2022-2023 Benefit to Benefit Comparison

Effective on your group's renewal on or after January 1, 2023

Below is an overview of changes and updates made to your medical plan which will take effect with your plan's renewal. **For a complete listing of all your benefits, limitations and exclusions, please review the complete Evidence of Coverage (EOC)**. Amounts listed below are the member's responsibility to pay after any applicable deductible (unless otherwise specified).

Anthem benefits are subject to regulatory review and approval.

ALL PLANS - GENERAL UPDATE			
APPLICABLE TO ALL PLANS: EOC LANGUAGE UPDATED WITH STATE MANDATES		**Description:**	***Impact:***
Sexually Transmitted Diseases Testing & Lab Costs (SB 306 effective Janaury 1, 2022)	All plans	Requires plans to provide coverage for home test kits for sexually transmitted diseases, as defined, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a health care provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.	***Plans must include coverage of home test kits for sexually transmitted diseases (STDs) when they are deemed medically necessary and ordered by a clinician or dispensed through a standing order at a pharmacy. The kits are to be covered at zero cost-share when ordered by an in-network provider.*** ***A "home test kit" is defined as a product used for a test recommended by the federal CDC and prevention guidelines or the United States Preventive Services Task Force that has been FDA-cleared or -approved to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting. Coverage includes any lab costs to process those kits.***
Colorectal Cancer Screening and Testing (AB 342 effective January 1, 2022)	All plans	Requires plans to provide coverage for colorectal cancer screening tests, and would require the required colonoscopy for a positive result on a test or procedure to be provided without cost sharing, unless the underlying test or procedure was a colonoscopy.	***Plans must include coverage without cost shares for: a) a colorectal cancer screening test assigned either a grade of A or B by the United States Preventive Services Task Force (USPSTF); and b) a colonoscopy that is required after a positive result on a test or procedure that is a colorectal cancer screening or laboratory test assigned either a grade of A or B by the USPSTF. This legislation allows cost-shares to be applied for items or services that are delivered by an out-of-network provider.***
Adverse Childhood Experiences (ACEs) Screening (SB 428 effective January 1, 2022)	All plans	Requires plans that provides coverage for pediatric services and preventive care must provide coverage for adverse childhood experiences screenings. A plan may apply cost-sharing requirements for this benefit.	***Plans that provide coverage for pediatric services and preventive care, must include coverage for adverse childhood experiences (ACEs) screenings. "ACEs" are events, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.***
Step Therapy (AB 347 effective January 1, 2022)	All plans	Addresses requirements carriers under the CA Health and Safety Code must adhere to regarding step therapy processes and procedures and appeal rights and processes.	***Plans are required to expeditiously grant step therapy exceptions within specified time periods when use of the prescription drug required under step therapy is inconsistent with good professional practice. AB 347 also permits providers to appeal a health plan's denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request.***

Telehealth Provider Act (AB 457 effective January 1, 2022)	All plans	Clarifies that if a health plan or insurer offers a service via telehealth to an enrollee or insured through a third-party corporate telehealth provider, specified conditions must be met.	***Requires plans to comply with specified notice and consent requirements if the plans offer a service via telehealth to an enrollee through a third-.party .corporate telehealth provider.***
Abortion Services Cost Sharing (SB 245 effective January 1, 2023)	PPO, HMO (non-HSA) plans:	Prohibits plans from imposing certain benefits for all abortion and abortion-related services.	***Prohibits a health care service plan from (a) imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement; (b) imposing any utilization management or utilization review, including prior authorization; and (c) annual or lifetime limits on coverage for all abortion and abortion-related services.***
Abortion Services Cost Sharing (SB 245 effective January 1, 2023)	CDH (HSA) Plans:	Prohibits plans from imposing certain benefits for all abortion and abortion-related services.	***Prohibits a health care service plan that is a high deductible health plan as defined by law, from (a) imposing coinsurance, copayment, or any other cost-sharing requirement once the enrollee's deductible has been satisfied for the benefit year; (b) imposing any utilization management or utilization review, including prior authorization; and (c) annual or lifetime limits on coverage for all abortion and abortion-related services.***
Timely Access (SB 221 effective July 1, 2022)	All plans	Addresses requirements to provide timely access standards for health care service plans (health plans) and insurers for nonemergency health care services.	***Requires that nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. This language does not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.***
Confidential Communication of Medical Information (AB 1184 effective July 1, 2022)	All plans	Addresses communications related to sensitive services in both the civil code and insurance code.	***Bill specifies the types of communications that are included in the sensitive service requirements. If a member does not invoke their privacy communication rights, when the member has inquired about or received services considered sensitive in nature, all communications to the member should be sent in the name of the member, not the subscriber, even (in certain circumstances) when the member is a minor. There are also requirements regarding how a member can find information/be notified about invoking their rights to confidential communication.***
Deductibles and Out-of-Pocket Expenses (SB 367 effective July 1, 2022)	All plans	Requires plans to notify enrollees of their rights to such accrual information and the ability to opt in to receiving the accrual information electronically instead of via mail. Delegated entities with claims payment functions must also comply with the provisions of SB 368.	***Requires a health care service plan or health insurer to monitor an enrollee's or insured's accrual balance toward their annual deductible and out-of-pocket maximum and to provide an enrollee or insured with their accrual balance toward their annual deductible and out-of-pocket maximum for every month in which benefits were used. This APL does not apply to health plan products that do not have a deductible or out-of-pocket maximum. to provide enrollees with their up-to-date accrual towards their annual deductible and out-of-pocket maximum for every month benefits were used until the accrual balances are met.***