HAWAIʻI MEDICAL SERVICE ASSOCIATION
BLUE CROSS BLUE SHIELD OF HAWAII

GOLD PPO I

SUMMARY OF CHANGES EFFECTIVE JANUARY 1, 2024

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 2024 *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 2024 *Guide to Benefits* or plan certificate, the 2024 *Guide to Benefits* or plan certificate takes precedence.

BENEFIT CHANGE

- **Annual Copayment Maximum.** The annual copayment maximum will change from $8,550 per person/$17,100 (maximum) per family to $8,700 per person/$17,400 (maximum) per family.

- **Annual Deductible.** An annual deductible will be added to the plan. The annual deductible is the dollar amount you must pay each calendar year before benefits subject to the annual deductible become available. The annual deductible amounts are $500 per person or $1,000 (maximum) per family.

- **Applied Behavior Analysis (ABA) Rendered by a Behavior Analyst Recognized by Us.** ABA services will be covered at the same benefit level as outpatient Behavioral Health – Hospital and Facility Services. This change complies with the Federal Mental Health Parity law which requires similar coverage and precertification for behavioral health services and similar services for other health conditions.

- **Oral Chemotherapy.** Benefits for Oral Chemotherapy will vary depending on whether the drug is a Specialty or Non-Specialty drug. Specialty Drugs are identified on HMSA's formulary and may be high-cost drugs, require specialized patient training, coordination of care, close supervision and monitoring on an ongoing basis. Benefits for Specialty Drugs are only available when purchased from a Contracted Specialty Drug Provider. Limited distribution drugs dispensed by a non-contracted plan provider will be covered the same as by a contracted plan provider.

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	**Nonparticipating**	**Participating**	**Nonparticipating**
Chemotherapy – Oral Drugs				
Oral Chemotherapy – Non-Specialty Drugs	Yes	Yes	None	None
Oral Chemotherapy – Specialty Drugs	Yes	Not Covered	None	Not Covered
90-Day at Retail Network or Mail Order – Oral Chemotherapy – Non-Specialty Drugs (84 – 90 Days)	Yes	Not Covered	None	Not Covered
90-Day at Retail Network or Mail Order – Oral Chemotherapy – Specialty Drugs (84 – 90 Days)	Not Covered	Not Covered	Not Covered	Not Covered

- **Orthodontic Services to Treat Orofacial Anomalies.** The benefit limitation for orthodontic services to treat orofacial anomalies will change from $5,500 to $6,900.

- **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**
Hospital and Facility Services	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Emergency Room	**Yes**	**Yes**	~~30%~~ **20%**	~~30%~~ **20%**
Physician Services				
Anesthesia	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Consultation Services	No	**Yes**	~~$40~~ **$60**	~~50%~~ **40%**
Physician Visits – Emergency Room	No	No	~~$40~~ **$60**	~~$40~~ **$60**
Physician Visits – **Primary Care Provider**	No	**Yes**	~~$40~~ **$30**	~~50%~~ **40%**
Physician Services – **Specialty Provider**	No	**Yes**	~~$40~~ **$60**	~~50%~~ **40%**
Physician Services – **Urgent Care Provider**	No	**Yes**	~~$40~~ **$45**	~~50%~~ **40%**
Surgical Services	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Bariatric Surgery	**Yes**	Not Covered	~~30%~~ **20%**	Not Covered
Testing, Laboratory and Radiology	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Chemotherapy and Radiation Therapy	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Other Medical Services and Supplies	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Advance Care Planning	No	**Yes**	None	~~50%~~ **40%**
Ambulance (air)	**Yes**	**Yes**	~~30%~~ **20%**	~~30%~~ **20%**
Implanted Internal Items/Implants – Outpatient	**Yes**	**Yes**	None	~~50%~~ **40%**
Medical Foods	**Yes**	**Yes**	20%	20%
Medical Nutrition Therapy	No	**Yes**	None	~~50%~~ **40%**
Orthodontic Services to Treat Orofacial Anomalies	No	No	None	None
Habilitative and Rehabilitative Therapy				
Physical, Occupational, and Speech Therapy – Inpatient	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Physical, Occupational, and Speech Therapy – Outpatient	No	**Yes**	~~30%~~ **$30**	~~50%~~ **40%**
Pulmonary Rehabilitation – Outpatient	No	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	**Nonparticipating**	**Participating**	**Nonparticipating**
Special Benefits – Disease Management and Preventive Services	No	**Yes**	None	~~50%~~ **40%**
Diabetes Prevention Program	No	Not Covered	None	Not Covered
Disease Management and Preventive Services Programs	No	Not Covered	None	Not Covered
Prostate Specific Antigen (PSA) Test (screening)	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Well Child Care Immunizations	No	No	None	None
Well Child Care Physician Office Visits and Laboratory Tests	No	No	None	~~50%~~ **40%**
Special Benefits for Men	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Special Benefits for Women	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Breast Pump	No	Not Covered	None	Not Covered
Contraceptive IUD, Implants, and Injectables	No	**Yes**	None	~~50%~~ **40%**
Tubal Ligation	No	**Yes**	None	~~50%~~ **40%**
Special Benefits for Homebound, Terminal, or Long-Term Care				
Home Health Care	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Hospice Services and Supportive Care	**Yes**	Not Covered	None	Not Covered
Behavioral Health – Mental health and Substance Abuse	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Applied Behavior Analysis Rendered by a Behavior Analyst Recognized by Us	**Yes**	**Yes**	~~$40~~ **20%**	~~50%~~ **40%**
Physician Services – Inpatient	No	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Physician Services – Outpatient	No	**Yes**	~~$40~~ **$30**	~~50%~~ **40%**
Organ and Tissue Transplants – Corneal and Kidney Transplants and Organ Donor Services	**Yes**	**Yes**	~~30%~~ **20%**	~~50%~~ **40%**
Other Organ and Tissue Transplants and Transplant Evaluation	**Yes**	Not Covered	None	Not Covered
Prescription Drugs and Supplies				
Tier 1	No	**Yes**	~~$25~~ **$15**	~~$25~~ **$15** plus 20% of remaining eligible charge

	Annual Deductible Applies?		Copayment Is (Percentage copayments are based on eligible charges)	
	Participating	**Nonparticipating**	**Participating**	**Nonparticipating**
Tier 2 and Contraceptive – Tier 2	No	**Yes**	~~$50~~ **$30**	~~$50~~ **$30** plus 20% of remaining eligible charge
Tier 3 and Contraceptive – Tier 3	No	**Yes**	~~$50 plus $50~~ **$25 plus $25** Tier 3 cost Share	~~$50 plus $50~~ **$25 plus $25** Tier 3 cost Share and 20% of remaining eligible charge
Tier 4	No	Not Covered	$200 ~~or 20% whichever is greater~~	Not Covered
Tier 5	No	Not Covered	~~$400 or 30% whichever is greater~~ **$200**	Not Covered
90-Day at Retail Network or Mail Order – Tier 1 (84 – 90 Days)	No	Not Covered	~~$50~~ **$30**	Not Covered
90-Day at Retail Network or Mail Order – Tier 2 and Contraceptive – Tier 2 (84 – 90 Days)	No	Not Covered	~~$100~~ **$60**	Not Covered
90-Day at Retail Network or Mail Order – Tier 3 and Contraceptive – Tier 3 (84 – 90 Days)	No	Not Covered	~~$100 plus $100~~ **$50 plus $50** Tier 3 Cost Share	Not Covered
Contraceptive Diaphragms/Cervical Caps	No	**Yes**	None	$10 per device
Contraceptive – Tier 1 and Over-the-counter (OTC)	No	**Yes**	None	~~$25~~ **$15** plus 20% of remaining eligible charge
Diabetic Supplies – Non-Preferred Formulary	No	**Yes**	~~$50~~ **$30**	~~$50~~ **$30 plus 20% of remaining eligible charge**
Diabetic Supplies – Preferred Formulary	No	**Yes**	None	None
90-Day at Retail Network or Mail Order – Diabetic Supplies – Non-Preferred Formulary (84 – 90 Days)	No	Not Covered	~~$100~~ **$60**	Not Covered
Spacers and Peak Flow Meters	No	**Yes**	None	None
USPSTF recommended drugs	No	**Yes**	None	20% of eligible charge

LANGUAGE CLARIFICATION

- **Recreational Therapy.** Recreational therapy and related programs are not covered and will be added to the Miscellaneous Exclusions section of the Guide to Benefits.