Changes to

all Small Business HMO plans (including SHOP/Mirror Plans)

Blue Shield of California

Effective January 1, 2015 and thereafter

This quick reference guide highlights changes and clarifications to your Blue Shield health coverage. This is only a summary. For detailed information about these changes, please read the new *Evidence of Coverage* (EOC) and *Summary of Benefits* (SOB) provided. Be sure to keep the EOC and SOB in your files for future reference. If you have any questions about programs and services, or questions about the changes listed below, please contact your benefits administrator or call Customer Service at **(888) 852-5345.**

The following changes have been made to your health plan.	
Health plan name changes	***Blue Shield of California has changed many of the names marketed for its health plans.*** *This change to health plan names could impact the plan you have. Blue Shield has prepared a "crosswalk" listing that shows the old plan name and the new plan name. This listing can be found on the plan names flyer enclosed in this kit and online at blueshieldca.com/producer.*
Mental Health Parity	***In accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA),*** *health plans and insurers are prohibited from applying financial requirements or treatment limits to mental health or substance abuse benefits that are more restrictive than limitations applied to medical/surgical benefits. The federal parity rules also apply to utilization management and other non-financial standards. Changes to mental health benefits are made to comply with these regulations.*
Oral anticancer medication	***In accordance with a new state law,*** *a $200 maximum member cost-share for prescription oral anticancer medications, up to a 30-day supply has been established. This $200 maximum cost-share applies after the brand drug or integrated deductible is met, when applicable.*
Out-of-pocket maximum change	***Pursuant to changes in the standardized benefit plans established by Covered California****, the out-of-pocket maximum for the SHOP/Mirror Gold and Silver HMO plans have changed. The new out-of-pocket maximum has been reduced from $6,350/$12,700 to $6,250/$12,500 per individual/family.*

Out-of-pocket maximum change	***Pursuant to IRS rules,*** *the out-of-pocket maximum for the Silver Access + HMO® $55 Off-Ex and Silver Local Access+ HMO® $55 Off -Ex have changed. The out-of-pocket maximum has been reduced from $6350/$12,700 to $6250/$12,500 per individual/family.*
Diagnostic laboratory, X-ray and imaging services co-pay changes	***Pursuant to IRS rules to ensure the benefits maintain their respective actuarial value,*** *the copayment for the Silver Access + HMO® $55 Off-Ex and the Silver Local Access+ HMO® $55 Off–Ex will increase from $25 to $30 for diagnostic laboratory, X-ray and imaging services.*
Generic prescription co-pay changes	***Pursuant to changes in the standardized benefit plans established by Covered California****, the generic co-pay for retail prescriptions for the Gold and Silver HMO Plans will be reduced from $19 to $15 and mail service prescriptions will be reduced from $38 to $30 for all generic drugs.*
Generic prescription co-pay changes	***Pursuant to changes in the standardized benefit plans established by Covered California****, the generic co-pay for retail prescriptions for the Silver HMO Plans will be reduced from $25 to $15 and Mail Service Prescriptions will be reduced from $50 to $30 for all generic drugs.*
Lab and X-ray copayments for OFF SHOP Silver HMO plans	***Pursuant to IRS rules to ensure the benefits maintain their respective actuarial value,*** *the copayment for the Silver Access + HMO® Access* $55 Off-Ex and Silver Local Access+ HMO® $55 Off -Ex *plans will be changed from $15 to $25 per visit for the following categories:* *1. Outpatient Laboratory and Pathology* *2. Outpatient X-ray and Diagnostic Imaging* *3. Outpatient Diagnostic Testing*
Pharmacy – Addition of a short cycle drug program for specialty drugs	***To help reduce waste and member out-of-pocket costs Blue Shield has implemented a new program.*** *Initial fills of select specialty drugs, typically used to treat complex or chronic conditions but which have a high incidence of side effects, will be limited to no more than a 15-day supply and the maximum member cost-share will be pro-rated for the member so that the member can see if they tolerate the drug.*

Pharmacy - Prescription prior authorization turnaround time	*The prior authorization process for receiving approval or denial based on medical necessity, for select formulary, non-formulary and specialty drugs, will comply with turnaround timeframes* ***required by state or federal law, which is 2 business days or 24 hours for exigent circumstances****. Previously, the approval was provided within five business days or within 72 hours for an expedited review. In addition, the definition for exigent, or special circumstance, is added* ***to clarify when a shorter prior authorization timeframe may be necessary****.*
Pharmacy - Smoking cessation drugs (prescription and over-the-counter) coverage	***As a preventive health benefit****, smoking cessation drugs (prescription and over-the-counter (OTC))* ***must now*** *be covered at a $0 cost share (no coinsurance or copayment). Previously smoking cessation drugs were only covered for certain plans where a cost share did apply.* *In addition, a prescription is required for coverage of OTC smoking cessation drugs.*
Pharmacy - Breast cancer preventive drug requirement	***As a preventive health benefit****, the preventive drugs for breast cancer, tamoxifen and raloxifene, will be covered at a $0 cost share for women determined to be at high-risk for developing breast cancer.*

The following clarifications have been made to your health plan.	
Elective abortion	*The Evidence of Coverage (EOC)/policy and Summary of Benefits language is* ***revised to remove any references to "elective" or "medically necessary" with regard to abortion services.***
Provider non-discrimination	***To provide consistency with how benefits are administered****, covered services has been expanded regarding the type of provider who administers the service. Previously, coverage was specific regarding who could perform the particular service. The benefits have been updated to include coverage for health care professionals who provide covered services within the scope of his or her state licensure or certification.*

Waiting Period Changes for Group Contract/Policies	***There are now four options available for the employer's waiting period that are clarified in the contract.*** *The employer decides which of the following four waiting periods will be used:* *1. First day of the month following the date of hire (currently in effect).* *2. First day of the month following 30 days (currently in effect). This option is the automatic default that has been in place throughout 2014. If the employer wants one of the other waiting period options, they must notify BSC at renewal and request through contract change or online.* *3. First day of the month following 60 days (new option).* *4. A 90-day waiting period with coverage effective on the 91st day (new option).*
EOC languages for all products	***To provide more clarification to members on network availability, the following language will be added to the EOC:*** *"The Member should contact Member Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Provider or MHSA Non-Participating Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Provider level."*
Footnote and language revisions	***To provide benefit clarification, the following footnote will be changed for covered services for the Mirror HMO plans to*** *specify the covered services that do not accrue to the Calendar Year Out-of-Pocket Maximum:* *Footnote currently states "Copayments marked with this footnote do not accrue to the calendar year out-of-pocket maximum".* *The footnotes will be updated as follows:* *"Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum except copayments or coinsurance for:* • *Charges in excess of specified benefit maximums* • *Family planning benefits: infertility services* *"Copayments, coinsurance and charges for services not accruing to the member's calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and Evidence of Coverage for additional details".*

Footnote and language revisions	***To provide benefit clarification, the following footnote and language revisions will be added for covered services for the Access+ HMO and Silver Local Access+ HMO plans:*** *A new footnote will be added that states "The following covered serves are subject to, and will accrue to the calendar year medical deductible:* • *Ambulance benefits* • *Emergency health coverage: emergency room services (facility)* • *Hospital benefits (facility services): inpatient (non-emergency) facility services and inpatient medically necessary skilled nursing services including sub-acute care* • *Hospital benefits (facility services); inpatient physician services* • *Mental health services: inpatient hospital services, and residential care* • *Chemical dependency services: inpatient hospital services for medical acute detoxification* *Preferred brand drugs, non-preferred brand drugs, and specialty drugs are subject to and accrue to a separate brand drug deductible".* *Language will also be added to clarify that the out-of pocket maximum includes the deductible. Currently, the footnote states "Calendar Year Out-of-Pocket Maximum". The footnote will be changed to "Calendar Year Out-of-Pocket Maximum (includes the calendar year medical deductible for many covered services)".* *Calendar Year Brand Drug Deductible now includes that it is separate from the calendar year medical deductible and accrues to the calendar year out-of-pocket maximum.* *Calendar Year Out-of-Pocket Maximum now states that it includes the calendar year medical deductible for many covered services.*

Footnote and language revisions	***To provide benefit clarification, the following footnotes will be changed for covered services for the following plans:*** ***Gold Access+ HMO $30 OffEx*** ***Gold Local Access+ HMO $30 OffEx*** ***Silver Access+ HMO $55 OffEx*** ***Silver Local Access+ HMO $55 OffEx*** *A new footnote will be added that states "The following covered serves are subject to, and will accrue to the calendar year medical deductible:* • *Ambulance benefits* • *Emergency health coverage: emergency room services (facility)* • *Hospital benefits (facility services): inpatient (non-emergency) facility services and inpatient medically necessary skilled nursing services including sub-acute care* • *Hospital benefits (facility services); inpatient physician services* • *Mental health services: inpatient hospital services, and residential care* • *Chemical dependency services: inpatient hospital services for medical acute detoxification* *Preferred brand drugs, non-preferred brand drugs, and specialty drugs are subject to and accrue to a separate brand drug deductible.* *Language will also be added to clarify that the out-of pocket maximum includes the deductible. Currently, the footnote states "Calendar Year Out-of-Pocket Maximum". The footnote will be changed to "Calendar Year Out-of-Pocket Maximum (includes the calendar year medical deductible for many covered services)".*
Radiological and Nuclear Imaging benefit clarification	***To provide benefit clarification,*** *the copayment for the radiological and nuclear imaging benefit on all HMO plans will be updated to reflect the copayment per visit. Previously the benefit just stated "copayment".*