Changes to all Small Business HSA-compatible high-deductible health plans (HDHP)

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 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 IRS rules,*** *the out-of-pocket maximum for the Bronze Full PPO HAS 5500 Off-Ex plans have changed. The out-of-pocket maximum has been reduced from $6350/$12,700 to $6250/$12,500 per individual/family.*

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 Full PPO HSA 2000 OffEx, Bronze, Full PPO HSA 3500 and Bronze Full PPO HSA 5500 will be reduced from $25 to $15 and mail service prescriptions will be reduced from $50 to $30 for all generic drugs.*
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 members with HSA-compatible plans, access can now be provided to select immunizations administered at the contracted retail pharmacy*** *and is covered under the member's medical benefit.* *Note: Vaccines include: Influenza, Shingles (Zostavax), Whooping cough (TDap), Pneumococcal (Pneumovax) , HPV & Meningococcal (Menactra/Menveo)*

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).*
Footnote and language revisions	***To provide benefit clarification, footnotes will be changed for covered services for members with HSA-compatible plans:*** *The footnotes currently state that 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*

	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.

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