

# Changes to All Small Business Full PPO Savings Plans (Off-Exchange) Blue Shield of California

As of July 1, 2017

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
<p>Calendar-Year Integrated Medical and Pharmacy Deductible</p>	<p><b><i>In accordance with 2017 IRS guidelines, the calendar-year integrated medical and pharmacy deductible for covered services from participating providers has changed.</i></b></p> <p><i>Impacted plans and changes:</i></p> <p><i>The Bronze Full PPO Savings 4500/30% OffEx plans will increase from \$4,500 individual/\$9,000 family to \$4,700 individual/\$9,400 family</i></p> <p><i>The calendar-year integrated medical and pharmacy deductible for covered services from non-participating providers has changed.</i></p> <p><i>Impacted plans and changes:</i></p> <p><i>The Bronze Full PPO Savings 4500/30% OffEx plans will increase from \$9,000 individual/\$18,000 family to \$9,400 individual/\$18,800 family</i></p> <p><i>The previous plans have changed from :</i> <i>Bronze Full PPO Savings 4500/30% OffEx</i></p> <p><i>to:</i> <i>Bronze Full PPO Savings 4700/40% OffEx</i></p>
<p>Calendar-Year Out-of-Pocket Maximum</p>	<p><b><i>In accordance with 2017 IRS guidelines, the calendar-year out-of-pocket maximums for covered services from participating providers has changed.</i></b></p>

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	<p><i>Impacted plans and changes:</i></p> <p><i>Silver Full PPO Savings 2000/20% OffEx, individual only plan, out-of-pocket maximum will increase from \$4,400 to \$5,050. Individual on a family plan, out-of-pocket maximum will increase from \$4,400 to \$5,050.</i></p> <p><i>Bronze Full PPO Savings 4500/30% OffEx will increase from \$6,500 individual/\$13,000 family to \$6,550 individual/\$13,100 family</i></p> <p><i>Bronze Full PPO Savings 5500/40% OffEx will increase from \$6,500 individual/\$13,000 family to \$6,550 individual/\$13,100 family</i></p>
<p>Plan coinsurance</p>	<p><b><i>To maintain the actuarial value of the health plan, the plan coinsurances for participating providers has changed.</i></b></p> <p><i>Impacted plans and changes:</i></p> <p><i>Bronze Full PPO 4700/40% OffEx, the coinsurance will increase from 30% to 40%</i></p> <p><i>Covered services include: allergy testing and treatment, emergency or authorized transport by ambulance, ambulatory surgery center, bariatric surgery, dialysis center, emergency room, vasectomy, home health care, inpatient and outpatient facility services, mental health and substance use disorder services, network specialty pharmacy tier 4 drugs and oral anticancer medications, orthotics and prosthetics, outpatient x-ray and imaging, pregnancy and maternity care, and skilled nursing facility</i></p>
<p>Emergency Services</p>	<p><b><i>To maintain the actuarial value of the health plan, the emergency room facility, not resulting in admission services have changed.</i></b></p> <p><i>Impacted plans and changes:</i></p> <p><i>Silver Full PPO Savings 2000/20% OffEx plan increased from \$100 per visit plus an additional 20% to \$150 per visit plus an additional 20%</i></p> <p><i>Bronze Full PPO Savings 4700/40% OffEx plan, the coinsurance will increase from \$100 per visit plus an additional 30% to \$250 per visit plus an additional 40%</i></p>
<p>Outpatient Prescription</p>	<p><b><i>To maintain the actuarial value of the health plan, the coverage structure has been adjusted so that all drug tiers</i></b></p>

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Drugs	<p>have a flat rate of 40% coinsurance up to \$500 per prescription at retail pharmacies. For mail-service pharmacies, all drug tiers have a flat rate of \$40 up to \$1,000 per prescription at mail-service pharmacies.</p> <p><i>Impacted plans:</i></p> <p>Bronze Full PPO Savings 4700/40% OffEx</p>
Medicare Part D Coverage	<p><b>To maintain the actuarial value of the health plan</b>, the plan has now changed from creditable to non-creditable coverage for Medicare Part D.</p> <p><i>Impacted plans:</i></p> <p>Bronze Full PPO Savings 4700/40% OffEx</p>
Diabetes Care	<p><b>In accordance with a standard plan design established by Covered California</b>, the office visits for Health Education Services, such as diabetes self-management training, are now offered at no cost to the member.</p>
Professional benefits	<p><b>Blue Shield is offering a new service addition for 2017.</b> Teladoc benefits is included in all health plans effective January 1, 2017. This was previously a buy-up service which is now being implemented as a standard plan benefit at a rate of \$5 per consultation with participating providers.</p>
Endnote	<p><b>To warrant benefit consistency and clarification</b>, the following information has been added to endnote 1 in the Summary of Benefits:</p> <p>Laboratory services, California Prenatal Screening Program. when received by a participating or non-participating provider are not subject to, and will not accrue towards the calendar year medical deductible.</p>
Diabetes Preventive Program	<p><b>In accordance with the United States Preventive Service Task Force (USPSTF)</b>, clinical screening for abnormal blood glucose, as part of cardiovascular risk assessment for adults 40 to 70 who are overweight or obese, is covered at no cost share.</p>

Non-Discrimination and  
Language Assistance notice

*In accordance with federal regulatory requirements, A non-discrimination notice is provided with required documents.*

<p>Dental Schedule and Limitation Table- Overdenture</p>	<p><b><i>Due to dental code updates performed by the American Dental Association, code D5860 overdenture complete was replaced by (D5863-D5866) because dental code D5860 is obsolete.</i></b></p> <p><u><i>The new codes are:</i></u></p> <p><i>D5862 Precision attachment, by report</i>  <i>D5863 Overdenture - complete maxillary once in a 5 year period</i>  <i>D5864 Overdenture partial maxillary - once in a 5 year period</i>  <i>D5865 Overdenture - complete mandibular once in a 5 year period</i>  <i>D5866 Overdenture-partial mandibular once in a 5 year period</i></p>
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Limitation of Quantity of Drugs that May Be Obtained Per Prescription or Refill	<b><i>In accordance with state regulatory requirements</i></b> , up to a 12-month of FDA-approved, self-administered hormonal contraceptive are covered. Previously, coverage was limited up to a 90 day supply.
Outpatient X-Ray, Imaging, Pathology and Laboratory Benefits	<b><i>In accordance with state regulatory requirements</i></b> , the California Prenatal Screening Program, which includes expanded Alpha Fetoprotein (AFP) genetic testing services, is covered at no cost.
Non-Participating Provider services at a Participating Facility	<b><i>In accordance with state requirements</i></b> , language has been added to clarify that cost sharing will not exceed the Participating Provider rate even if received by a Non-Participating Provider for services received by a contracting professional to prohibit balancing billing.
Timely Access to Care	<b><i>In accordance with state requirements</i></b> , Urgent Care and Non-Urgent Care, service level agreements have been listed out to provide Members timely access to care expectations from Participating Providers.

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

Description	Summary
<p>Mental Health and Substance Use Disorder</p>	<p><b><i>In order to clarify benefit intent, the following changes have been made to the Mental Health Section of the SOB:</i></b></p> <p style="padding-left: 40px;"><i>Clearly distinguish "Mental Health and Behavioral Health – Non Routine Outpatient Services" from "Routine Outpatient Services"</i></p> <p><i>Similarly, the following clarification has been made to the Substance Use Disorder section of the SOB in order to align with the Mental Health section:</i></p> <p style="padding-left: 40px;"><i>The Outpatient services have been split out into two subgroupings, Substance Use Disorder – Routine Outpatient Services and Non-Routine Outpatient Services</i></p> <p><i>The line item for "Post-discharge ancillary care" has been removed from the SOB, but continues to be covered and adjudicated with no change.</i></p> <p><i>In order to align with Covered California naming conventions, Office-Based Opioid Treatment (OBOT) has been redefined as "Office Based Opioid Detoxification and/or Maintenance Therapy".</i></p>
<p>Pregnancy and Maternity Care</p>	<p><b><i>In order to clarify benefit intent, the following change has been made to the SOB:</i></b></p> <p><i>The Postnatal physician office visit now represents the cost of the initial visit, rather than that of a subsequent visit.</i></p>
<p>Pediatric Vision</p>	<p><b><i>Due to requirements provided by the Department of Managed Health Care, the following clarifications have been made to the SOB:</i></b></p> <p><i>Coverage for Eyewear/Materials applies to either a pair of</i></p>

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	<p><i>eyeglasses or a one-year supply of contact lenses, but not both.</i></p> <p><i>For the Optional Lenses and Treatment section, Polycarbonate Lenses is given a full benefit line item as opposed to being described in text only in the Lenses section.</i></p> <p><i>For the Low-Vision Testing and Equipment section, two additional line items have been inserted to provide a comprehensive description of this benefit. These two benefits are:</i></p> <ul style="list-style-type: none"> <li><i>a) Comprehensive Low Vision Exam, once every five Calendar Years; and</i></li> <li><i>b) Low Vision Devices, one aid per calendar year.</i></li> </ul>
<p>Pediatric Dental</p>	<p><b><i>Due to requirements provided by the Department of Managed Healthcare, the following clarifications have been made to the SOB:</i></b></p> <p><i>The benefit matrix for embedded Pediatric Dental has been revised to align with On Exchange plan designs. This includes regrouping dental benefits into sub-benefit categories.</i></p> <p><i>The Diagnostic and Preventive Dental section has expanded to provide a more comprehensive understanding of covered benefits, which are at no cost to the member. Services include: oral exams, preventive X-rays and cleanings, tooth sealants, topical fluoride applications, and fixed space maintainers.</i></p>
<p>Endnotes</p>	<p><b><i>Due to requirements provided by the Department of Managed Health Care, the three endnotes related to Pediatric Dental benefits were deleted from the SOB:</i></b></p> <ul style="list-style-type: none"> <li><i>a) Caries-Risk Management Assessment (CAMBRA);</i></li> <li><i>b) Posterior Composite Resin, or Acrylic Restorations;</i></li> <li><i>and</i></li> <li><i>c) Medically Necessary Orthodontia.</i></li> </ul>

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<p>Outpatient Prescription Drugs</p>	<p><i>Effective January 1, 2017, in accordance with California law, the EOC was updated to reflect that there is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Furthermore, Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See Prior Authorization/Exception Request Process/Step Therapy section."</i></p> <p><i>The "Outpatient Prescription Drug Benefits" section of the EOC was also revised to detail the new requirements related to step therapy.</i></p>
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<p><i>Outpatient Prescription Drug Benefits: Endnote 1</i></p>	<p><b><i>Due to requirements provided by the Department of Managed Health Care, Outpatient Prescription drug benefits are not subject to the Calendar Year Integrated Medical and Pharmacy Deductible. It was previously noted these drugs are subject to the Calendar Year Integrated Medical and Pharmacy Deductible.</i></b></p> <p><i>Therefore, the following language was added to Endnote 1:</i></p> <p><i>Outpatient prescription drug benefits: contraceptives drugs and devices.</i></p>
<p><i>Base Infertility Coverage</i></p>	<p><b><i>In order to simplify benefit meaning, the following information was added to the Summary of Benefits.</i></b></p> <p><i>(Not covered except for diagnosis and treatment of the cause of infertility (unless your plan includes additional coverage). Member share of cost will be based on the service received.)</i></p>
<p><i>Calendar Year Deductible and Out of Pocket Maximum language</i></p>	<p><b><i>In order to clarify benefit intent, language has changed to clarify that the plan follows split and not combined accrual rules:</i></b></p> <p><i>"...Participating Providers only accrue to the Participating Provider Medical Deductible."</i></p> <p><i>"Participating Providers accrue only to the Participating Provider Out-of-Pocket Maximum."</i></p> <p><i>Impacted Plans:</i></p> <p><i>Silver Full PPO Savings 2000/20% OffEx</i></p>