

# Changes to All Small Business PPO Mirrored plans Blue Shield of California

As of June 1, 2018

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 Blue Shield representative or call Group Employer Services at **(800) 325-5166**.

The following changes are made to your health plan.

Description	Summary
Product Name	<p><b>Due to plan changes from Covered California</b>, the following Product Names have been updated to reflect the correct frequencies:</p> <p><b>From:</b> Gold 80 PPO 0/30 <b>To:</b> Gold 80 PPO 0/25</p>
Calendar year pharmacy deductible change	<p><b>Due to plan changes from Covered California</b>, the Calendar year pharmacy deductible for participating providers will change for the following plan:</p> <p>Silver 70 PPO 2000/45 <b>From:</b> \$250 individual \$500 family <b>To:</b> \$125 individual \$250 family</p>
Calendar year medical deductible	<p><b>Due to plan changes from Covered California</b>, the Calendar year medical deductible for non-participating providers will change for the following plan:</p> <p>Bronze 60 PPO 6300/75 <b>From:</b> \$7,000 individual \$14,000 family maximum <b>To:</b> \$6,300 individual \$12,600 family maximum</p>
Calendar-Year Out-of-Pocket Maximum	<p><b>Due to plan changes from Covered California</b>, the Calendar-year out-of-pocket maximums for participating providers will change for the following plans:</p> <p>Platinum 90 PPO 0/15 <b>From:</b> \$4,000 individual \$8,000 family maximum <b>To:</b> \$3,350 individual \$6,700 family maximum</p> <p>Gold 80 PPO 0/25 <b>From:</b> \$6,750 individual \$13,500 family maximum <b>To:</b> \$6,000 individual \$12,000 family maximum</p>

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	<p>Silver 70 PPO 2000/45  <b>From:</b> \$6,800 individual \$13,600 family maximum  <b>To:</b> \$7,000 individual \$14,000 family maximum</p> <p>Bronze 60 PPO 6300/75  <b>From:</b> \$6,800 individual \$13,600 family maximum  <b>To:</b> \$7,000 individual \$14,000 family maximum</p>
Primary care office visit	<p><b>In keeping with the standard Covered California plan design,</b> cost share for Primary care office visit will change for the following plan:</p> <p>Gold 80 PPO 0/25  <b>From:</b> \$30  <b>To:</b> \$25</p>
Acupuncture services	<p><b>In keeping with the standard Covered California plan design,</b> cost share for Acupuncture services will change for the following plans:</p> <p>Gold 80 PPO 0/25  <b>From:</b> \$30  <b>To:</b> \$25</p>
Urgent care physician services	<p><b>In keeping with the standard Covered California plan design,</b> Urgent care physician services will change for the following plan:</p> <p>Gold 80 PPO 0/25  <b>From:</b> \$30  <b>To:</b> \$25</p>
Laboratory Center	<p><b>In keeping with the standard Covered California plan design,</b> Laboratory center will change for the following plan:</p> <p>Platinum 90 PPO 0/15  <b>From:</b> \$20  <b>To:</b> \$15</p>
Outpatient department of a hospital Benefits	<p><b>In keeping with the standard Covered California plan design,</b> Outpatient department of a hospital Benefits will change for the following plan:</p> <p>Platinum 90 PPO 0/15  <b>From:</b> \$20  <b>To:</b> \$15</p>

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	<p>Gold 80 PPO 0/25</p> <p><b>From</b> \$30</p> <p><b>To:</b> \$25</p>
Outpatient radiology center	<p><b>In keeping with the standard Covered California plan design,</b> Outpatient radiology center Benefits will change for the following plan:</p> <p>Platinum 90 PPO 0/15</p> <p><b>From:</b> \$40</p> <p><b>To:</b> \$30</p>
Office Location	<p><b>In keeping with the standard Covered California plan design,</b> Office Location Benefits will change for the following plans:</p> <p>Platinum 90 PPO 0/15</p> <p><b>From:</b> \$40</p> <p><b>To:</b> \$30</p> <p>Gold 80 PPO 0/25</p> <p><b>From:</b> \$30</p> <p><b>To:</b> \$25</p>
Office visit, including physician office visit	<p><b>In keeping with the standard Covered California plan design,</b> Office visit, including physician office visit Benefits will change for the following plans:</p> <p>Gold 80 PPO 0/25</p> <p><b>From:</b> \$30</p> <p><b>To:</b> \$25</p>

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

Description	Summary
Ambulance Benefits	<p><b>In order to better explain what this benefit covers,</b> the Ambulance benefit was updated to be defined as the (1) ambulance (ground and air) to emergency ambulance (surface and air) and (2) authorized ambulance to pre-authorized non-emergency ambulance transportation in the EOC.</p>
Calendar Year Medical Deductible	<p><b>In order to better explain what this benefit covers,</b> the Calendar Year Medical Deductible description has been revised for clarification in the SOB and EOC.</p> <p>- Language was removed and revised to state that for covered services provided at a participating facility by health</p>

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	<p>professionals who are non-participating providers, these services accrue to the participating provider deductible... - Individual medical deductible within a family medical deductible description was updated.</p>
Calendar Year Out-of-Pocket Maximum	<p><b>In order to better explain what this benefit covers,</b> the Calendar Year Out-of-Pocket Maximum description has been revised to specify that Participating Provider amounts accrue only to the Participating Out-of-Pocket Maximum in the EOC and SOB.</p>
Calendar Year Pharmacy Deductible	<p><b>To comply with Covered California's medical plan requirements,</b> the Calendar Year Pharmacy Deductible language was removed for Tier 1 Drugs subject to pharmacy deductible in the EOC.</p>
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits	<p><b>Due to requirements provided by the Department of Managed Healthcare (DMHC),</b> members can request prior authorization from Blue Shield of California for acceptance into approved clinical trials where the clinical trial would be appropriate.</p>
Home Health Care Benefits	<p><b>To be consistent with Covered California medical plan requirements,</b> the visit per day limit was changed from 4 to 3 for Home Health Care Benefit in the EOC.</p>
Infertility Definition	<p><b>To be consistent with language definitions,</b> the definition for infertility has been changed to clearly define infertility as a demonstrated condition recognized by a licensed physician and surgeon as the inability to conceive a pregnancy or to carry a pregnancy to a live birth after specific requirements are met, and to align with the definition in the EOC.</p>
Mental Health and Behavioral Health Office Visit	<p><b>To be consistent with standard health industry terminology,</b> the Mental Health and Behavioral Health Routine Outpatient Services was changed to Mental Health and Behavioral Health Office Visit in the EOC and SOB.</p>
MHSA Participating Providers	<p><b>To comply with California law,</b> the revised Choice of Providers section informs members that MHSA services received at an MHSA participating provider facility will be covered at the MHSA participating provider level of benefits, even if the health professional is an MHSA participating provider or non-participating provider, in the EOC.</p>
Office Visits for Outpatient Mental Health Services and Behavioral Health Treatment	<p><b>To comply with Covered California's medical plan requirements,</b> the Routine Outpatient Mental Health Services and Behavioral Health Treatment was changed to Office Visits for Outpatient Mental Health Services and Behavioral Health Treatment in the EOC to match the SOB.</p>
Other Outpatient Mental Health Services	<p><b>To comply with Covered California's medical plan requirements,</b> the Non-Routine Mental Health Services was changed to Other Outpatient Mental Health Services in the EOC and the SOB.</p>
Pediatric Vision Benefits	<p><b>In order to better explain what this benefit covers,</b> language in the Pediatric Vision section of the EOC was updated to define additional coverage for dilation if required. In addition, Vision</p>

	<i>Plan Administrator (VPA) is identified as the participating provider throughout the EOC.</i>
Pediatric Vision Benefits	<b>Due to requirements provided by the DMHC</b> , there are updates to reflect coverage and limits for spectacle lenses and eyewear material for multiple type of lenses and lens powers. Please refer to the Pediatric Vision section of the EOC.
Pediatric Vision - Contact lenses	<b>In order to better explain what this benefit covers</b> , the contact lenses monthly supply amounts have been revised. In addition, the contact lenses fitting benefit has been added in the EOC and SOB.
Dental Schedule and Limitation Table	<b>To comply with Covered California's 2018 Dental Copay Schedule</b> , revisions were made to some diagnostic codes, descriptions, and limitations in the EOC. The following CDT codes changed CDT codes D5511, D5512, D5611, D5612, D7979, D9222, and D9239. See the Dental Schedule and Limitations Table in the EOC for more information.
Pediatric Dental	<b>Due to requirements provided by the DMHC</b> , Timely Access to Care Services section was added to the EOC to provide guidelines schedule for timely access to care from dental providers and the availability of interpreter's service at the time of the member's appointment.
Pediatric Dental Coverage	<b>To be consistent with standard health industry terminology</b> , the term "Dentally Necessary" was changed to "Medically Necessary" where the reference is exclusive to dental service in the EOC and SOB.
Physician office visits: prenatal and initial postnatal	<b>In order to better explain and simplify this benefit</b> , separate benefit names for pregnancy office visits for initial prenatal, preconception and postnatal visits were combined into one benefit description "Physician office visits: prenatal and Initial postnatal" in SOB.
Physician or surgeon services in an inpatient facility	<b>In order to better explain and simplify this benefit</b> , separate benefit names were created in the SOB for inpatient facility and outpatient facility services "Physician or surgeon services in an inpatient facility" & "Physician or surgeon services in an outpatient facility"
Pregnancy and maternity care	<b>In order to better explain what this benefit covers</b> , an endnote was added in the SOB to clarify costs associated with preventive office visits when combined with other services.
Preventive Health Services	<b>In order to better explain what this benefit covers</b> , the Preventive Note has been revised to clarify costs associated with preventive office visits when combined with other services on the SOB.
Primary Care Physician (PCP)	<b>In order to better explain what this benefit covers</b> , restructured language for readability in the EOC.

<p>Principle Limitations, Exceptions, Exclusions, Exclusions and Reductions General Exclusion and Limitations</p>	<p><b>Due to requirements provided by the DMHC,</b> Updates were made to General Exclusions #1 &amp; #37 to remove exclusionary language from physical examination, immunization, and vaccinations to ensure coverage for Severe Mental Illness and Serious Disturbance of a Child, as these exclusions no longer apply.</p> <p>Also, exclusion #23, which concerns services performed in a hospital by house officers, residents, interns, and others, was updated to define "others" as "other professionals in training without supervision of an attending physician in association with an accredited clinical education program."</p>
<p>Rehabilitation and habilitative services</p>	<p><b>Due to requirements provided by the DMHC,</b> the EOC was updated to better define the following:</p> <ul style="list-style-type: none"> <li>- No visit limit for rehabilitation or habilitative services.</li> <li>- Rehabilitative/habilitative health care services</li> </ul>
<p>Speech Therapy Benefits (Rehabilitation and Habilitative Services)</p>	<p><b>Due to requirements provided by the DMHC,</b> language was updated for Speech Therapy to include "Rehabilitation and Habilitative Services" when listing Speech Therapy Benefits in the EOC.</p>
<p>Continuity of Care</p>	<p><b>To comply with SB133,</b> the EOC was updated to explain how a member can qualify for Continuity of Care. Specific instructions are given for eligible members. See Continuity of Care section in the EOC for more information</p>
<p>Calendar Year Deductible footnote</p>	<p><b>In order to accurately represent what Benefits count towards the Calendar Year Deductible,</b> an endnote was changed for products that have a Calendar Year Deductible. The following statement was removed "Essential health benefits count towards the Calendar Year Deductible." Some Essential health benefits do not count towards the Calendar Year Deductible. E.g. Preventative Services.</p>
<p>Calendar Year Out-of-Pocket Maximum</p>	<p><b>In order to better explain what is covered in the Calendar Year Out-of-Pocket Maximum,</b> an endnote was changed. The following statement was removed "bariatric surgery: additional covered travel expenses for bariatric surgery." Members do not pay a copay/coinsurance for travel expenses. Blue Shield reimburses a specific amount. See the Bariatric Travel Expense Reimbursement for Residents of Designated Counties section of the EOC for more information.</p>

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