Changes to

all Small Business PPO 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 in 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	***To be consistent with the Covered California mandate****, the out-of-pocket maximum for the SHOP/Mirror Bronze PPO plans have changed. The new out-of-pocket maximum has been reduced from $6,350/$12,700 to $6250/$12,500 per individual/family.*

Out-of-pocket maximum change	***Pursuant to IRS rules,*** *the out-of-pocket maximum for the Gold Full PPO 750 Off-Ex, Silver Full PPO 1250 Off-Ex, Silver Full PPO 1700 Off-Ex and Bronze Full PPO 4500 Off-Ex plans have changed. The out-of-pocket maximum has been reduced from $6,350/$12,700 ($6,500/13,000 for Bronze Full PPO 4500 Off-Ex) to $6250/$12,500 per individual/family.*
Change in prescription deductible	***Pursuant to IRS rules to ensure the benefits maintain their respective actuarial value,*** *the copayment deductible will be reduced from $500 to $225 for the Bronze Full PPO 4500 Off-Ex plan.*
Coinsurance Change	***To be consistent with how other benefits are administered under the health plan,*** *the coinsurance for Bronze Full PPO 4500 OffEx will decrease from 40% to 30% for both participating and non participating providers.*
Generic prescription co-pay changes	***Pursuant to changes in the standardized benefit plan established by Covered California****, the generic co-pay for retail prescriptions for the Silver Full PPO HSA 2000 OffEx, Bronze Full PPO HSA 3500 OffEx and Bronze Full PPO HSA 5500 OffEx will be reduced from $25 to $15 and mail service prescriptions will be reduced from $50 to $30 for all generic drugs.*
First Dollar Coverage	***Pursuant to changes in the standardized benefit plan established by Covered California,*** *acupuncture, diabetes care, medical treatment for the teeth, gums, jaw joints, or jaw bones, prosthetic appliance services, rehabilitation and habilitation services, and speech therapy visits will now apply to the First Dollar Coverage, in which the first 3 office visits will be covered before the Calendar Year Medical Deductible is met, for the Bronze 60 PPO Network 2 without Child Dental and Bronze 60 PPO Network 2 Mirror.*
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.*
Pharmacy – Increased access to vaccines through select retail pharmacies	***For PPO members, access can now be provided to select immunizations administered at the contracted retail pharmacy*** *and is covered under the member's medical benefits.* *Note: Vaccines include: Influenza, Shingles (Zostavax), Whooping cough (TDap), Pneumococcal (Pneumovax) , HPV & Meningococcal (Menactra/Menveo)*

The following <u>clarifications</u> 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.

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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 Qualified Health Plan 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, footnotes will be changed for all OFF SHOP PPO plans.*** *Footnote 1 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:* *• Additional payment for failure to utilize the benefit management program: additional or reduced payments* *• Charges in excess of specified benefit maximums* *• Bariatric surgery: covered travel expenses for bariatric surgery"* *Footnote 2 currently states "Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield's allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum"* *The footnote will be updated as follows:* *"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 footnotes and language revisions will be changed for covered services for the following plans:*** ***Gold Full PPO 750 OffEx*** ***Silver Full PPO 1250 OffEx*** ***Silver Full PPO 1700 OffEx*** ***Bronze Full PPO 4500 OffEx*** *Previously the footnote only stated "Calendar Year Brand Drug Deductible". The footnote has been updated to state the Calendar Year Brand Drug Deductible is separate from the calendar year medical deductible and accrues to the calendar year out-of-pocket maximum.*

All Blue Shield plans are subject to limitations and exclusions. This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the group contract for the exact terms and conditions of coverage. Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation