

HAWAI'I MEDICAL SERVICE ASSOCIATION  
 BLUE CROSS BLUE SHIELD OF HAWAII

**SILVER PPO 3500**

**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 Deductible.** The separate \$500 per person/\$1,000 (maximum) per family annual deductible for specialty prescription drugs will be removed. Specialty prescription drugs will be subject to the plan's combined annual deductible of \$3,500 per person/\$7,000 (maximum) per family.
- **Annual Preventive Health Evaluation.** The Annual Preventive Health Evaluation (APHE) benefit will be modified to allow members the flexibility to receive one preventive visit a year from their Primary Care Provider, which could include a physical exam.
- **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 allergy testing.
- **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)	
	Participating	Nonparticipating	Participating	Nonparticipating
<b>Behavioral Health - Mental Health and Substance Abuse</b>				
Physician Services – Outpatient	No	Yes	\$30-\$35	40%
<b>Other Medical Services and Supplies</b>				
Applied Behavior Analysis rendered by a Behavior Analyst Recognized by Us	No	Yes	\$30-\$35	40%

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	Nonparticipating	Participating	Nonparticipating
Nutritional Counseling	No	Yes	\$30-\$35	40%
<b>Physician Services</b>				
Consultation Services	No	Yes	\$65-\$35	40%
Physician Visits – Emergency Room	No	No	\$65-\$35	\$65-\$35
Physician Visits – Primary Care Provider (PCP)	No	Yes	\$30-\$35	40%
Physician Visits – Specialist	No	Yes	\$65-\$35	40%
Physician Visits – Urgent Care	No	Yes	\$75-\$55	40%
<b>Prescription Drugs and Supplies – Contraceptives</b>				
Contraceptive - Tier 2	No-Yes	Yes	\$50	\$50 plus 20% of remaining eligible charge
Contraceptive - Tier 3	No-Yes	Yes	\$50 plus \$50 Tier 3 Cost Share	\$50 plus \$50 Tier 3 Cost Share and 20% of remaining eligible charge
90-Day at Retail Network or Mail Order Contraceptive - Tier 2 (84 – 90 Days)	No-Yes	Not Covered	\$125	Not Covered
90-Day at Retail Network or Mail Order Contraceptive - Tier 3 (84 – 90 Days)	No-Yes	Not Covered	\$125 plus \$150 Tier 3 Cost Share	Not Covered
<b>Prescription Drugs and Supplies – Tier 2</b>				
Tier 2	No-Yes	Yes	\$50	\$50 plus 20% of remaining eligible charge
90-Day at Retail Network or Mail Order Tier 2 (84 – 90 Days)	No-Yes	Not Covered	\$125	Not Covered
<b>Prescription Drugs and Supplies – Tier 3</b>				
Tier 3	No-Yes	Yes	\$50 plus \$50 Tier 3 Cost Share	\$50 plus \$50 Tier 3 Cost Share and 20% of remaining eligible charge
90-Day at Retail Network or Mail Order Tier 3 (84 – 90 Days)	No-Yes	Not Covered	\$125 plus \$150 Tier 3 Cost Share	Not Covered

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	Nonparticipating	Participating	Nonparticipating
<b>Prescription Drugs and Supplies – Tier 4</b>				
Tier 4	Yes	Not Covered	40%-\$200 or 20% whichever is greater	Not Covered
<b>Prescription Drugs and Supplies – Tier 5</b>				
Tier 5	Yes	Not Covered	40%-\$400 or 30% whichever is greater	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](http://hmsa.com/precert).