HAWAIʻI MEDICAL SERVICE ASSOCIATION
BLUE CROSS BLUE SHIELD OF HAWAII

GOLD HMO

SUMMARY OF CHANGES EFFECTIVE JANUARY 1, 2019

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 2019 *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 2019 *Guide to Benefits* or plan certificate, the 2019 *Guide to Benefits* or plan certificate takes precedence.

BENEFIT MODIFICATIONS

- **Advance Care Planning.** Advance care planning will be covered with no member copayment when received from a participating provider.
- **Annual Copayment Maximum.** The annual copayment maximum will change from $7,350 per person/$14,700 (maximum) per family to $7,900 per person/$15,800 (maximum) per family.
- **Annual Preventive Health Evaluation.** The physical examination benefit will be modified as an Annual Preventive Health Evaluation (APHE) benefit. The APHE will allow members age 22 years and older the flexibility to receive one preventive visit a year from their Primary Care Provider, which could include a physical exam. The APHE will be covered with no member copayment.
- **Chlamydia and Gonorrhea Screenings for Men.** Chlamydia and gonorrhea screenings for men will be covered at the same benefit level as other preventive services with no member copayment when received from a participating provider.
- **Diabetes Prevention Program.** The Diabetes Prevention Program is a new long-term lifestyle change program aimed at lowering the risk of diabetes and improving health. The program will be covered with no member copayment when received from a participating provider.
- **Genetic Testing, Screening, and Counseling.** The genetic testing and screening benefit will be modified to include genetic counseling. Services will be covered at the same benefit level as diagnostic testing – outpatient.
- **Shift Work Sleep Disorder Drugs.** The exclusion for shift work sleep disorder drugs will be removed. Shift work sleep disorder drugs will be covered at the same benefit level as other prescription drugs.
- **Summary of Benefits and Your Payment Obligations (Guide to Benefits Chapter 3).** Copayments for the following services will change.

	Annual Deductible Applies	Copayment Is (percentage copayments are based on eligible charges)
Behavioral Health – Mental health and Substance Abuse		
Hospital and Facility Services - Inpatient	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Habilitative and Rehabilitative Therapy		
Physical and Occupational Therapy - Outpatient	~~No~~ **Yes**	$15
Speech Therapy Services - Outpatient	~~No~~ **Yes**	$15

	Annual Deductible Applies	Copayment Is (percentage copayments are based on eligible charges)
Hospital and Facility Services		
Hospital Room and Board	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Intensive Care Unit/Coronary Care Unit	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Intermediate Care Unit	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Isolation Care Unit	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Skilled Nursing Facility	Yes	$300 per day up to ~~$1,200~~ **$1,500** maximum per admission
Testing, Laboratory and Radiology		
Diagnostic Testing – Outpatient	~~No~~ **Yes**	$15
Radiology (General) - Outpatient	~~No~~ **Yes**	$15

	Annual Deductible Applies?		Your Copayment Amount Is: (Copayments are based on eligible charges)	
	Network	Non-Network	Network	Non-Network
Prescription Drugs and Supplies - Contraceptives				
Contraceptive - Tier 1	No	Yes	None	~~$7~~ **$10** plus 20% of remaining eligible charge
Prescription Drugs and Supplies - Tier 1				
Tier 1	No	Yes	~~$7~~ **$10**	~~$7~~ **$10** plus 20% of remaining eligible charge
90-Day at Retail Network or Mail Order Tier 1 (84 – 90 Days)	No	Not Covered	~~$11~~ **$20**	Not Covered

LANGUAGE CLARIFICATIONS

- **Annual Precertification List Updates.** The precertification list will be simplified in the Guide to Benefits. Current services that require precertification can be found at hmsa.com/precert.