behavior Analysis.
  - Behavioral Health - Physician Services - Outpatient.
  - Physician Services - Consultation Services and Physician Visits.
  - Nutritional Counseling.
- **Prescription Drugs and Supplies:**
  - **Oral Chemotherapy Drugs.** The dispensing limitation for non-Specialty oral chemotherapy drugs will increase. Retail or mail order pharmacies may dispense up to a 90-day supply.
  - **Tier 1.** For drugs and supplies received from a participating provider, the copayment will change from $10 to $15. For drugs and supplies received from a nonparticipating provider, the copayment will change from $10 plus 20% of remaining eligible charge after annual deductible to $15 plus 20% of remaining eligible charge after annual deductible.
  - **Tier 1 Contraceptives.** For contraceptives received from a nonparticipating provider, the copayment will change from $10 plus 20% of remaining eligible charge after annual deductible to $15 plus 20% of remaining eligible charge after annual deductible.
  - **Tier 1 - 90-Day at Retail Network or Mail Order Tier 1 (84 – 90 Days).** For drugs and supplies received from a participating provider, the copayment will change from $20 to $40.
  - **Tier 5.** For drugs and supplies received from a participating provider, the copayment will change from $200 or 30%, whichever is greater, after annual deductible, to $400 or 30%, whichever is greater, after annual deductible.

LANGUAGE CLARIFICATIONS

- **Hawaii State Residency Requirements.** Eligibility requirements will be updated to clarify if you enroll in an HMSA plan because you intend to reside in the State of Hawaii, HMSA reserves the right to request documentation verifying that you have moved to and reside in Hawaii. If HMSA determines, in its sole discretion, that such documentation does not verify that you have fulfilled your intent to reside in Hawaii, HMSA may rescind your coverage.
- **Tuberculin Test.** Tuberculosis (TB) screening test has been added to the U.S. Preventive Services Task Force (USPSTF) list of grade B recommendations. Therefore, to comply with federal law, TB screenings will be covered at the same benefit as other USPSTF screenings, which is at no cost when obtained from a participating provider.
- **Prescription Drugs and Supplies:**
  - **Drug Categories.** Drug category names will be changed to match the pharmaceutical industry. The following changes will be made:

Current	New
Other Brand Name Drug	Non-Preferred Formulary Drug
Other Brand Name Specialty Drug	Non-Preferred Formulary Specialty Drug
Preferred Drug	Preferred Formulary Drug
Preferred Specialty Drug	Preferred Formulary Specialty Drug

- **Non-Formulary Exceptions.** The Non-Formulary Exceptions criteria will change. Currently, if a drug is not listed in one of the five benefit tiers and is not excluded, a Non-Formulary Exception to cover the drug may be provided after trying and failing all alternative formulary drugs. The criteria will change to require the trial and failure of at least 3 or all formulary alternatives, whichever is less.