HAWAIʻI MEDICAL SERVICE ASSOCIATION
BLUE CROSS BLUE SHIELD OF HAWAII

CATASTROPHIC PLAN

SUMMARY OF CHANGES EFFECTIVE JANUARY 1, 2025

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 2025 *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 2025 *Guide to Benefits* or plan certificate, the 2025 *Guide to Benefits* or plan certificate takes precedence.

BENEFIT CHANGE

- **Annual Copayment Maximum.** The annual copayment maximum will change from $9,450 per person to $9,200 per person.
- **Annual Deductible.** The annual deductible will change from $9,450 per person to $9,200 per person.
- **Cardiac Rehabilitation.** Cardiac rehabilitation will be covered at the same benefit level as the Physical and Occupational Therapy – Outpatient benefit.
- **Orthodontic Services to Treat Orofacial Anomalies.** The benefit limitation for Orthodontic Services to Treat Orofacial Anomalies will change from $6,900 to $6,930.
- **Summary of Benefits and Your Payment Obligations (Guide to Benefits – Chapter 3).** The following changes will be made to the benefit and payment chart:

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	**Nonparticipating**	**Participating**	**Nonparticipating**
Pediatric Vision Care Services				
Pediatric Routine Vision Exam	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $35~~ **None of actual charge**
Pediatric Vision Care Services - Appliances				
Pediatric Contact Lenses	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $112~~ **None of actual charge**
Pediatric Frames	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $60~~ **None of actual charge**
Pediatric Standard Size Plastic Lenses – Single Vision	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $25~~ **None of actual charge**
Pediatric Standard Size Plastic Lenses – Bifocal	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $40~~ **None of actual charge**

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	**Nonparticipating**	**Participating**	**Nonparticipating**
Pediatric Standard Size Plastic Lenses – Trifocal or Lenticular	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $55~~ **None of actual charge**
Pediatric Vision Care Services - Other Services				
Pediatric Standard Contact Lens Fitting and Follow-Up Visits	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $40~~ **None of actual charge**
Pediatric Photochromic/Transitions Plastic Lenses	~~No~~ **Yes**	Not Covered	None	Not Covered
Pediatric Standard Plastic Scratch-Resistant Coating	~~No~~ **Yes**	Not Covered	None	Not Covered
Pediatric Standard Polycarbonate Lenses	~~No~~ **Yes**	Not Covered	None	Not Covered
Pediatric Standard Progressive Lenses	~~No~~ **Yes**	~~No~~ **Yes**	None	~~All charges over $55~~ **None of actual charge**
Pediatric Tinting	~~No~~ **Yes**	Not Covered	None	Not Covered
Pediatric Ultraviolet (UV) Protective Coating	~~No~~ **Yes**	Not Covered	None	Not Covered