MASSACHUSETTS

2019 Product and Benefit Updates

Small Employers

(with 2-50 enrolled with 50 or fewer full-time employees)

At Blue Cross Blue Shield of Massachusetts, we're leading the way to lower costs, better health, and great member service. In fact, for the past two years we've ranked "Highest in Member Satisfaction among Commercial Health Plans in Massachusetts" by J.D. Power!

Effective January 1, 2019, we're making changes to our health plans to help lower medical costs over the long term and expanding the types of programs that qualify for reimbursement under our Fitness and Weight-Loss benefits. These updates also ensure that we continue to meet the ongoing requirements of health care reform, while providing you with access to high-quality, affordable health plans.

Read on to find out more about these important changes and how they impact you and your employees.

Expanded Fitness and Weight-Loss Reimbursement Benefits

Effective upon renewal starting January 1, 2019, we'll expand the definition of qualifying programs for our Fitness and Weight-Loss Reimbursements. This will provide more options for members who use these types of programs and reward them for a broader range of healthy behaviors.

Qualified Fitness Programs

Our Fitness Reimbursement will expand to cover instructor-led group classes at fitness studios. Members will be able to get reimbursed for membership and class fees at:

- Full-service health clubs with a variety of exercise equipment, including cardiovascular and strength-training equipment
- Starting in 2019—Fitness studios that offer instructor-led group classes for cardiovascular and strength training, such as yoga, Pilates, kickboxing, indoor cycling, and other exercise programs

Qualified Weight-Loss Programs

Our Weight-Loss Reimbursement will expand to cover online or in-person weight-loss programs with services that align with National Institutes of Health (NIH) guidelines for choosing an effective weight loss program. Members will be able to get reimbursed for participation fees at:

- Hospital-based programs and Weight Watchers®˝ (in-person)
- Starting in 2019—Weight Watchers online and non-hospital programs (in-person or online) with a combined focus on healthy eating, exercise, and counseling with a certified health professional

New Forms for Reimbursements

We're creating new forms for reimbursement requests that will include the expanded reimbursements.

Split-Level Cost-Sharing for Diagnostic Tests and Imaging Services

Costs for outpatient diagnostic tests and imaging services, like labs, X-rays, and high-tech imaging, performed at hospitals or hospital-based outpatient centers are often among the highest. Effective January 1, 2019, upon renewal, we'll apply two cost-share levels for these services in all Merged Market (groups of 1-50) medical plans, except Blue Options plans, Blue Select plans, Connector plans, and plans with Hospital Choice Cost Sharing.

How It Works

After their deductible is met, members will have lower copayments and co-insurance when they receive diagnostic tests and imaging services at independent clinical labs or freestanding imaging centers. They'll pay higher costs when receiving these services in a hospital setting.

This benefit update promotes use of lower-cost, high-quality providers and is an opportunity for members to pay less for these services at free-standing, non-hospital locations. Members will receive the same services, just at a different location.

Support for Your Employees

To help members learn more about this important benefit change, we're creating online and print support communications. If your plan will include this benefit update on renewal, you'll be able to help your enrolled employees learn about this important benefit change with an account toolkit. The toolkit, which will include an email template and fact sheet, will be a great way to help spread the word. Look for more details in the December edition of the *Important Administrative Information* (*IAI*) newsletter.

PPO Split Copayment

Beginning January 1, 2019 upon renewal, we'll have two levels of copayment for outpatient office visits for medical care on all PPO plans, except PPO Options plans.

A lower copayment will apply for services provided by the most commonly used health care providers:

- a family or general practitioner
- internist
- OB/GYN
- pediatrician
- geriatric specialist
- nurse midwife
- limited services clinic
- behavioral health provider
- multispecialty provider group
- physician assistant
- nurse practitioner

A higher copayment will apply to any other covered provider.

The new split-level copayments will be included for the following plans:

- Preferred Blue® PPO $500 Deductible with Hospital Choice Cost Sharing
- Preferred Blue® PPO $1,000 Deductible
- Preferred Blue® PPO $1,000 Deductible with Hospital Choice Cost Sharing
- Preferred Blue® PPO $2,000 Deductible
- Preferred Blue® PPO $2,000 Deductible with Hospital Choice Cost Sharing
- Preferred Blue® PPO Basic $2,000
- Preferred Blue® PPO $3,000 Deductible
- Preferred Blue® PPO $3,000 Deductible with Hospital Choice Cost Sharing
- Preferred Blue® PPO Saver $2,000
- Preferred Blue® PPO Saver $3,000
- Preferred Blue® PPO Basic Saver

New HSA-Qualified High Deductible Health Plan

Our new plan, HMO Blue New England Saver $3,000 with Hospital Choice Cost Sharing, combines the benefits of a High Deductible Health Plan (lower premium in exchange for a higher deductible) with Hospital Choice Cost Sharing that allows members to pay less when they choose to get care from select providers that we designate as high quality and lower cost. And since this plan qualifies for a Health Savings Account (HSA), it also allows members to save money tax-free to cover their deductible and other qualified expenses or for their future health care needs. Contact your account executive for more information on this new plan and to learn about our preferred HSA vendors.

Some Saver Plans Get Deductible Updates

We're making it easier to satisfy the deductible on certain Saver plans. We'll no longer require that the entire family deductible be met before benefits are provided for any individual enrolled in the plan. This means that no one member will have to pay more than the per member deductible, even though they're enrolled in a family plan.

These changes are effective January 1, 2019, upon renewal, on the HMO Blue New England Basic Saver, Preferred Blue® PPO Basic Saver, and HMO Blue New England Saver $3,000 with Hospital Choice Cost Sharing plans only.

Select Home Delivery

Effective January 1, 2019 upon renewal, our Select Home Delivery program will be added to all HMO Blue Select, HMO Blue New England, and Preferred Blue® PPO Plans. This program encourages members to use mail order for certain maintenance medications, such as those used to treat high blood pressure or high cholesterol. Filling these prescriptions through our mail service pharmacy is more cost effective and can help members save time and money.

Members will be allowed two fills of their maintenance medications at a retail pharmacy before they must contact Express Scripts®˝ (ESI) to transition to mail, or notify ESI of their decision to stay with a retail pharmacy. ESI issues three letters letting members know that they must decide before their third fill of their maintenance medication. If no decision is made by the third fill, the member will be responsible for the full cost of the medication.

Proton Pump Inhibitors Excluded from Pharmacy Coverage

Effective January 1, 2019, all proton pump inhibitors will be excluded from our pharmacy benefit coverage, except for members under the age of 18 and those taking combination medications to treat H. pylori. Formulary exceptions, including those previously approved, will no longer be available for this class of medication, except for members under the age of 18 and those taking combination medications to treat H. pylori.

We're making this change to encourage the use of more cost-effective, over-the-counter alternatives. This change applies to all commercial plans, group Medex®˝ plans with three-tier pharmacy benefits, and Managed Blue for Seniors plans.

Brand-Name Prescription Drugs Purchased Outside of Massachusetts

Effective January 1, 2019, on plan renewal, members buying a brand-name medication at a pharmacy outside of Massachusetts will pay more if a generic equivalent is available. In addition to their copay (when applicable, deductible may apply first), these members will pay all costs above the allowed charge for the generic drug equivalent. However, members won't pay more if their provider requests that they take the brand-name medication.

Example: Member with a $25 Copay for Tier 1 Preferred Generic Drugs

Tier	Medication	Allowed Amount	Copay
Tier 4: Non-Preferred Brand-Name Drugs	Coumadin	$500	$225
Tier I: Preferred Generic Drugs	warfarin	$80	$25

In this example, the member's total cost for the brand-name drug would be $445. This includes the difference between the allowed amounts for the brand-name drug and the generic equivalent ($420) plus the member's $25 copay.

In Massachusetts, a mandatory generics law already exists that requires pharmacists to dispense the generic equivalent of a brand-name medication when available. This change aligns with the Massachusetts generics law and supports our vision of making quality health care affordable.

Out-of-Pocket Maximum Limit

All health plans must include an out-of-pocket maximum that limits costs for all Essential Health Benefits, including pharmacy. Out-of-pocket costs include copayments, co-insurance, and deductibles.

Our standard health plans include an out-of-pocket maximum that is set at, or below, the Affordable Care Act's (ACA) 2019 limits.

ACA's Annual Out-of-Pocket Maximum for 2019:

Plan Type	Self-Only Coverage (Individual)	Family Coverage
Health Savings Account (HSA) qualified high-deductible health plans	$6,750	$13,500
Non-HSA qualified health plans	$7,900	$15,800

2019 Actuarial Value Calculator Changes

The Affordable Care Act (ACA) requires health insurance plan issuers to use an Actuarial Value (AV) Calculator to determine levels of coverage in the individual and small group markets.

As a result, changes to out-of-pocket costs (like copayments, coinsurance, deductibles, or maximum out-of-pocket amounts) are needed across all our small group plans to ensure that we meet certain levels of cost sharing required under the ACA. The changes will vary by plan design and are aimed at improving competitiveness and achieving premium reductions.

To review cost share amounts and benefit changes, please refer to the Summary of Benefits or Plan Changes fact sheets.

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