

Legislative, Healthcare Reform and Other Plan Changes

Grandfathered and Non-Grandfathered Plans

Prescription Drug Benefit Changes

We're making the following changes to your prescription drug benefits:

- To comply with a new Ohio law, members of self-funded public entities now have similar cost-sharing requirements when taking chemotherapy drugs by mouth as they do when having these drugs injected. Note: This change does not affect plans where prescription drug expenses are already subject to a deductible and coinsurance.

Updated Federally Mandated Fees

The federal government has updated its federally mandated fees. Self-funded groups are responsible for calculating and paying these fees directly to the government:

- Patient-Centered Outcomes Research Institute (PCORI): \$2.08 per member per year
- Transitional Reinsurance Program fee: \$44 per member per year

Non-Grandfathered Plans Only

Preventive Care Changes

The following recently added preventive care drugs and services are covered at no cost to members if they meet certain criteria:

- Certain prescriptions used to prepare for a colonoscopy for members age 50 to 75
- Certain drugs used to help stop using tobacco up to a 180-day supply per year
- Certain drugs used to prevent primary breast cancer in women, including tamoxifen and raloxifene
- Low-dose CT scans for tobacco users age 55 to 80

Preventive care federal guidance is subject to change. For more information about preventive care, visit MedMutual.com/PreventiveCare.

Maximum Out-of-Pocket Limit Changes

The maximum out of pocket (MOOP) is the most money a member can spend out of his or her own pocket to pay for covered services related to Essential Health Benefits received from an in-network provider. For 2015, the MOOP limit is \$6,600 for single coverage and \$13,200 for family coverage. Your plan may have a lower MOOP amount, especially high-deductible health plans with health savings accounts. The MOOP limit is subject to change each year based on federal guidance. Also, effective with your first plan year in 2015, the MOOP limits include those amounts members pay in copays, deductibles and coinsurance toward prescription drug expenses.

Federal Mental Health Parity

If your plan is subject to the Mental Health Parity and Addiction Equity Act, your plan must cover residential treatment for medically necessary mental health and substance abuse conditions. Providers must submit supporting documentation for prior approval. This law applies on the first day of the first plan year on or after July 1, 2014, and new plans effective on or after July 1, 2014. If you are a self-funded non-federal government plan with 100 or more employees, you are allowed to opt out of the mental health/substance abuse parity requirements, provided you follow the applicable CMS procedures, which include applying to CMS for a waiver and notifying employees.