Changes to

All Small Business HMO plans (Off-Exchange)

Blue Shield of California

As of January 1, 2016

This notice describes changes and clarifications to your Blue Shield health coverage upon the group's renewal date. For detailed information about these changes, please read the *Evidence of Coverage* (EOC) and *Summary of Benefits* (SOB). If you have any questions about the changes listed below, please contact your benefits administrator or call Customer Service at **(888) 852-5345.**

The following changes are made to your health plan.

Description	Summary
Health plan name changes	***Pursuant to a standard plan naming convention established by Covered California and for uniformity of our portfolio,*** *Blue Shield of California has updated the names of all Small Business health plans based on the following naming convention:* *[metal tier]+[plan type]+[deductible amount/office visit copay]+OffEx* *Please see the crosswalk entitled "New plan names for 2016 for Small Business" enclosed in the renewal packet for the new name of your health plan. This notice refers plans by an abbreviated 2016 plan names. For example, "Platinum HMO 0/25 OffEx plans" applies to "Platinum Access+ HMO 0/25 OffEx", "Platinum Local Access+ HMO 0/25 OffEx", and "Platinum Trio ACO HMO 0/25 OffEx."*
Pediatric dental	***Blue Shield will be offering pediatric dental benefits in all health plans effective January 1, 2016.*** *Previously, this essential health benefit was issued as a rider with all ACA health plans.*
Calendar-year out-of-pocket maximum	***Pursuant to 2016 IRS guidelines****, the calendar-year out-of-pocket maximums for covered services from participating providers for all Silver HMO 1700/55 OffEx plans will increase from $6,250 individual/$12,500 to $6,500 individual/$13,000 family.*
Prescription drug formulary tiers	***Pursuant to the standardized benefit plans established by Covered California and for uniformity of our portfolio****, all prescription drug tiers under the Standard Formulary will be revised as follows:* ***Tier names in 2015*** → ***Tier names in 2016*** *Generic Drugs* → *Tier 1 - Mostly Generic Drugs and low-cost, Preferred Brand Drugs* *Preferred Brand Drugs* → *Tier 2 - Preferred Brand Drug and Non-Preferred Generic Drugs* *Non-Preferred Brand Drugs* → *Tier 3 - Non-Preferred Brand Drugs, and Non-Preferred Generic Drugs* *Specialty Drugs* → *Tier 4 - Specialty Drugs or net drug cost per prescription >$600* *Formerly, prescription drugs under Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs applied to the calendar-year brand drug deductible. Now, prescription drugs under Tiers 2, 3, and 4 apply to the calendar-year pharmacy deductible, if applicable. Also, non-specialty drugs under Tiers 4 are now available through the mail order program.*

Description	Summary
	Drugs not listed on the Standard Formulary may be covered with prior authorization review and approval for medical necessity. Members using these drugs will be allowed continued access without prior authorization, while prior authorization is required for new prescriptions. Please review your EOC and SOB for additional details. *Members can contact Customer Service at the number provided on the back page of the EOC to ask if a specific drug is included in the formulary or to request a printed copy of the formulary. Members can also find the drug formulary at https://www.blueshieldca.com/bsca/pharmacy*
Specialist physician office visits	***To maintain the actuarial value of the health plan,*** *Blue Shield will change the copayment for referred specialist physician office visits as follows:* *For all Platinum HMO 0/25 OffEx plans, the copayment for specialist physician office visits when referred by a physician will increase from $25 per visit to $50 per visit.* *For all Gold HMO 1700/30 OffEx plans, the copayment for all specialist physician office visits when referred by a physician will increase from $30 per visit to $50 per visit.*
Laboratory, X-Ray, and radiological and nuclear imaging services	***To maintain the actuarial value of the health plan,*** *Blue Shield will change the copayment for laboratory, X-ray, and radiological and nuclear imaging services as follows:* *For all Platinum HMO 0/25 OffEx plans:* • *Diagnostic laboratory will increase from no charge to $20 per visit.* • *Diagnostic X-ray will increase from no charge to $50 per visit.* • *Radiological and nuclear imaging services performed at a freestanding radiological center will increase from no charge to $50 per visit.* • *Radiological and nuclear imaging services performed at an outpatient unit of a hospital will increase from no charge to $200 per visit.* *For all Silver HMO 1700/55 OffEx plans:* • *Diagnostic laboratory will increase from $30 per visit to $55 per visit.* • *Diagnostic X-ray will increase from $30 per visit to $55 per visit.* • *Radiological and nuclear imaging services performed at a freestanding radiological center will increase from $30 per visit to $55 per visit.*
Emergency services (not resulting in admission to a hospital)	***To maintain the actuarial value of the health plan,*** *Blue Shield will change the copayment for emergency room not resulting in admission to a hospital and for physician services at an emergency room as follows:* *For all Platinum HMO 0/25 OffEx plans, the copayment for emergency room services will increase from $200 per visit to $250 per visit.* *For all Silver HMO 1700/55 OffEx plans, the copayment for emergency room will increase from $200 per visit to $275 per visit.*

The following clarifications are made to the description of benefits to your health plan.

Description	Summary
Pediatric dental posterior composite resin	*The following footnote is added to the "Pediatric Dental Benefits" section of the SOB to clarify that the plan covers posterior composite resin at the amalgam filling rate:* *"Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the Member will be responsible for the difference in cost between the Posterior composite resin and amalgam filling."*
Substance use disorder	*The definition of outpatient substance use disorder services is added to the EOC, as follows:* *"Outpatient Substance Use Disorder Services – Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions, including but not limited to the following:* *1) Professional (Physician) office visits* *2) Partial Hospitalization* *3) Intensive Outpatient Program* *4) Office-Based Opioid Treatment* *5) Post-discharge ancillary care services.* *These services may also be provided in the office, home, or other non-institutional setting."*
Speech therapy services	*The benefit description for speech therapy services are clarified as follow.* *The previous language in the 2015 EOC:* *Benefits are provided for outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist or other appropriately licensed or certified Health Care Provider pursuant to a written treatment plan for an appropriate time to (1) correct or improve the speech abnormality (2) evaluate the effectiveness of treatment; or (3) provide Habilitation services for the Member.* *The updated language in the 2016 EOC:* *Benefits are provided for medically necessary outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist/pathologist, or other appropriately licensed or certified Health Care Provider pursuant to a written treatment plan to correct or improve (1) communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.*

This plan is pending regulatory approval