

Access+ HMO

Combined Evidence of Coverage and Disclosure Form

San Francisco Health Service System Fund

Effective Date: January 1, 2019

Group Number: W0051448

Blue Shield of California

Combined Evidence of Coverage and Disclosure Form

Access+ HMO

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Notice About This Group Health Plan: Blue Shield makes this health plan available to Employees through a contract with the Employer. The Group Health Service Contract (Contract) includes the terms in this combined Evidence of Coverage and Disclosure Form, as well as other terms. A copy of the Contract is available upon request. A Summary of Benefits is provided with, and is incorporated as part of, the combined Evidence of Coverage and Disclosure Form. The Summary of Benefits sets forth the Member's share-of-cost for Covered Services under the benefit plan.

Please read this combined Evidence of Coverage and Disclosure Form carefully and completely to understand which services are Covered Services, and the limitations and exclusions that apply to the plan. Pay particular attention to those sections of the combined Evidence of Coverage and Disclosure Form that apply to any special health care needs.

Blue Shield provides a matrix summarizing key elements of this Blue Shield health plan at the time of enrollment. This matrix allows individuals to compare the health plans available to them. The combined Evidence of Coverage and Disclosure Form is available for review prior to enrollment in the plan.

For questions about the this plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this combined Evidence of Coverage and Disclosure Form.

Notice About Plan Benefits: No Member has the right to receive Benefits for services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Continuation of Group Coverage provision in this combined Evidence of Coverage and Disclosure Form.

Benefits are available only for services and supplies furnished during the term this health plan is in effect and while the individual claiming Benefits is actually covered by this group Contract.

Benefits may be modified during the term as specifically provided under the terms of this combined Evidence of Coverage and Disclosure Form, the group Contract or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this plan.

Notice About Reproductive Health Services: Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at Blue Shield's Customer Service telephone number provided on the back page of this combined Evidence of Coverage and Disclosure Form to ensure that you can obtain the health care services that you need.

Notice About Contracted Providers: Blue Shield contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. To learn more about this payment system, contact Customer Service.

Notice About Health Information Exchange Participation: Blue Shield participates in the **California Integrated Data Exchange (Cal INDEX)** Health Information Exchange ("HIE") making its Members' health information available to Cal INDEX for access by their authorized health care providers. Cal INDEX is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Cal INDEX HIE to support the provision of safe, high-quality care.

Cal INDEX respects Members' right to privacy and follows applicable state and federal privacy laws. Cal INDEX uses advanced security systems and modern data encryption techniques to protect Members' privacy and the security of their personal information. The Cal INDEX notice of privacy practices is posted on its website at www.calindex.org.

Every Blue Shield Member has the right to direct Cal INDEX not to share their health information with their health care providers. Although opting out of Cal INDEX may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Cal INDEX. No doctor or hospital participating in Cal INDEX will deny medical care to a patient who chooses not to participate in the Cal INDEX HIE.

Members who do not wish to have their healthcare information displayed in Cal INDEX, should fill out the online form at www.calindex.org/opt-out or call Cal INDEX at (888) 510-7142.

Blue Shield of California

Member Bill of Rights

As a Blue Shield Plan Member, you have the right to:

- 1) Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
- 2) Receive information about all health services available to you, including a clear explanation of how to obtain them.
- 3) Receive information about your rights and responsibilities.
- 4) Receive information about health plan, the services we offer you, the Physicians and other practitioners available to care for you.
- 5) Select a Primary Care Physician and expect his/her team of health workers to provide or arrange for all the care that you need.
- 6) Have reasonable access to appropriate medical services.
- 7) Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
- 8) A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- 9) Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- 10) Receive preventive health services.
- 11) Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
- 12) Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Primary Care Physician.
- 13) Communicate with and receive information from Customer Service in a language you can understand.
- 14) Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
- 15) Obtain a referral from your Primary Care Physician for a second opinion.
- 16) Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
- 17) Voice complaints about the health plan or the care provided to you.
- 18) Participate in establishing Public Policy of the Blue Shield health plan, as outlined in your combined Evidence of Coverage and Disclosure Form or Group Health Service Agreement.
- 19) Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

Blue Shield of California

Member Responsibilities

As a Blue Shield Member, you have the responsibility to:

- 1) Carefully read all Blue Shield health plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out-of-pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield membership as explained in the combined Evidence of Coverage and Disclosure Form.
- 2) Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
- 3) Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.
- 4) Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
- 5) Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
- 6) Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
- 7) Make and keep medical appointments and inform the Plan Physician ahead of time when you must cancel.
- 8) Communicate openly with the Primary Care Physician you choose so you can develop a strong partnership based on trust and cooperation.
- 9) Offer suggestions to improve the Blue Shield health plan.
- 10) Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, Family status and other health plan coverage.
- 11) Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
- 12) Select a Primary Care Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection.
- 13) Treat all Plan personnel respectfully and courteously as partners in good health care.
- 14) Pay your Premiums, Copayments, Coinsurance and charges for non-Covered Services on time.
- 15) For Mental Health and Substance Use Disorder Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA).

Summary of Benefits	7
Introduction to the Blue Shield Access+ HMO Health Plan.....	13
How to Use This Health Plan	13
Selecting a Primary Care Physician.....	13
Primary Care Physician Relationship	14
Role of the Primary Care Physician	14
Obstetrical/Gynecological (OB/GYN) Physician Services	14
Referral to Specialty Services.....	14
Role of the Medical Group or IPA	15
Changing Primary Care Physicians or Designated Medical Group or IPA	15
Access+ Specialist.....	16
Access+ Satisfaction.....	16
Mental Health and Substance Use Disorder Services.....	16
Continuity of Care by a Terminated Provider	17
Continuity of Care for New Members by Non-Contracting Providers	17
Second Medical Opinion	18
Urgent Services	18
Emergency Services	19
Claims for Emergency and Urgent Services.....	19
NurseHelp 24/7 sm	20
Life Referrals 24/7.....	20
Blue Shield Online	20
Health Education and Health Promotion Services.....	20
Timely Access to Care.....	20
Cost Sharing	21
Limitation of Liability	22
Out-of-Area Services	22
Inter-Plan Arrangements	23
Blue Shield Global Core.....	24
Utilization Management	24
Principal Benefits and Coverages (Covered Services).....	24
Allergy Testing and Treatment Benefits.....	25
Ambulance Benefits	25
Ambulatory Surgery Center Benefits	25
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits	25
Diabetes Care Benefits	26
Dialysis Benefits	27
Durable Medical Equipment Benefits	27
Emergency Room Benefits.....	27
Family Planning and Infertility Benefits	28
Hearing Aid Services Benefit.....	28
Home Health Care Benefits.....	29
Home Infusion and Home Injectable Therapy Benefits	29
Hospice Program Benefits	30
Hospital Benefits (Facility Services).....	32
Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits	32
Mental Health and Substance Use Disorder Benefits.....	33
Orthotics Benefits.....	34
Outpatient X-Ray, Pathology and Laboratory	35
PKU Related Formulas and Special Food Products Benefits	35
Podiatric Benefits	35
Pregnancy and Maternity Care Benefits	35
Preventive Health Benefits	35
Professional (Physician) Benefits.....	36
Prosthetic Appliances Benefits.....	37
Reconstructive Surgery Benefits	38
Rehabilitative and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy)	38
Skilled Nursing Facility Benefits	38
Speech Therapy Benefits (Rehabilitative and Habilitative Services)	38

PENDING REGULATORY APPROVAL

Transgender Benefits.....	39
Transplant Benefits.....	39
Urgent Services Benefits.....	39
Principal Limitations, Exceptions, Exclusions and Reductions.....	40
General Exclusions and Limitations.....	40
Medical Necessity Exclusion.....	43
Limitations for Duplicate Coverage.....	43
Exception for Other Coverage.....	44
Claims Review.....	44
Reductions - Third Party Liability.....	44
Coordination of Benefits.....	45
Conditions of Coverage.....	46
Eligibility and Enrollment.....	46
Effective Date of Coverage.....	47
Premiums (Dues).....	47
Grace Period.....	48
Plan Changes.....	48
Renewal of Group Health Service Contract.....	48
Termination of Benefits (Cancellation and Rescission of Coverage).....	48
Extension of Benefits.....	50
Group Continuation Coverage.....	50
General Provisions.....	53
Plan Service Area.....	53
Liability of Subscribers in the Event of Non-Payment by Blue Shield.....	54
Right of Recovery.....	54
No Lifetime Benefit Maximum.....	54
No Annual Dollar Limits on Essential Health Benefits.....	54
Payment of Providers.....	54
Facilities.....	54
Independent Contractors.....	55
Non-Assignability.....	55
Plan Interpretation.....	55
Public Policy Participation Procedure.....	55
Confidentiality of Personal and Health Information.....	56
Access to Information.....	56
Grievance Process.....	56
Medical Services.....	56
Mental Health and Substance Use Disorder Services.....	57
External Independent Medical Review.....	58
Department of Managed Health Care Review.....	58
Customer Service.....	59
Definitions.....	59
Notice of the Availability of Language Assistance Services.....	72
Outpatient Prescription Drug Rider.....	73
Acupuncture and Chiropractic Services Rider.....	80
Infertility Services Rider.....	83
Contacting Blue Shield of California.....	86

Summary of Benefits

San Francisco Health Service System Custom Access+ HMO 25

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California benefit Plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC)¹. Please read both documents carefully for details.

Provider Network:

Access+ HMO Network

This benefit Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

		When using a Participating Provider ³
Calendar Year medical Deductible	<i>Individual coverage</i>	\$0
	<i>Family coverage</i>	\$0: individual \$0: Family

Calendar Year Out-of-Pocket Maximum⁴

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

When using a Participating Provider ³	
<i>Individual coverage</i>	\$2,000
<i>Family coverage</i>	\$2,000: individual \$4,000: Family

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Preventive Health Services⁶	\$0	
California Prenatal Screening Program	\$0	
Physician services		
Primary care office visit	\$25/visit	
Access+ specialist care office visit (self-referral)	\$30/visit	
Other specialist care office visit (referred by PCP)	\$25/visit	
Physician home visit	\$25/visit	
Physician or surgeon services in an Outpatient Facility	\$0	
Physician or surgeon services in an inpatient facility	\$0	
Other professional services		
Other practitioner office visit <i>Includes nurse practitioners, physician assistants, and therapists.</i>	\$25/visit	
Teladoc consultation	\$0	
Family planning		
• Counseling, consulting, and education	\$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0	
• Tubal ligation	\$0	
• Vasectomy	\$75/surgery	
• Infertility services	50%	
Podiatric services	\$25/visit	
Pregnancy and maternity care⁶		
Physician office visits: prenatal and postnatal	\$0	
Physician services for pregnancy termination	\$0	
Emergency services		
Emergency room services <i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>	\$100/visit	
Emergency room Physician services	\$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
Urgent care center services	\$25/visit	
Ambulance services <i>This payment is for emergency or authorized transport.</i>	\$50/transport	
Outpatient Facility services Ambulatory Surgery Center Outpatient department of a Hospital: surgery Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	\$100/surgery \$100/surgery \$0	
Inpatient facility services Hospital services and stay Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i> <ul style="list-style-type: none"> • Special transplant facility inpatient services • Physician inpatient services 	\$200/admission \$200/admission \$0	
Diagnostic x-ray, imaging, pathology, and laboratory services <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i> Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i> <ul style="list-style-type: none"> • Laboratory center • Outpatient department of a Hospital X-ray and imaging services <i>Includes diagnostic mammography.</i> <ul style="list-style-type: none"> • Outpatient radiology center • Outpatient department of a Hospital Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i> <ul style="list-style-type: none"> • Office location 	\$0 \$0 \$0 \$0	

Benefits⁵

Your payment

	When using a Participating Provider³	CYD² applies
<ul style="list-style-type: none"> • Outpatient department of a Hospital 	\$0	
Radiological and nuclear imaging services		
<ul style="list-style-type: none"> • Outpatient radiology center 	\$0	
<ul style="list-style-type: none"> • Outpatient department of a Hospital 	\$0	
Rehabilitative and Habilitative Services		
<i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.</i>		
Office location	\$25/visit	
Outpatient department of a Hospital	\$25/visit	
Durable medical equipment (DME)		
DME	\$0	
Breast pump	\$0	
Orthotic equipment and devices	\$0	
Prosthetic equipment and devices	\$0	
Home health services		
<i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period, except hemophilia and home infusion nursing visits.</i>		
Home health agency services	\$25/visit	
<i>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>		
Home visits by an infusion nurse	\$25/visit	
Home health medical supplies	\$0	
Home infusion agency services	\$0	
Hemophilia home infusion services	\$0	
<i>Includes blood factor products.</i>		
Skilled Nursing Facility (SNF) services		
<i>Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>		
Freestanding SNF	\$0	
Hospital-based SNF	\$0	

Benefits⁵

Your payment

	When using a Participating Provider ³	CYD ² applies
Hospice program services <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0	
Other services and supplies Diabetes care services <ul style="list-style-type: none"> • Devices, equipment, and supplies • Self-management training Dialysis services PKU product formulas and Special Food Products Allergy serum Hearing services <ul style="list-style-type: none"> • Hearing aids and equipment <i>Up to \$2,500 per ear, per member, per 36 months.</i>	\$0 \$25/visit \$0 \$0 50% \$0	

Mental Health and Substance Use Disorder Benefits

Your payment

	When using a MHSA Participating Provider ³	CYD ² applies
<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).</i>		
Outpatient services Office visit, including Physician office visit Other outpatient services, including intensive outpatient care, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment Partial Hospitalization Program Psychological Testing	\$25/visit \$0 \$0 \$0	
Inpatient services Physician inpatient services Hospital services Residential Care	\$0 \$200/admission \$200/admission	

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

If this benefit Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✓) in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowed Charges. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

The Blue Shield Access+ HMO Health Plan

Introduction to the Blue Shield Access+ HMO Health Plan

The Access+ HMO offers a wide choice of Physicians, Hospitals and Non-Physician Health Care Practitioners and includes special features such as Access+ Specialist and Access+ Satisfaction.

This Blue Shield of California (Blue Shield) combined Evidence of Coverage and Disclosure Form describes the health care coverage that is provided under the Group Health Service Contract between Blue Shield and the Contractholder (Employer). A Summary of Benefits is provided with, and is incorporated as part of, this combined Evidence of Coverage and Disclosure Form.

Please read this combined Evidence of Coverage and Disclosure Form and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about the role of the Primary Care Physician in the coordination and authorization of Covered Services and Member responsibilities such as payment of Copayments, Coinsurance and Deductibles.

Capitalized terms in this combined Evidence of Coverage and Disclosure Form have a special meaning. Please see the *Definitions* section for a clear understanding of these terms. Members may contact Blue Shield Customer Service with questions about their Benefits. Contact information can be found on the back page of this combined Evidence of Coverage and Disclosure Form.

How to Use This Health Plan

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Selecting a Primary Care Physician

Each Member must select a general practitioner, family practitioner, internist, obstetrician/gynecologist, or pediatrician as their Primary Care Physician at the time of enrollment. Individual Family members must also designate a Primary Care Physician, but each may select a different provider as their Primary Care Physician. A list of Blue Shield Access+ HMO Providers is available online at www.blueshieldca.com. Members may also call the Customer Service Department at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form for assistance in selecting a Primary Care Physician.

The Member's Primary Care Physician must be located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If the Member does not select a Primary Care Physician at the time of enrollment, Blue Shield will designate a Primary Care Physician and the Member will be notified. This designation will remain in effect until the Member requests a change.

A Primary Care Physician must also be selected for a newborn or child placed for adoption within 31 days from the date of birth or placement for adoption. The selection may be made prior to the birth or placement for adoption and a pediatrician may be selected as the Primary Care Physician. For the month of birth, the Primary Care Physician must be in the same Medical Group or Independent Practice Association (IPA) as the mother's Primary Care Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Primary Care Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If a Primary Care Physician is not selected for the child, Blue Shield will designate a Primary Care Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred.

To change the Primary Care Physician for the child after the first month, see the section below on *Changing Primary Care Physicians or Designated Medical Group or IPA*.

The child must be enrolled with Blue Shield to continue coverage beyond the first 31 days from the date of birth or placement for adoption. See the *Eligibility and Enrollment* section for additional information.

Primary Care Physician Relationship

The Physician-patient relationship is an important element of an Access+ HMO Plan. The Member's Primary Care Physician will make every effort to ensure that all Medically Necessary and appropriate professional services are provided in a manner compatible with the Member's wishes. If the Member and Primary Care Physician fail to establish a satisfactory relationship or disagree on a recommended course of treatment, the Member may contact Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form for assistance in selecting a new Primary Care Physician. If a Member is not able to establish a satisfactory relationship with his or her Primary Care Physician, Blue Shield will provide access to other available Primary Care Physicians. Members who repeatedly fail to establish a satisfactory relationship with a Primary Care Physician may lose eligibility for enrollment in the Plan. Prior to taking disenrollment action, Blue Shield will provide the Member with a written warning that describes the unacceptable conduct and gives the Member an opportunity to respond.

Role of the Primary Care Physician

The Primary Care Physician chosen by the Member at the time of enrollment will coordinate all Covered Services including primary care, preventive services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological Physician services, Access+ Specialist, and Mental Health and Substance Use Disorder Services), Hospice admission through a Participating Hospice Agency, Emer-

gency Services, Urgent Services and Hospital admission. The Primary Care Physician will also manage prior authorization when needed.

Because Physicians and other Health Care Providers set aside time for scheduled appointments, the Member should notify the provider's office within 24 hours if unable to keep an appointment. Some offices may charge a fee (not to exceed the Member's Copayment or Coinsurance) unless the missed appointment was due to an emergency situation or 24-hour advance notice is provided.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/or gynecological (OB/GYN) Covered Services by an obstetrician/gynecologist or family practice Physician who is not her designated Primary Care Physician without a referral from the Primary Care Physician or Medical Group/IPA. However, the obstetrician/gynecologist or family practice Physician must be in the same Medical Group/IPA as the Member's Primary Care Physician.

Obstetrical and gynecological services are defined as Physician services related to:

- 1) prenatal, perinatal and postnatal (pregnancy) care,
- 2) diagnose and treatment of disorders of the female reproductive system and genitalia,
- 3) treatment of disorders of the breast,
- 4) routine annual gynecological/well-woman examinations.

Obstetrical/Gynecological Physician services are separate from the Access+ Specialist feature described later in this section.

Referral to Specialty Services

Although self-referral to Plan Specialists is available through the Access+ Specialist feature, Blue Shield encourages Members to receive specialty services through a referral from their Primary Care Physician.

When the Primary Care Physician determines that specialty services, including laboratory and X-ray, are Medically Necessary, he or she will initiate a referral to a designated Plan Provider and request necessary authorizations. The Primary Care Physician will generally refer the Member to a Specialist or other Health Care Provider within the same Medical Group/IPA. The Specialist or other Health Care Provider will send a report to the Primary Care Physician after the consultation so that the Member's medical record is complete.

In the event no Plan Provider is available to perform the needed services, the Primary Care Physician will refer the Member to a non-Plan Provider after obtaining authorization. Specialty services are subject to all benefit and eligibility provisions, exclusions and limitations described in this combined Evidence of Coverage and Disclosure Form.

See the *Mental Health and Substance Use Disorder* section for information regarding Mental Health and Substance Use Disorder Services.

Role of the Medical Group or IPA

Most Blue Shield Access+ HMO Primary Care Physicians contract with a Medical Group or IPA to share administrative and authorization responsibilities (some Primary Care Physicians contract directly with Blue Shield). The Primary Care Physician coordinates the Member's care within the Member's Medical Group/IPA and directs referrals to Medical Group/IPA Specialists or Hospitals, unless care for the Member's health condition is unavailable within the Medical Group/IPA.

The Member's Medical Group/IPA ensures that a full panel of Specialists is available and assists the Primary Care Physician with utilization management of Plan Benefits. Medical Groups/IPAs also have admitting arrangements with Blue Shield's contracted Hospitals within their service area. The Medical Group/IPA also works with the Primary Care Physician to authorize Covered Services and ensure that Covered Services are performed by Plan Providers.

The Member's Primary Care Physician and Medical Group/IPA are listed on the Member's Access+ identification card.

Changing Primary Care Physicians or Designated Medical Group or IPA

Members may change their Primary Care Physician or Medical Group/IPA by calling Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form. If the selected Medical Group/IPA does not have an affiliation with the Member's Primary Care Physician, a change in Medical Group/IPA may also require the Member to select a new Primary Care Physician.

Changes in Medical Group/IPA or Primary Care Physician are effective the first day of the month following notice of approval by Blue Shield. Once the change of Primary Care Physician is effective, all care must be provided or arranged by the new Primary Care Physician, except for OB/GYN services and Access+ Specialist visits as noted in earlier sections.

Once the Medical Group/IPA change is effective, authorizations for Covered Services provided by the former Medical Group/IPA are no longer valid. Care must be transitioned to specialists within the new Medical Group/IPA, and except for Access+ Specialist visits, new authorizations must be obtained. Members may call Customer Service for assistance with Primary Care Physician or Medical Group/IPA changes.

Voluntary Medical Group/IPA changes are not permitted while the Member is confined to a Hospital or during the third trimester of pregnancy. The effective date of the new Medical Group/IPA will be the first of the month following discharge from the Hospital, or when pregnant, following the completion of postpartum care.

Additionally, changes in Primary Care Physician or Medical Group/IPA during an on-going course of treatment may interrupt care. For this reason, the effective date of a Primary Care Physician or Medical Group/IPA change, when requested during an on-going course of treatment, will be the first of the month following the date it is medically

appropriate to transfer the Member's care to a new Primary Care Physician or Medical Group/IPA, as determined by Blue Shield.

Exceptions must be approved by a Blue Shield Medical Director. For information about approval for an exception to the above provisions, please contact Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form.

If a Member's Primary Care Physician terminates participation in the Plan, Blue Shield will notify the Member in writing and designate a new Primary Care Physician who is immediately available to provide the Member's medical care. Members may also make their own selection of a new Primary Care Physician within 15 days of this notification. The Member's selection must be approved by Blue Shield prior to receiving any Covered Services under the Plan.

Access+ Specialist

The Member may arrange an office visit with an Access+ Specialist within their Primary Care Physician's Medical Group/IPA without a referral from the Primary Care Physician. The Member is responsible for the Copayment or Coinsurance listed in the Summary of Benefits for each Access+ Specialist visit including the initial visit and follow up care not referred through the Member's Primary Care Physician.

An Access+ Specialist visit includes:

- 1) an examination or other consultation including diagnosis and treatment provided by a Medical Group or IPA Plan Specialist without a Primary Care Physician referral;
- 2) Conventional X-rays (diagnostic and nuclear imaging such as CT, MRI, or bone density measurement is not included);
- 3) Laboratory services;

An Access+ Specialist visit does not include:

- 1) Services which are not otherwise covered;

- 2) Services provided by a non-Access+ Provider (such as Podiatry and Physical Therapy), except for X-ray and laboratory services as described above;
- 3) Allergy testing;
- 4) Endoscopic procedures;
- 5) Diagnostic and nuclear imaging including CT, MRI, or bone density measurement;
- 6) Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics;
- 7) Infertility services;
- 8) Emergency Services;
- 9) Urgent Services;
- 10) Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services;
- 11) Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Primary Care Physician;
- 12) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Primary Care Physician;

Access+ Satisfaction

Members may provide Blue Shield with feedback regarding the service received from Plan Physicians. If a Member is dissatisfied with the service provided during an office visit with a Plan Physician, the Member may contact Customer Service at the number provided on the back page of the combined Evidence of Coverage and Disclosure Form

Mental Health and Substance Use Disorder Services

Blue Shield contracts with a Mental Health Service Administrator (MHSA) to underwrite and deliver all Mental Health and Substance Use Disorder Services through a unique network of MHSA Participating Providers. All non-emergency Mental Health and Substance Use Disorder Hospital admissions and Other Outpatient Mental Health

and Substance Use Disorder Services must be arranged through and authorized by the MHSA. Members are not required to coordinate Mental Health and Substance Use Disorder Services through their Primary Care Physician.

All Mental Health and Substance Use Disorder Services must be provided by an MHSA Participating Provider, apart from the exceptions noted in the next paragraph. Information regarding MHSA Participating Providers is available online at www.blueshieldca.com. Members, or their Primary Care Physician, may also contact the MHSA directly at 1-877-263-9952 to obtain this information.

Mental Health and Substance Use Disorder Services received from an MHSA Non-Participating Provider will not be covered except as an Emergency or Urgent Service or when no MHSA Participating Provider is available to perform the needed services and the MHSA refers the Member to an MHSA Non-Participating Provider and authorizes the services. Mental Health and Substance Use Disorder Services received from a health professional who is an MHSA Non-Participating Provider at a facility that is an MHSA Participating Provider will also be covered. Except for these stated exceptions, all charges for Mental Health or Substance Use Disorder Services not rendered by an MHSA Participating Provider will be the Member's responsibility. For complete information regarding Benefits for Mental Health and Substance Use Disorder Services, see the *Mental Health and Substance Use Disorder Benefits* section.

Prior Authorization

The MHSA Participating Provider must obtain prior authorization from the MHSA for all non-emergency Mental Health and Substance Use Disorder inpatient admissions including Residential Care, and Other Outpatient Mental Health and Substance Use Disorder Services.

For prior authorization of Mental Health and Substance Use Disorder Services, the MHSA Participating Provider should contact the MHSA at 1-877-263-9952 at least five business days prior to the admission. The MHSA will render a decision

on all requests for prior authorization of services as follows:

- 1) for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- 2) for other services, within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within two business days of the decision.

If prior authorization is not obtained for an inpatient mental health or substance Use Disorder Hospital admission or for any Other Outpatient Mental Health and Substance Use Disorder Services and the services provided to the member are determined not to be a Benefit of the plan, or were not medically necessary, coverage will be denied. Prior authorization is not required for an emergency mental health or substance Use Disorder Hospital admission.

Continuity of Care by a Terminated Provider

Members who (1) are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; (2) are children from birth to 36 months of age; or (3) have received authorization from a terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield provider network. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a terminated provider.

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who (1) are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; (2) are children

from birth to 36 months of age; or (3) have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with the non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

Second Medical Opinion

Members who have questions about their diagnoses, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may request a referral from their Primary Care Physician to another Physician for a second medical opinion. The Member's Primary Care Physician may also offer a referral to another Physician for a second opinion.

If the second opinion involves care provided by the Member's Primary Care Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA. If the second opinion involves care received from a Specialist, the second opinion may be provided by any Blue Shield Network Specialist of the same or equivalent specialty, as authorized by either the Member's Medical Group/IPA or Blue Shield of California. All second opinion consultations must be authorized by the Medical Group/IPA or Blue Shield of California.

State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Customer Service Department at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form.

Urgent Services

The Blue Shield Access+ HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of your Primary Care Physician Service Area.

Urgent Services are defined as those Covered Services rendered outside of the Primary Care Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Primary Care Physician Service Area.

Out-of-Area Follow-up Care is defined as non-emergent Medically Necessary out-of-area services to evaluate the Member's progress after an initial Emergency or Urgent Service.

(Urgent care) While in your Primary Care Physician Service Area

If you require urgent, same-day care for a condition that could reasonably be treated in your Primary Care Physician's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), you must first call your Primary Care Physician. However, you may go directly to an urgent care clinic when your assigned Medical Group/IPA has provided you with instructions for obtaining care from an urgent care clinic in your Primary Care Physician Service Area.

Outside of California

The Blue Shield Local Access+ HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. Urgent Services may be obtained from any provider; however, using the BlueCard® or Blue Shield Global Core programs can be more cost-effective

and may eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. See the *Inter-Plan Arrangements* section of this EOC for more information on the BlueCard[®] and Blue Shield Global Core programs.

Out-of-Area Follow-up Care is also covered and services may be received through the BlueCard[®] or Blue Shield Global Core programs. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

Within California

If you are temporarily traveling within California, but are outside of your Primary Care Physician Service Area, if possible you should call Shield Concierge at the number provided on the back page of this booklet for assistance in receiving Urgent Services through a Blue Shield of California provider. You may also locate a Blue Shield provider by visiting our web site at www.blueshieldca.com. However, you are not required to use a Blue Shield of California provider to receive Urgent Services; you may use any California provider.

Out-of-Area Follow-up Care is also covered through a Blue Shield of California provider or from any California provider. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

If services are not received from a Blue Shield of California provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for Urgent Services obtained outside of your Primary Care Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Primary Care Physician Service Area

within California, the amount you pay, if not subject to a flat dollar Copayment, is calculated based on Blue Shield's Allowed Charges.

Emergency Services

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. For information on Emergency Services received outside of California through the BlueCard and Blue Shield Global Core programs, see the section on *Inter-Plan Arrangements*.

For Emergency Services from any provider, the Member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowed Charges Blue Shield is obligated to pay.

Members who reasonably believe that they have an Emergency Medical Condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital.

Members should go to the closest Plan Hospital for Emergency Services whenever possible. The Member should notify their Primary Care Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization.

Claims for Emergency and Urgent Services

If Emergency or Urgent Services are not received from a Blue Shield of California provider, the Member may be required to pay the provider for the entire cost of the service and request reimbursement from Blue Shield. A completed claim form and medical records must be submitted to Blue Shield within one year of the service date. Claims for Emergency or Urgent Services will be reviewed retrospectively for coverage.

For information on claims for Emergency or Urgent Services received outside of California see the *Inter-Plan Arrangements* section of the EOC.

NurseHelp 24/7sm

The NurseHelp 24/7 program offers Members access to registered nurses 24 hours a day, seven days a week. Registered nurses can provide assistance in answering many health-related questions, including concerns about:

- 1) symptoms the patient is experiencing;
- 2) minor illnesses and injuries;
- 3) chronic conditions;
- 4) medical tests and medications; and
- 5) preventive care

Members may obtain this service by calling the toll-free telephone number at 1-877-304-0504 or by participating in a live online chat at www.blueshieldca.com. There is no charge for this confidential service.

In the case of a medical emergency, call 911.

For personalized medical advice, Members should consult with their Primary Care Physician.

Life Referrals 24/7

The Life Referrals 24/7 program offers Members access to professional counselors 24 hours a day, seven days a week for psychosocial support services. Professional Counselors can provide confidential telephone support, including concerns about:

- 1) information;
- 2) consultations; and
- 3) referrals for health and psychosocial issues.

Members may obtain this service by calling the toll-free telephone number at 1-800-985-2405. There is no charge for this confidential service.

Blue Shield Online

Blue Shield’s internet site is located at www.blueshieldca.com. Members with internet access may view and download healthcare information.

Health Education and Health Promotion Services

Blue Shield offers a variety of health education and health promotion services including, but not limited to, a prenatal health education program, interactive online healthy lifestyle programs, and a monthly e-newsletter.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Plan Providers:

Urgent Care	Access to Care
For Services that don’t need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	Access to Care
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	Access to Care
Access to a health professional for telephone screenings	24 hours/day, 7 days/week

Note: For availability of interpreter services at the time of the Member’s appointment, consult the list of Blue Shield Access+ HMO Providers available at www.blueshieldca.com or by calling

Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the *Notice of the Availability of Language Assistance Services* section of this EOC.

Cost Sharing

The Summary of Benefits provides the Member's Copayment, Coinsurance, Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum amounts.

Calendar Year Medical Deductible

The Calendar Year Medical Deductible is the amount an individual or a Family must pay for Covered Services each year before Blue Shield begins payment in accordance with this combined Evidence of Coverage and Disclosure Form and Health Service Agreement. The Calendar Year Medical Deductible does not apply to all plans. When applied, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. Information specific to the Member's plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Medical Deductible applies to a particular Covered Service. Covered Services received at a facility that is a Plan Provider will accrue to the Calendar Year Medical Deductible whether Services are provided by a health professional who is a Plan Provider or non-Plan Provider.

There are individual and Family Calendar Year Medical Deductible amounts. The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Medical Deductible within the Family Medical Deductible. This means Blue Shield will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met.

Once the respective Deductible is reached, Covered Services are paid as the Allowed Charges,

less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. If a benefit plan has any Calendar Year Medical Deductible, it will accumulate toward the Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Out-of-Pocket Maximum. Covered Services received at a facility that is a Plan Provider will accrue to the Calendar Year Out-of-Pocket Maximum whether Services are provided by a health professional who is a Plan Provider or non-Plan Provider.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts. The individual Calendar Year Out-of-Pocket Maximum applies when an individual is covered by the plan. The Family Calendar Year Out-of-Pocket Maximum applies when a Family is covered by the plan. There is an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means that any Family member who meets the individual Out-of-Pocket Maximum will receive 100% Benefits for Covered Services, before the Family Out-of-Pocket Maximum is met.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amounts. When the respective maximum is reached, Covered Services will be paid by Blue Shield at 100% of the Allowed Charges or contracted rate for the remainder of the Calendar Year.

Charges for services that are not covered and charges in excess of the Allowed Charges or the contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Liability of Subscriber or Member for Payment

As described in *Role of the Primary Care Physician* and adjacent sections above, in general all services must be prior authorized by the Primary Care Physician or Medical Group/IPA. In addition, as designated in *Prior Authorization*, under *Mental Health and Substance Use Disorder Services* above, non-emergency inpatient and other outpatient Mental Health and Substance Use Disorder Services must be prior authorized by the MHSA. However, a Member will not be responsible for payment of covered Mental Health and Substance Use Services requiring prior authorization solely because an MHSA Participating Provider fails to obtain prior authorization.

The following services do not require prior authorization by the Member's Primary Care Physician, Medical Group/IPA, or the MHSA:

- 1) Emergency Services
- 2) Urgent Services
- 3) Access+ Specialist visits
- 4) Hospice program services provided by a Participating Hospice Agency after the Member has been referred and accepted into the Hospice Program
- 5) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the Primary Care Physician's Medical Group/IPA; and
- 6) Routine Outpatient Mental Health and Substance Use Disorder Services by an MHSA Participating Provider.

In general, the Member is responsible for payment for:

- 1) Any services that are not Covered Services; and
- 2) Any Covered Services (except Emergency Services or Urgent Services) that are rendered by a non-Plan Provider, unless the Member has been referred to such services by their Primary Care Physician or the MHSA and the services are prior authorized by the Primary Care Physician or the MHSA. Prior authorization will not be granted and payment will

not be made for services (other than Emergency Services or Urgent Services) that are rendered by a non-Plan Provider unless there is no Plan Provider available to render such services.

Limitation of Liability

Members shall not be responsible to Plan Providers or health professionals who are non-Plan Providers rendering Services at a Plan Provider facility for payment of services if they are a Benefit of the Plan. When Covered Services are rendered by a Plan Provider, or rendered by a health professional who is a non-Plan Provider at a Plan Provider facility, the Member is responsible only for the applicable Deductible, Copayment or Coinsurance, except as set forth in the Third Party Liability section. Members are responsible for the full charges for any non-Covered Services they obtain.

If a Plan Provider terminates his or her relationship with the Plan, affected Members will be notified. Blue Shield will make every reasonable and medically appropriate provision necessary to have another Plan Provider assume responsibility for the Member's care. The Member will not be responsible for payment (other than the applicable Deductible, Copayment or Coinsurance) to a former Plan Provider for any authorized services received. Once provisions have been made for the transfer of the Member's care, the services of the former Plan Provider are no longer covered.

Out-of-Area Services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain Emergency or Urgent Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of California, you will receive it from one of two kinds of providers. Most providers are participating providers and contract with the local Blue Cross and/or Blue Shield plan in that other geographic area (Host Blue). Some providers are non-participating providers because they don't contract with the Host Blue.

The Blue Shield Access+ HMO plan provides limited coverage for healthcare services received outside of California. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Arrangement.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. BlueCard Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services outside of California, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayments, Coinsurance, and Deductible amounts, if any, as stated in the Summary of Benefits.

When you receive Out-of-Area Covered Health Care Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Out-of-Area Covered Health Care Services, if not a flat dollar copayment, is calculated based on the lower of:

- 1) The billed charges for your Out-of-Area Covered Health Care Services; or
- 2) The negotiated price that the Host Blue makes available to Blue Shield.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing as noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because these adjustments will not be applied retroactively to claims already paid.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or fee as part of the claim charge passed on to you.

Claims for covered Emergency Services are paid based on the Allowed Charges as defined in this EOC.

Non-participating Providers Outside of California

Coverage for health care services provided outside of California and within the BlueCard Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will normally be

based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Out-of-Area Covered Health Care Services as described in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Blue Shield of California for reimbursement. Blue Shield will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. Blue Shield pays claims for covered Emergency Services based on the Allowed Charges as defined in this EOC.

Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (BlueCard Service Area), you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is not served by a Host Blue. As such, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Submitting a Blue Shield Global Core Claim

When you pay for Out-of-Area Covered Health Care Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core

claim form and send the claim form with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Utilization Management

State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing Blue Shield's Utilization Management Program is available online at www.blueshieldca.com or Members may call Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form to request a copy.

Principal Benefits and Coverages (Covered Services)

Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurance, charges in excess of Benefit maximums and Plan Provider provisions.

These services and supplies are covered only when Medically Necessary and authorized by the Member's Primary Care Physician, the Medical Group/IPA, the Mental Health Service Administrator (MHSA), or Blue Shield, as required. Unless specifically authorized, Covered Services must be provided by the Member's Primary Care Physician, an Obstetrical/Gynecological Physician within the Member's Medical Group/IPA, an Access+ Specialist, or an MHSA Participating Provider. All terms, conditions, Limitations, Exceptions, Exclusions and Reductions set forth in this combined Evidence of Coverage and Disclosure Form apply as well as conditions or limitations illustrated in the benefit descriptions below. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will

provide Benefits based on the most cost-effective service.

When appropriate, the Primary Care Physician will assist the Member in applying for admission into a Hospice program through a Participating Hospice Agency. Hospice services obtained through a Participating Hospice Agency after the Member has been admitted into the Hospice program, do not require authorization.

The applicable Copayment and Coinsurance amounts for Covered Services, are shown on the Summary of Benefits. The Summary of Benefits is provided with, and is incorporated as part of, the combined Evidence of Coverage and Disclosure Form.

The determination of whether services are Medically Necessary, urgent or emergent will be made by the Medical Group/IPA, the MHSA or by Blue Shield. This determination will be based upon a review that is consistent with generally accepted medical standards, and will be subject to grievance in accordance with the procedures outlined in the *Grievance Process* section.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Allergy Testing and Treatment Benefits

Benefits are provided for allergy testing and treatment, including allergy serum.

Ambulance Benefits

Benefits are provided for (1) emergency ambulance services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) pre-authorized, non-emergency ambulance transportation (surface and air) from one medical facility to another. Ambulance services are required to be provided by a state licensed ambulance or a psychiatric transport van.

Ambulatory Surgery Center Benefits

Benefits are provided for surgery performed in an Ambulatory Surgery Center.

Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition when prior authorized through the Member's Primary Care Physician, and:

- 1) the clinical trial has a therapeutic intent and the Primary Care Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
- 2) the Hospital and/or Physician conducting the clinical trial is a Plan Provider, unless the protocol for the trial is not available through a Plan Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits.

"Routine patient care" consists of those services that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial, but does not include:

- 1) the investigational item, device, or service, itself;
- 2) drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
- 3) services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
- 4) any item or service that is provided solely to satisfy data collection and analysis needs and

that is not used in the direct clinical management of the patient;

- 5) services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
- 6) services customarily provided by the research sponsor free of charge for any enrollee in the trial;
- 7) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An “approved clinical trial” means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other life-threatening condition, and is limited to a trial that is:

- 1) federally funded and approved by one or more of the following:
 - a) one of the National Institutes of Health;
 - b) the Centers for Disease Control and Prevention;
 - c) the Agency for Health Care Research and Quality;
 - d) the Centers for Medicare & Medicaid Services;
 - e) a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;
 - f) qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
 - g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest

scientific standards by qualified individuals who have no interest in the outcome of the review; or

- 2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

“Life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item, for the management and treatment of diabetes:

- 1) Blood glucose monitors, including those designed to assist the visually impaired;
- 2) insulin pumps and all related necessary supplies;
- 3) podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; and
- 4) visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of insulin.
- 5) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets);
- 6) disposable hypodermic needles and syringes needed for the administration of insulin and glucagon;
- 7) pen delivery systems for the administration of insulin as determined by Blue Shield to be Medically Necessary.

For coverage of insulin and glucagon refer to the *Outpatient Prescription Drug Benefits* section, if selected as an optional Benefit by your Employer.

Diabetic Outpatient Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management, training, education and medical nutrition therapy when directed or prescribed by the Member's Primary Care Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetic educator.

Dialysis Benefits

Benefits are provided for dialysis services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

Included in this Benefit are dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis.

Durable Medical Equipment Benefits

Benefits are provided for durable medical equipment (DME) for Activities of Daily Living, supplies needed to operate DME, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function. Other covered items include peak flow monitor for self-management of asthma, glucose monitor for self-management of diabetes, apnea monitor for management of newborn apnea, breast pump and home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more pro-

fessionally recognized DME items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

No DME Benefits are provided for the following:

- 1) rental charges in excess of the purchase cost;
- 2) replacement of DME except when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the *Outpatient Prescription Drug Benefits* section for benefits for asthma inhalers and inhaler spacers);
- 3) breast pump rental or purchase when obtained from a non-Plan Provider;
- 4) for repair or replacement due to loss or misuse;
- 5) for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and
- 6) for backup or alternate items.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

For Members in a Hospice program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal disease or terminal illness and related conditions are provided by the Hospice Agency.

Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. Covered non-Emergency Services and emergency room follow-up services within the Primary Care Physician service area (e.g., suture removal, wound check, etc.) must be authorized by Blue Shield or obtained through the Member's Primary Care Physician.

Emergency Services are services provided for an Emergency Medical Condition, including a psychiatric Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive emergency admission notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an Emergency Medical Condition.

Emergency Services Provided at a Non-Plan Hospital Following Stabilization of an Emergency Medical Condition

When the Member's Emergency medical condition is stabilized, and the treating health care provider at the non-Plan Hospital believes additional Medically Necessary Hospital services are required, the non-Plan Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital services by the non-Plan Hospital.

If Blue Shield determines the Member may be safely transferred to a Hospital that is contracted with the Plan and the Member refuses to consent to the transfer, the non-Plan Hospital must provide the Member with written notice that the Member will be financially responsible for 100% of the cost for services provided following stabilization of the Emergency medical condition. As a result, the Member may be billed by the non-Plan Hospital. Members should contact Customer Service at the number provided on the back page of the combined Evidence of Coverage and Disclosure Form for questions regarding improper billing for services received from a non-Plan Hospital.

For information on Emergency Services received outside of California, see the *Inter-Plan Arrangements* section of the EOC.

Family Planning and Infertility Benefits

Benefits are provided for the following family planning services without illness or injury being present:

- 1) Family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; and
- 2) Vasectomy.

Benefits are provided for Infertility services, except as excluded in the *Principal limitations, Exceptions, Exclusions and Reductions* section, including professional, Hospital, Ambulatory Surgery Center, and ancillary services to diagnose and treat the cause of Infertility.

See also the *Preventive Health Benefits* section for additional family planning services.

Hearing Aid Services Benefit

The hearing aid Services Benefit is limited to a Benefit maximum as shown on the Summary of Benefits. The hearing aid Services Benefit is separate and apart from the other Benefits described in your combined Evidence of Coverage and Disclosure Form. You are not required to use a Blue Shield participating provider to obtain these services as Blue Shield does not maintain a network of contracted providers for these services. You may obtain these services from any provider of your choosing and submit a claim to Blue Shield for reimbursement for covered Services up to the maximum allowance.

Hearing Aids and Ancillary Equipment

The Benefit is provided for hearing aids and ancillary equipment up to the maximum shown on the Summary of Benefits in any 36 month period. You are responsible for the cost of any hearing aid Services which are in excess of this Benefit allowance.

The hearing aid Benefit includes: a hearing aid instrument, monaural or binaural including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

- 1) Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
- 2) Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
- 3) Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any 36-month period;
- 4) Surgically implanted hearing devices.

Hearing aids and ancillary equipment are not included in the calculation of the Subscriber's Maximum Calendar Year Copayment Responsibility.

Home Health Care Benefits

Benefits are provided for home health care services when ordered and authorized through the Member's Primary Care Physician.

Covered Services are subject to any applicable Deductibles, Copayments and Coinsurance. Visits by home health care agency providers are covered up to the combined per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled services are covered up to four visits per day, two hours per visit up to the Calendar Year visit maximum. The visit maximum includes all home health visits by any of the following professional providers:

- 1) registered nurse;
- 2) licensed vocational nurse;
- 3) physical therapist, occupational therapist, or speech therapist; or

- 4) medical social worker.

Intermittent and part-time visits by a home health agency to provide services from a Home Health Aide are covered up to four hours per visit, and are included in the Calendar Year visit maximum.

For the purpose of this Benefit, each two-hour increment of a visit from a nurse, physical therapist, occupational therapist, speech therapist, or medical social worker counts as a separate visit. Visits of two hours or less shall be considered as one visit. For visits from a Home Health Aide, each four-hour increment counts as a separate visit. Visits of four hours or less shall be considered as one visit.

Medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan and related laboratory services are covered in conjunction with the professional services rendered by the home health agency.

This Benefit does not include medications or injectables covered under the Home Infusion/Home Injectable Therapy Benefit or under the Benefit for Outpatient Prescription Drugs, if selected as an optional Benefit by your Employer.

Skilled services provided by a home health agency are limited to a combined visit maximum as shown in the Summary of Benefits per Member per Calendar Year for all providers other than Plan Physicians.

See the *Hospice Program Benefits* section for information about admission into a Hospice program and specialized Skilled Nursing services for Hospice care.

For information concerning diabetic self-management training, see the *Diabetes Care Benefits* section.

Home Infusion and Home Injectable Therapy Benefits

Benefits are provided for home infusion and injectable medication therapy when ordered and authorized through the Member's Primary Care Physician.

Services include home infusion agency Skilled Nursing visits, infusion therapy provided in infusion suites associated with a home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit, medications injected or administered intravenously and related laboratory services when prescribed by the Primary Care Physician and prior authorized, and when provided by a home infusion agency. Services related to hemophilia are described separately.

This Benefit does not include medications, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefits, if selected as an optional Benefit by your Employer, and services related to hemophilia which are described below.

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the Non-Participating home infusion agency and Blue Shield. Shift care and private duty nursing must be prior authorized by Blue Shield.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. Members may also verify this information by calling Customer Service at the telephone number provided on the back page of this combined Evidence of Coverage and Disclosure Form.

Participating Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following evaluation by the Member's Primary Care Physician, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once authorized by Blue Shield, the blood factor product is covered on a regularly

scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the *Emergency Room Benefits* section.)

Included in this Benefit is the blood factor product for in-home infusion by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home except for services in infusion suites managed by a Participating Hemophilia Infusion Provider, and services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other Benefits described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

No Benefits are provided for:

- 1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
- 2) services from a hemophilia treatment center or any provider not authorized by Blue Shield; or,
- 3) self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under Outpatient Prescription Drug Benefits, if selected as an optional Benefit by your Employer, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

Hospice Program Benefits

Benefits are provided for services through a Participating Hospice Agency when an eligible Member requests admission to, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by their Primary Care Physician's certification and the admission must receive prior approval from Blue Shield. Members with a Terminal Disease or Terminal Illness who have not yet elected to enroll in a Hospice program may receive a pre-hospice consultative visit from a Participating Hospice Agency.

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver and the Family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Participating Hospice Agency.

- 1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.
- 2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:
 - a) Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;
 - b) Home Health Aide services to provide Primary Care care (supervised by a registered nurse);
 - c) homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);
 - d) bereavement services for the immediate surviving Family members for a period of at least one year following the death of the Member;
 - e) medical social services including the utilization of appropriate community resources;
 - f) counseling/spiritual services for the Member and Family;
 - g) dietary counseling;
 - h) medical direction provided by a licensed Physician acting as a consultant to the interdisciplinary Hospice team and to the Member's Primary Care Physician with regard to pain and symptom management and as a liaison to community physicians;
 - i) physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;
 - j) respiratory therapy;
 - k) volunteer services.
- 3) Drugs, DME, and supplies.
- 4) Continuous home care when Medically Necessary to achieve palliation or management of acute medical symptoms including the following:
 - a) Eight to 24 hours per day of continuous Skilled Nursing care (eight-hour minimum);
 - b) homemaker or Home Health Aide services up to 24 hours per day to supplement skilled nursing care.
- 5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.
- 6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members may receive care for two 90-day periods followed by an unlimited number of 60-day periods of care depending on their diagnosis. The extension of care continues through another Period of Care if the Primary Care Physician recertifies that the Member is Terminally Ill.

Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain

circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

- 1) Semi-private room and board unless a private room is Medically Necessary.
- 2) General nursing care and special duty nursing.
- 3) Meals and special diets.
- 4) Intensive care services and units.
- 5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.
- 6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
- 7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield.
- 8) Drugs and oxygen.
- 9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.
- 10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.
- 11) Dialysis, radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
- 12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.
- 13) Subacute Care.
- 14) Medical social services and discharge planning.

15) Inpatient services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder detoxification is authorized through the Member's Primary Care Physician.

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

- 1) Dialysis services.
- 2) Outpatient Care.
- 3) Surgery.
- 4) Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
- 5) Routine newborn circumcision within 18 months of birth.

Covered Physical Therapy, Occupational Therapy and Speech Therapy services provided in an outpatient Hospital setting are described under the *Rehabilitative and Habilitative Benefits (Physical, Occupational and Respiratory Therapy)* and *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* sections.

Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits

Benefits are provided for Hospital and professional services provided for conditions of the teeth,

gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

- 1) treatment of tumors of the gums;
- 2) treatment of damage to natural teeth caused solely by an Accidental Injury is limited to palliative services necessary for the initial medical stabilization of the Member as determined by Blue Shield;
- 3) non-surgical treatment (e.g. splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
- 4) surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
- 5) treatment of maxilla and mandible (Jaw Joints and Jaw Bones);
- 6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;
- 7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair; or
- 8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck.
- 9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

No Benefits are provided for:

- 1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of

cleft palate, including treatment to alleviate TMJ;

- 2) dental implants (endosteal, subperiosteal or transosteal);
- 3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- 4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and
- 5) fluoride treatments except when used with radiation therapy to the oral cavity.

Mental Health and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health and Substance Use Disorder Services for Blue Shield Members within California. All non-emergency inpatient Mental Health and Substance Use Disorder Services, including Residential Care, and Other Outpatient Mental Health and Substance Use Disorder Services must be prior authorized by the MHSA.

Office Visits for Outpatient Mental Health and Substance Use Disorder Services

Benefits are provided for professional office visits for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions in the individual, Family or group setting.

Other Outpatient Mental Health and Substance Use Disorder Services

Benefits are provided for Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions. These services may also be provided in the office, home or other non-institutional setting. Other Outpatient Mental Health and Substance Use Disorder Services include, but may not be limited to the following:

- 1) Behavioral Health Treatment (BHT) – professional services and treatment programs, in-

cluding applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

BHT is covered when prescribed by a Plan Physician or licensed psychologist and provided under a treatment plan developed by an MHSA Participating Provider. BHT must be obtained from MHSA Participating Providers.

Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

- 2) Electroconvulsive Therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.
- 3) Intensive Outpatient Program – an outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- 4) Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment
- 5) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.
- 6) Psychological Testing – testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.
- 7) Transcranial Magnetic Stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

Benefits are provided for inpatient Hospital and professional services in connection with acute hospitalization for the treatment of Mental Health or Substance Use Disorder Conditions

Benefits are provided for inpatient and professional services in connection with a Residential Care admission for the treatment of Mental Health or Substance Use Disorder Conditions

See *Hospital Benefits (Facility Services), Inpatient Services for Treatment of Illness or Injury* for information on Medically Necessary inpatient substance use disorder detoxification.

Orthotics Benefits

Benefits are provided for orthotic appliances and devices for maintaining normal Activities of Daily Living only. Benefits include:

- 1) shoes only when permanently attached to such appliances;
- 2) special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
- 3) knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- 4) functional foot orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- 5) initial fitting and adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

No Benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet not listed above. No Benefits are provided

for backup or alternate items, or replacement due to loss or misuse.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

Outpatient X-Ray, Pathology and Laboratory

Benefits are provided for X-ray services, diagnostic testing, clinical pathology, and laboratory services to diagnose illness or injury.

Benefits are provided for genetic testing for at risk Members according to Blue Shield medical policy and for prenatal genetic screening and diagnostic services as follows:

- 1) prenatal genetic screening to identify women who are at increased risk for carrying a fetus with a specific genetic disorder;
- 2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy.

Routine laboratory services performed as part of a preventive health screening are covered under the *Preventive Health Benefits* section.

PKU Related Formulas and Special Food Products Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products for the dietary treatment of phenylketonuria (PKU). All formulas and Special Food Products must be prescribed and ordered through the appropriate health care professional.

Podiatric Benefits

Podiatric services include office visits and other Covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services, including surgical procedures, are customarily provided by a licensed doctor of podiatric medicine. Covered laboratory and X-ray services provided in conjunction with this Benefit are described under the *Outpatient X-ray, Pathology and Laboratory Benefits* section.

PENDING REGULATORY APPROVAL

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

- 1) prenatal care;
- 2) outpatient maternity services;
- 3) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);
- 4) inpatient Hospital maternity care including labor, delivery and post-delivery care;
- 5) abortion services; and
- 6) outpatient routine newborn circumcision within 18 months of birth.

See the *Outpatient X-ray, Pathology and Laboratory Benefits* section for information on prenatal genetic screening and diagnosis of genetic disorders of the fetus for high risk pregnancy. The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed Health Care Provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

Preventive Health Benefits

Preventive Health Services are only covered when provided or arranged by the Member's Primary Care Physician.

Preventive Health Services include primary preventive medical and laboratory services for early detection of disease as specifically listed below:

- 1) evidence-based items, drugs or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
- 2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule /United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- 4) with respect to women, such additional preventive care and screenings not described in item 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at www.blueshieldca.com/preventive or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in items 1) through 4) above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation

Diagnostic audiometry examinations are covered under the *Professional (Physician) Benefits*.

PENDING REGULATORY APPROVAL

Professional (Physician) Benefits

Benefits are provided for services of Physicians for treatment of illness or injury, as indicated below:

- 1) Physician office visits for examination, diagnosis, and treatment of a medical condition, disease or injury;
- 2) Specialist office visits for second medical opinion or other consultation and treatment;
- 3) Mammography and Papanicolaou’s tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
- 4) Preoperative treatment;
- 5) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;
- 6) Outpatient surgical procedures;
- 7) Outpatient routine newborn circumcision within 18 months of birth;
- 8) Office administered Injectable medications approved by the Food and Drug Administration (FDA) as prescribed or authorized by the Primary Care Physician;
- 9) Outpatient radiation therapy and chemotherapy for cancer, including catheterization, and associated drugs and supplies;
- 10) Diagnostic audiometry examination;
- 11) Physician visits to the home;
- 12) Inpatient medical and surgical Physician services when Hospital or Skilled Nursing Facility services are also covered;
- 13) Routine newborn care in the Hospital including physical examination of the infant and counseling with the mother concerning the infant during the Hospital stay;
- 14) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m.

by secure online video, 7 days a week. If your Primary Care Physician's office is closed and you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit <http://www.teladoc.com/bsc>. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation Services are not intended to replace services from your Primary Care Physician but are a supplemental service. You do not need to contact your Primary Care Physician before using Teladoc consultation Services.

Teladoc physicians do not issue prescriptions for substances controlled by the DEA, non-therapeutic, and/or certain other drugs which may be harmful because of potential for abuse.

Note: If medications are prescribed, and your Employer selected the optional *Outpatient Prescription Drug Benefits* Supplement as a Benefit, the applicable Copayment or Coinsurance will apply. Teladoc consultation services are not available for specialist services or Mental Health and Substance Use Disorder Services. However, telehealth services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers.

A Plan Physician may offer extended-hour and urgent care services on a walk-in basis in a non-Hospital setting such as the Physician's office or an urgent care center. Services received from a Plan Physician at an extended-hour facility will be reimbursed as a Physician office visit. A list of urgent care providers may be found online at www.blueshieldca.com or by calling Customer Service

Covered laboratory and X-ray services provided in conjunction with the professional services listed

above are described under the *Outpatient X-ray, Pathology and Laboratory Benefits* section.

Preventive Health Benefits, Mental Health and Substance Use Disorder Benefits, Hospice Program Benefits, and Reconstructive Surgery Benefits are described elsewhere under *Principal Benefits and Coverages (Covered Services)*.

Prosthetic Appliances Benefits

Benefits are provided for Prostheses for Activities of Daily Living, at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. Benefits include:

- 1) Tracheoesophageal voice prosthesis (e.g. Blom-Singer device), artificial larynx, or other prosthetic device for speech following laryngectomy (covered as a surgical professional benefit);
- 2) artificial limbs and eyes;
- 3) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;
- 4) Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- 5) supplies necessary for the operation of Prostheses;
- 6) initial fitting and replacement after the expected life of the item; and
- 7) repairs, except for loss or misuse.

Routine maintenance is not covered. No Benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided above). No Benefits are provided for backup or alternate items.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see the *Reconstructive Surgery Benefits* section.

Reconstructive Surgery Benefits

Benefits are provided to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following to: (1) improve function; or (2) create a normal appearance to the extent possible. Benefits include dental and orthodontic services that are an integral part of surgery for cleft palate procedures. Reconstructive Surgery is covered to create a normal appearance only when it offers more than a minimal improvement in appearance.

In accordance with the Women’s Health & Cancer Rights Act, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons.

Rehabilitative and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy)

Benefits are provided for outpatient Physical, Occupational, and Respiratory Therapy pursuant to a written treatment plan, and when rendered in the provider’s office or outpatient department of a Hospital.

Blue Shield reserves the right to periodically review the provider’s treatment plan and records for Medical Necessity.

Benefits for Speech Therapy are described in the *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* section.

PENDING REGULATORY APPROVAL

See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitative services rendered in the home.

Skilled Nursing Facility Benefits

Benefits are provided for Skilled Nursing services in a Skilled Nursing Unit of a Hospital or a free-standing Skilled Nursing Facility, up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Benefit Period, except that room and board charges in excess of the facility’s established semi-private room rate are excluded. A “Benefit Period” begins on the date the Member is admitted into the facility for Skilled Nursing services, and ends 60 days after being discharged and Skilled Nursing services are no longer being received. A new Benefit Period can begin only after an existing Benefit Period ends.

Speech Therapy Benefits (Rehabilitative and Habilitative Services)

Benefits are provided for Medically Necessary Outpatient Speech Therapy services when ordered by the Member’s Primary Care Physician and provided by a licensed speech therapist/pathologist or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

Continued outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider’s treatment plan and records may be reviewed periodically for Medical Necessity.

Except as specified above and as stated under the *Home Health Care Benefits* and *Hospice Program Benefits* sections, no outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

See the *Home Health Care Benefits* and the *Hospice Program Benefits* sections for information on coverage for Speech Therapy services rendered in the home. See the *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

Transgender Benefits

The Access+ HMO Plan provides coverage for Medically Necessary services for the treatment of gender dysphoria. This includes both medical and mental health Benefits. Travel and lodging expenses may also be covered when necessary to obtain Covered Services and authorized in advance by Blue Shield.

No other services are covered under the Access+ HMO Plan that are transgender services or are related to the treatment of gender identity disorder (gender dysphoria), except for Medically Necessary treatment of complications arising from any gender identity disorder (gender dysphoria) services.

Transplant Benefits

Transplant benefits include coverage for donation-related services for a living donor (including a potential donor), or a transplant organ bank. Donor services must be directly related to a covered transplant and must be prior authorized by Blue Shield. Donation-related services include harvesting of the organ, tissue, or bone marrow and treatment of medical complications for a period of 90 days following the evaluation or harvest service.

Tissue and Kidney Transplant

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient. Benefits also include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special Transplant

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield to

provide the procedure, (2) prior authorization is obtained, in writing from Blue Shield and (3) the recipient of the transplant is a Subscriber or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

Failure to obtain prior written authorization and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this Benefit:

- 1) Human heart transplants;
- 2) Human lung transplants;
- 3) Human heart and lung transplants in combination;
- 4) Human liver transplants;
- 5) Human kidney and pancreas transplants in combination;
- 6) Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
- 7) Pediatric human small bowel transplants;
- 8) Pediatric and adult human small bowel and liver transplants in combination.

Urgent Services Benefits

To receive urgent care within your Primary Care Physician Service Area, call your Primary Care Physician's office or follow instructions given by your assigned Medical Group/IPA in accordance with the *How to Use This Health Plan* section.

When outside the Plan Service Area, Members may receive care for Urgent Services as follows:

Inside California

For Urgent Services within California but outside the Member's Primary Care Physician Service Area, the Member should, if possible, contact Blue Shield

Member Services at the number provided on the back page of this booklet in accordance with the *How to Use This Health Plan* section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Provider. Members may also locate a Blue Shield Provider by visiting Blue Shield's internet site at www.blueshieldca.com. You are not required to use a Blue Shield of California provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

Outside California or the United States

When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard or Blue Shield Global Core participating provider. When a BlueCard or Blue Shield Global Core participating provider is available, you should obtain Urgent Services and Out-of-Area Follow-up Care from a participating provider whenever possible, but you may also receive care from a non-participating provider. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

For information on claims for Urgent Services received outside of California, see the *Inter-Plan Arrangements* section of the EOC.

Up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits. Blue Shield may direct the Member to receive the additional Follow-up Care from their Primary Care Physician.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

- 1) routine physical examinations, except as specifically listed under *Preventive Health Benefits*, or for immunizations and vaccinations by any mode of administration (oral, injection or

otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;

- 2) for hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
- 3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;
- 4) inpatient treatment in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
- 5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under *Hospice Program Benefits*;
- 6) services in connection with private duty nursing, except as provided under Home Health Care Benefits, home infusion/home injectable therapy Benefits, and except as provided through a Participating Hospice Agency;
- 7) prescription and non-prescription food and nutritional supplements, except as provided under home infusion/home injectable therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;
- 8) eye exams and refractions, lenses and frames for eyeglasses, and contact lenses except as specifically listed under *Prosthetic Appliances Benefits*, and video-assisted visual aids or video magnification equipment for any purpose;
- 9) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

PENDING REGULATORY APPROVAL

- 10) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under *Prosthetic Appliances Benefits*;
- 11) for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits* and *Hospital Benefits (Facility Services)*;
- 12) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits* and *Hospital Benefits (Facility Services)*;
- 13) for Cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages).
- 14) for Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member.

This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
- 15) for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
- 16) any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, services incident to reversal of surgical sterilization, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan, *except for services covered under the Infertility Services Rider*;
- 17) home testing devices and monitoring equipment except as specifically provided under *Durable Medical Equipment Benefits*;
- 18) genetic testing except as described in the sections on *Outpatient X-ray, Pathology and Laboratory Benefits*;
- 19) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Plan Providers;
- 20) services performed in a Hospital by house officers, residents, interns, and others in training;
- 21) services performed by a Close Relative or by a person who ordinarily resides in the Member's home;
- 22) services (except for services received under the Behavioral Health Treatment benefit under *Mental Health and Substance Use Disorder Benefits*) provided by an individual or entity that:

- is not appropriately licensed or certified by the state to provide health care services;
- is not operating within the scope of such license or certification; or

does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;

- 23) massage therapy that is not Physical Therapy or a component of a multimodality Rehabilitative Services treatment plan;
- 24) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under *Diabetes Care Benefits*. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
- 25) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
- 26) services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under *Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits*;
- 27) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions

set forth in California Health & Safety Code, Section 1367.21 have been met;

- 28) for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, home infusion/home injectable therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
- 29) patient convenience items such as telephone, television, guest trays, and Primary Care hygiene items;
- 30) for disposable supplies for home use , such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under *Durable Medical Equipment Benefits, Home Health Care Benefits, Hospice Program Benefits, or Outpatient Prescription Drug Benefits*.
- 31) services for which the Member is not legally obligated to pay, or for services for which no charge is made;
- 32) services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;
- 33) for incident to acupuncture, except as specifically provided;
- 34) for spinal manipulation and adjustment, except as specifically provided under *Professional (Physician) Benefits (other than for*

Mental Health and Substance Use Disorder Benefits) in the Plan Benefits section;

- 35) transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van);
- 36) Drugs dispensed by a Physician or Physician's office for outpatient use;
- 37) for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Primary Care Physician, Emergency Services or Urgent Services as provided under *Emergency Room Benefits* and *Urgent Services Benefits* in the Plan Benefits section.
- 38) for inpatient and Other Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA;
- 39) for Outpatient prescription drugs;
- 40) for contraceptives and contraceptive devices, except as specifically provided under *Family Planning and Infertility Services Benefits*; oral contraceptives and diaphragms are excluded; no benefits are provided for contraceptive implants; and
- 41) services not specifically listed as a Benefit. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.

See the Grievance Process for information on filing a grievance, the Member's right to seek assistance from the Department of Managed Health Care, and the Member's right to independent medical review.

Medical Necessity Exclusion

The Benefits of this Plan are provided only for services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary and may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

Limitations for Duplicate Coverage

Medicare Eligible Members

- 1) Blue Shield will provide benefits before Medicare in the following situations:
 - a) When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
 - b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
 - c) When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
- 2) Blue Shield will provide benefits after Medicare in the following situations:
 - a) When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
 - b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100

employees (as defined by Medicare Secondary Payer laws).

- c) When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
- d) When the Member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed Charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

If the Member is a qualified veteran Blue Shield will pay the reasonable value or Blue Shield's Allowed Charges for Covered Services provided at a Veterans Administration facility for a condition that is not related to military service. If the Member is a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or Blue Shield's Allowed Charges for Covered Services provided at a Department of Defense facility, even if provided for conditions related to military service.

Members Covered by Another Government Agency

If the Member is entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and this Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowed Charges).

Contact Customer Service for any questions about how Blue Shield coordinates group plan benefits in the above situations.

Exception for Other Coverage

A Plan Provider may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under this Plan.

Claims Review

Blue Shield reserves the right to review all claims to determine if any exclusions or other limitations apply. Blue Shield may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants to evaluate claims.

Reductions - Third Party Liability

If another person or entity, through an act or omission, causes a Member to suffer an injury or illness, and if Blue Shield paid Benefits for that injury or illness, the Member must agree to the provisions listed below. In addition, if the Member is injured and no other person is responsible but the Member receives (or is entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, the Member must agree to the following provisions.

- 1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.
- 2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- 3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (a) because the Member does not receive the full amount of damages that the Member claimed or (b) because the Member had to pay attorneys' fees.
- 4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

If the Member does seek damages for his or her illness or injury, the Member must tell Blue Shield promptly that the Member has made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for, the Member must seek recovery of Blue Shield's Benefit payments and liabilities, and the Member must tell Blue Shield about any recoveries the Member obtains, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of the Member's claim in order to reimburse Blue Shield to the full amount of Benefits Blue Shield has paid or will pay. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code Section 3040.

Blue Shield may request that the Member sign a reimbursement agreement consistent with this provision.

Further, if the Member receives services from a participating Hospital for such injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by Blue Shield and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

IF THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"), THE MEMBER IS ALSO REQUIRED TO DO THE FOLLOWING:

PENDING REGULATORY APPROVAL

- 1) Ensure that any recovery is kept separate from and not comingled with any other funds or the Member's general assets and agree in writing that the portion of any recovery required to satisfy the lien or other right of Recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield;
- 2) Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to the plan of the monies owed it.

Coordination of Benefits

Coordination of benefits (COB) is utilized when a Member is covered by more than one group health plan. Payments for allowable expenses will be coordinated between the two plans up to the maximum benefit amount payable by each plan separately. Coordination of benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable expenses. The coordination of benefits rules also provide consistency in determining which group health plan is primary and avoid delays in benefit payments. Blue Shield follows the rules for coordination of benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group health plans. The following is a summary of those rules.

- 1) When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering the Member as an employee will provide its benefits before the plan covering the Member as a Dependent.
- 2) Coverage for dependent children:
 - a) When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
 - b) When the parents are divorced and the specific terms of the court decree state that one

of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.

- c) When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.
- d) When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:
 - i) The plan of the custodial parent
 - ii) The plan of the stepparent
 - iii) The plan of the non-custodial parent.
- 3) If the above rules do not apply, the plan which has covered the Member for the longer period of time is the primary plan. There may be exceptions for laid-off or retired employees.
- 4) When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.
- 5) Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

These coordination of benefits rules do not apply to the programs included in the *Limitation for Duplicate Coverage* section.

Conditions of Coverage

Eligibility and Enrollment

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the Employer. An Employee who resides or works

in the Plan Service area is eligible for coverage as a Subscriber the day following the date he or she completes the waiting period established by the Employer. The Employee's spouse or Domestic Partner and all Dependent children who reside or work in the Plan Service Area are eligible for coverage at the same time. (Special arrangements may be available for Dependents who are full-time students; Dependents of Subscribers who are required by court order to provide coverage; and Dependents and Subscribers who are long-term travelers. Please contact the Member Services Department to request an Away From Home Care (AFHC) Program Brochure which explains these arrangements including how long AFHC coverage is available. This brochure is also available at <https://www.blueshieldca.com> for HMO Members).

An Employee or the Employee's Dependents may enroll when initially eligible or during the Employer's annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, a date 12 months from the date a written request for enrollment is made, the Employer's annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in the health program offered by the Employer. Please see the definition of Late Enrollee and Special Enrollment Period in the *Definitions* section for details on these rights. For additional information on enrollment periods, please contact the Employer or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be eligible immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their eligibility under this health plan solely because of age, may be eligible for coverage if they continue to meet the definition of Dependent.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group health plan. If the Employer fails to meet these requirements, this coverage will terminate. See the *Termination of Benefits* section of this combined Evidence of Coverage and Disclosure Form for further information. Employees will receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

If a Member commits any of the following acts, he or she will immediately lose eligibility to continue enrollment:

- 1) Abusive or disruptive behavior which:
 - a) threatens the life or well-being of plan personnel, or providers of services;
 - b) substantially impairs the ability of Blue Shield to arrange for services to the Member; or
 - c) substantially impairs the ability of providers of services to furnish services to the Member or to other patients.
- 2) Failure or refusal to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the plan.

Subject to the requirements described under the Continuation of Group Coverage provision in this combined Evidence of Coverage and Disclosure Form, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this health plan when coverage would otherwise terminate.

Effective Date of Coverage

Blue Shield will notify the eligible Employee/Subscriber of the effective date of coverage for the Employee and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the effective date.

PENDING REGULATORY APPROVAL

Dependents may be enrolled within 31 days of the Employee's eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents qualify for a Special Enrollment Period, and the Premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the Premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Employee qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 31 days of the event, the effective date of enrollment will be as follows:

- 1) For the case of a birth, adoption, placement for adoption, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption or court order of guardianship.
- 2) For marriage or Domestic Partnership the coverage effective date shall be the first day of the month following the date the request for special enrollment is received.

Premiums (Dues)

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. Blue Shield will provide the Employer with information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the Employer to Blue Shield. Any amount the Subscriber must contribute is set by the Employer. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

Grace Period

After payment of the first Premium, the Contractholder is entitled to a grace period of 30 days for the payment of any Premiums due. During this grace period, the Contract will remain in force. However, the Contractholder will be liable for payment of Premiums accruing during the period the Contract continues in force.

Plan Changes

The Benefits and terms of this health plan, including but not limited to, Covered Services, Deductible, Copayment, Coinsurance and annual Out-of-Pocket Maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days written notice of any such change.

Benefits for services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

Renewal of Group Health Service Contract

This Contract has a term beginning with the eligible Employer's effective date of coverage. So long as the Employer continues to qualify for this health plan and continues to offer this plan to its Employees, Employees and Dependents will have an annual Open Enrollment period before the end of the term to make any changes to their coverage. The Employer will give notice of the annual Open Enrollment period.

Blue Shield will offer to renew the Employer's Group Health Service Contract except in the following instances:

- 1) non-payment of Premiums;
- 2) fraud or intentional misrepresentation of material fact;

- 3) failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
- 4) termination of plan type by Blue Shield;
- 5) Employer relocates outside of California; or
- 6) Employer is an association and association membership ceases.

Termination of Benefits (Cancellation and Rescission of Coverage)

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive Benefits of this health plan following termination of a Member's coverage.

Cancellation at Member Request

If the Subscriber is making any contribution towards coverage for himself or herself, or for Dependents, the Subscriber may request termination of this coverage. If coverage is terminated at the Subscriber's request, coverage will end at 11:59 p.m. Pacific Time on The last date for which Premiums have been paid.

Cancellation of Member's Enrollment by Blue Shield

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber and Employer:

- 1) Providing false or misleading material information on the enrollment application or otherwise to the Employer or Blue Shield ; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;
- 2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
- 3) Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the Employer does not meet the applicable eligibility, participation and contribution requirements of the Contract, Blue Shield will cancel this coverage after 30 days' written notice to the Employer.

Any Premium paid Blue Shield for a period extending beyond the cancellation date will be refunded to the Employer. The Employer will be responsible to Blue Shield for unpaid Premium prior to the date of cancellation.

Blue Shield will honor all claims for Covered Services provided prior to the effective date of cancellation.

See the Cancellation and Rescission provision for termination for fraud or intentional misrepresentations of material fact.

Cancellation by the Employer

This health plan may be cancelled by the Employer at any time provided written notice is given to all Employees and Blue Shield to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Employer's Non-Payment of Premium

Blue Shield may cancel this health plan for non-payment of Premium. If the Employer fails to pay the required Premium when due, coverage will terminate upon expiration of the 30-day grace period following notice of termination for nonpayment of premium. The Employer will be liable for all Premium accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will mail the Employer a Cancellation Notice (or Notice Confirming Termination of Coverage). The Employer must provide enrolled Employees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional

misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield or the Employer, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

If a Member is hospitalized or undergoing treatment for an ongoing condition and the Contract is cancelled for any reason, including non-payment of Premium, no Benefits will be provided unless the Member obtains an Extension of Benefits. (See the Extension of Benefits provision for more information.)

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Employer Group Health Service Contract is discontinued, (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (see Cancellation for Non-Payment of Premium – Notices), or (4) the last day of the month in which the Subscriber and Dependents become ineligible for coverage, except as provided below.

Even if a Subscriber remains covered, his Dependents' coverage may end if a Dependent become ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible on the last day of the month in which his or her 26th birthday

occurs, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 30 days following the Dependent's birth or placement for adoption, Benefits under this health plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the Employer or Blue Shield for information on options for continued group coverage or individual options. If the Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Reinstatement

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact Blue Shield or the Employer regarding reinstatement options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or Dependents qualify for a Special Enrollment Period (see Special Enrollment Periods in the Definitions section). The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under this health plan and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits, subject to all

limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on which a replacement carrier provides coverage to the Member.

No extension will be granted unless Blue Shield receives written certification of such Total Disability from a Physician within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Blue Shield.

Group Continuation Coverage

Please examine your options carefully before declining this coverage.

A Subscriber can continue his or her coverage under this group health plan when the Subscriber's Employer is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member may elect to continue group coverage under this Plan if the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan. Under COBRA, a Member is entitled to benefits if at the time of the

qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

- 1) With respect to the Subscriber:
 - a) the termination of employment (other than by reason of gross misconduct); or
 - b) the reduction of hours of employment to less than the number of hours required for eligibility.
- 2) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
 - a) the death of the Subscriber; or
 - b) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
 - c) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
 - d) the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or
 - e) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
 - f) a Dependent child's loss of Dependent status under this Plan.

- 3) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children (a Dependent spouse and Dependent children cannot elect COBRA on their own and are only eligible for COBRA if the Subscriber elects to enroll), the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
- 4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

- 1) With respect to COBRA enrollees:

The Member is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this plan because of a Qualifying Event.

The Employer is responsible for notifying its COBRA administrator (or plan administrator if the Employer does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, the Subscriber's Medicare entitlement or the Employer's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, the Member's

coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2) With respect to Cal-COBRA enrollees:

The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If the Member does not notify Blue Shield within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

If this plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this plan for the balance of the period that

the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Group Continuation Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than three years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this plan.

Notification Requirements

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuation of coverage under Cal-COBRA. If the enrollee is eligible and chooses to continue coverage under Cal-COBRA, the enrollee must notify Blue Shield of their Cal-COBRA election at least 30 days before COBRA termination.

Note: A Dependent spouse and Dependent children cannot elect COBRA on their own and are

only eligible for COBRA if the Subscriber elects to enroll.

Payment of Premiums (Dues)

Premiums for the Member continuing coverage shall be 102 percent of the applicable group Premium rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Premium rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the Premiums for months 19 through 29 shall be 150 percent of the applicable group Premium rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, Premiums for Cal-COBRA coverage shall be 110 percent of the applicable group Premium rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all Premium contributions to Blue Shield in the manner and for the period established under this plan.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premium must be paid within 45 days of the date the Member provided written notification to the plan of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The Premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Member from continuation coverage.

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Member's coverage under this plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as Premiums are timely paid.

Termination of Group Continuation Coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

- 1) discontinuance of this Group Health Service Contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
- 2) failure to timely and fully pay the amount of required Premiums to the COBRA administrator or the Employer or to Blue Shield as applicable. Coverage will end as of the end of the period for which Premiums were paid;
- 3) the Member becomes covered under another group health plan;
- 4) the Member becomes entitled to Medicare;
- 5) the Member commits fraud or deception in the use of the services of this plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the (USERRA). Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, Labor Code requirements for Medical Disability.

General Provisions

Plan Service Area

The geographic area served by this Plan is defined as the Plan Service Area. Subscribers and Dependents must live or work within the prescribed

Plan Service Area to enroll in this Plan and to maintain eligibility in this Plan. For specific information on the boundaries of the Plan Service Area members may call Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form. (Special arrangements may be available for Dependents who are full-time students or do not live in the Subscriber's home. Please contact the Member Services Department to request an Away From Home Care Program Brochure which explains these arrangements).

Liability of Subscribers in the Event of Non-Payment by Blue Shield

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield and its Plan Providers stipulates that the Subscriber shall not be responsible to the Plan Provider for compensation for any services to the extent that they are provided in the Member's group contract. Plan Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments, Coinsurance, and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If services are provided by a non-Plan provider, the Member is responsible for all amounts Blue Shield does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Member is responsible for any charges above the Benefit maximums.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment

of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

No Lifetime Benefit Maximum

There is no maximum limit on the aggregate payments made by Blue Shield for Covered Services provided under this Group Health Service Contract.

No Annual Dollar Limits on Essential Health Benefits

This Plan contains no annual dollar limits on essential benefits as defined by federal law.

Payment of Providers

Blue Shield generally contracts with groups of Physicians to provide services to Members. A fixed, monthly fee is paid to the groups of Physicians for each Member whose Primary Care Physician is in the group. This payment system, capitation, includes incentives to the groups of Physicians to manage all services provided to Members in an appropriate manner consistent with the contract.

Members who want to know more about this payment system, may contact Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form or talk to their Plan Provider.

PLEASE READ THE FOLLOWING INFORMATION EXPLAINING FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Facilities

Blue Shield has established a network of Physicians, Hospitals, Participating Hospice Agencies, and Plan Non-Physician Health Care Practitioners in the Member's Primary Care Physician Service Area.

The Primary Care Physician(s) the Subscriber and Dependents select will provide telephone access 24 hours a day, seven days a week so that Members can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the plan network provide access to 24-hour Emergency Services. The list of the Hospitals, Physicians and Participating Hospice Agencies in the Member's Primary Care Physician Service Area indicates the location and phone numbers of these Providers. Contact Customer Service at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form for information on Plan Non-Physician Health Care Practitioners in the Member's Primary Care Physician Service Area.

For Urgent Services when the Member is within the United States, simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, seven days a week. For Urgent Services outside the United States, call collect 1-804-673-1177 24 hours a day. Blue Shield will identify the Member's closest BlueCard Program provider. Urgent Services when the Member is outside the BlueCard Service Area are available through the Blue Shield Global Core. For Urgent Services when the Member is within California, but outside of the Primary Care Physician Service Area, the Member should, if possible, contact Blue Shield Customer Service at the number provided on the back page of this EOC in accordance with the How to Use This Health Plan section. For urgent care services when the Member is within the Primary Care Physician Service Area, contact the Primary Care Physician or follow instructions provided by the Member's assigned Medical Group/IPA.

Independent Contractors

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, or other provider or their employees.

Non-Assignability

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield. Possession of a Blue Shield ID card confers no right

to services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

Plan Providers are paid directly by Blue Shield or the Medical Group/IPA.

If the Member receives services from a non-Plan provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the non-Plan provider. The Member or the provider of service may not request that the payment be made directly to the provider of service.

Plan Interpretation

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan. Blue Shield shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan.

Public Policy Participation Procedure

This procedure enables Members to participate in establishing the public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of Members who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, §1369).

At least one third of the Board of Directors of Blue Shield of California is comprised of Subscribers who are not Employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

Please follow the following procedure:

- 1) Recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of the letter.
- 2) Please include name, address, phone number, Subscriber number, and group number with each communication.
- 3) The public policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with the letter.
- 4) Public policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes within 10 business days after the minutes have been approved.

Confidentiality of Personal and Health Information

Blue Shield protects the privacy of individually identifiable personal information, including Protected Health Information. Individually identifiable personal information includes health, financial, and/or demographic information - such as name, address, and social security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this combined Evidence
PENDING REGULATORY APPROVAL

of Coverage and Disclosure Form, or by accessing Blue Shield's internet site at www.blueshieldca.com and printing a copy.

Members who are concerned that Blue Shield may have violated their privacy rights, or who disagree with a decision Blue Shield made about access to their individually identifiable personal information, may contact Blue Shield at:

Correspondence Address:

Blue Shield of California Privacy Office
P.O. Box 272540
Chico, CA 95927-2540

Access to Information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in their possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

Grievance Process

Blue Shield has established a grievance procedure for receiving, resolving and tracking Members' grievances with Blue Shield.

Medical Services

The Member, a designated representative, or a provider on behalf of the Member, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination

concerning a claim or service. Members may contact Blue Shield at the telephone number as noted on the back page of this combined Evidence of Coverage and Disclosure Form. If the telephone inquiry to Customer Service does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Member may also submit the grievance online by visiting our web site at www.blueshieldca.com.

For all grievances except denial of coverage for a Non-Formulary Drug: Blue Shield will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service.

For grievances due to denial of coverage for a Non-Formulary Drug: If your Employer selected the optional *Outpatient Prescription Drug Benefits Supplement* as a Benefit and Blue Shield denies an exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or

24 hours in exigent circumstances. For additional information, please contact Customer Service.

For all grievances: The grievance system allows Subscribers to file grievances for within 180 days following any incident or action that is the subject of the Member's dissatisfaction.

Mental Health and Substance Use Disorder Services

Members, a designated representative, or a provider on behalf of the Member may contact the MHSA by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the MHSA at the telephone number provided below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Member's satisfaction, the Member may submit a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Department. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms must be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting www.blueshieldca.com.

1-877-263-9952

Blue Shield of California

Mental Health Service Administrator

P.O. Box 719002

San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

If the grievance involves an MHSA Non-Participating Provider, the Member should contact the Blue Shield Customer Service Department as shown on the back page of this combined Evidence of Coverage and Disclosure Form.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE NOTE: If the Employer's group health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of the Member's claim have been completed and the claim has not been approved. Additionally, the Member and the Member's plan may have other voluntary alternative dispute resolution options, such as mediation.

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service

is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-256-9404** and use the your plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You

may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, (**www.hmo-help.ca.gov**), has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment you or your Dependents and you feel that such action was due to reasons of health or utilization of benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

Customer Service

For questions about services, providers, Benefits, how to use this plan, or concerns regarding the quality of care or access to care, contact Blue Shield's Customer Service Department. Customer Service can answer many questions over the telephone. Contact Information is provided on the last page of this combined Evidence of Coverage and Disclosure Form.

For all Mental Health and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and Substance Use Disorder Services, MHSA Participating Providers, or Mental Health and Substance Use Disorder Benefits. Members may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952
Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

Definitions

When the following terms are capitalized in this combined Evidence of Coverage and Disclosure Form, they will have the meaning set forth below:

Access+ Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the Access+ HMO Plan and for Mental Health Services, an MHSA Participating Provider.

Accidental Injury — definite trauma resulting from a sudden unexpected and unplanned event, occurring by chance, caused by an independent external source.

Activities of Daily Living (ADL) — mobility skills required for independence in normal, everyday living. Recreational, leisure, or sports activities are not considered ADL.

Allowed Charges —

- For a Plan Provider: the amounts a Plan Provider agrees to accept as payment from Blue Shield.
- For a non-Plan Provider: the amounts paid by Blue Shield when services from a non-Plan Provider are covered and are paid as a Reasonable and Customary Charge.

Ambulatory Surgery Center — an Outpatient surgery facility which:

- 1) is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,
- 2) provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital.

Behavioral Health Treatment — professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Benefits (Covered Services) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

BlueCard Service Area – the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

Blue Shield of California – a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this combined Evidence of Coverage and Disclosure Form, as Blue Shield.

Calendar Year — the 12-month consecutive period beginning on January 1 and ending on December 31 of the same calendar year.

Close Relative — the spouse, Domestic Partner, children, brothers, sisters, or parents of a Member.

Coinsurance – the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Copayment — the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those Medically Necessary supplies and services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Creditable Coverage —

1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage

issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

- 2) The Medicare Program pursuant to Title XVIII of the Social Security Act.
- 3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as MediCal in California).
- 4) Any other publicly sponsored program of medical, Hospital or surgical care, provided in this state or elsewhere.
- 5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq.
- 6) A medical care program of the Indian Health Service or of a tribal organization.
- 7) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq..
- 8) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
- 9) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).
- 10) Any other Creditable Coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory

care by a Physician) or care furnished to a Member who is mentally or physically disabled, and

- 1) Who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or
- 2) when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount which the Member must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Group Health Service Contract.

Dependent - an individual who is enrolled and maintains coverage under this Agreement, and who meets one of the following eligibility requirements, as:

- 1) A Dependent spouse is an individual who is legally married to the Subscriber, or a survivor of a retired Subscriber, and who is/was not legally separated from the Subscriber.
- 2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in this Agreement.
- 3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship).
- 4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

- a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
- b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and
- c) thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:
 - i) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
 - ii) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Domestic Partner — an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

- 1) Both partners are (a) 18 years of age or older and (b) of the same or different sex;
- 2) The partners share (a) an intimate and committed relationship of mutual caring and (b) the same common residence;
- 3) The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
- 4) Both partners were mentally competent to consent to a contract when their domestic partnership began.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Domiciliary Care — care provided in a Hospital

or other licensed facility because care in the individual's home is not available or is unsuitable.

Emergency Medical Condition (including a psychiatric emergency) — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1) placing the Member's health in serious jeopardy;
- 2) serious impairment to bodily functions;
- 3) serious dysfunction of any bodily organ or part.

Emergency Services — the following services provided for an Emergency Medical Condition:

- 1) A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, and
- 2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the Member.

'Stabilize' means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Post-Stabilization Care means Medically Necessary services received after the treating Physician determines the Emergency Medical Condition is stabilized.

Employee — an individual who meets the eligibility requirements set forth in the Group Health

Service Contract between Blue Shield and the Employer.

Employer (Contractholder) — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least one employee and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any state government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature.

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Generic Drugs — Drugs that are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug

Group Health Service Contract (Contract) — the contract for health coverage between Blue Shield and the Employer (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.

Habilitative Services –Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

Hemophilia Infusion Provider — a provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

Note: A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

HMO Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the HMO Plan and for Mental Health and Substance Use Disorder Services, an MHSa Participating Provider.

Home Health Aide – an individual who has successfully completed a state-approved training program, is employed by a home health agency or hospice program, and provides personal care services in the patient's home.

Hospice or Hospice Agency — an entity which provides Hospice services to persons with a Terminal Disease or Illness and holds a license, currently in effect, as a Hospice pursuant to California Health and Safety Code Section 1747, or is licensed as a home health agency pursuant to California Health and Safety Code Sections 1726 and 1747.1 and has Medicare certification.

Hospital — an entity which is:

- 1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and which provides 24-hour a day nursing service by registered nurses; or
- 2) a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
- 3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

A facility which is principally a rest home, nursing home, or home for the aged, is not included in this definition.

Host Blue — The local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the BlueCard Service Area.

Independent Practice Association (IPA) — a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members.

Infertility — the Member must be actively trying to conceive and has;

- 1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- 2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth.

Intensive Outpatient Program — an outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient's condition

requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

Inter-Plan Arrangements – Blue Shield’s relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

Late Enrollee — an eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the annual date a written request for coverage is made or at the Employer’s next Open Enrollment Period.

An eligible Employee or Dependent may qualify for a Special Enrollment Period.

Medical Group — an organization of Physicians who are generally located in the same facility and provide Benefits to Members.

Medical Necessity – (Medically Necessary) — Benefits are provided only for services which are Medically Necessary.

- 1) Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are:
 - a) consistent with Blue Shield medical policy; and,
 - b) consistent with the symptoms or diagnosis; and,
 - c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; and,
 - d) furnished at the most appropriate level which can be provided safely and effectively to the patient.

- 2) If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.
- 3) Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician’s office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered.
- 4) Inpatient services which are not Medically Necessary include hospitalization:
 - a) for diagnostic studies that could have been provided on an Outpatient basis;
 - b) for medical observation or evaluation;
 - c) for personal comfort;
 - d) in a pain management center to treat or cure chronic pain; or
 - e) for inpatient Rehabilitative Services that can be provided on an outpatient basis.
- 5) Blue Shield reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member — an individual who is enrolled and maintains coverage under the Group Health Service Contract as either a Subscriber or a Dependent.

Mental Health Condition — mental disorders listed in the most current edition of the Diagnostic & Statistical Manual of Mental Disorders (DSM), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Service Administrator (MHSA) —The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with

the MHSAs to underwrite and deliver Blue Shield's Mental Health and Substance Use Disorder Services through a separate network of MHSAs Participating Providers.

Mental Health Services — services provided to treat a Mental Health Condition.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSAs for the provision of Mental Health or Substance Use Disorder Services.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSAs for the provision of Mental Health Services or Substance Use Disorder Services.

Non-Participating Pharmacy — a pharmacy which does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.

Other Outpatient Mental Health and Substance Use Disorder Services — Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions including, but not limited to, the following:

- 1) Partial Hospitalization
- 2) Intensive Outpatient Program
- 3) Electroconvulsive Therapy
- 4) Office-Based Opioid Treatment
- 5) Transcranial Magnetic Stimulation
- 6) Behavioral Health Treatment
- 7) Psychological Testing

These services may also be provided in the office, home or other non-institutional setting.

Outpatient Mental Health and Substance Use Disorder Services (Office Visits) — professional (Physician) office visits for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions, including the individual, family or group setting.

Occupational Therapy — treatment under the direction of a Physician and provided by a certified occupational therapist, or other appropriately licensed Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period — that period of time set forth in the Contract during which eligible Employees and their Dependents may enroll in this coverage, or transfer from another health benefit plan sponsored by the Employer to this coverage.

Orthosis (Orthotics) — an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable body parts.

Out-of-Area Covered Health Care Services — Medically Necessary Emergency Services or Urgent Services provided outside of California or Out-of-Area Follow-up Care.

Out-of-Area Follow-up Care — non-emergent Medically Necessary services to evaluate the Member's progress after Emergency or Urgent Service provided outside the service area.

Out-of-Pocket Maximum — the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, or charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.

Outpatient Facility — a licensed facility which provides medical and/or surgical services on an outpatient basis. The term does not include a Physician's office or a Hospital.

Outpatient Substance Use Disorder Services — Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions including, but not limited to, the following:

- 1) Professional (Physician) office visits
- 2) Partial Hospitalization
- 3) Intensive Outpatient Program

- 4) Office-Based Opioid Treatment
- 5) Post-discharge ancillary care services.

These services may also be provided in the office, home or other non-institutional setting.

Partial Hospitalization Program (Day Treatment) — an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Patients may be admitted directly to this level of care, or transferred from inpatient care following acute stabilization.

Participating Hemophilia Infusion Provider — a Hemophilia Infusion Provider that has an agreement with Blue Shield to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

Participating Hospice or Participating Hospice Agency — an entity which: (1) provides Hospice services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification; and (2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Participating Pharmacy — a pharmacy which has agreed to a contracted rate for covered Drugs for Blue Shield Members. These pharmacies participate in the Blue Shield Pharmacy Network.

Period of Care – the timeframe the Primary Care Physician certifies or recertifies that the Member requires and remains eligible for Hospice care, even if the Member lives longer than one year. A Period of Care begins the first day the Member receives Hospice services and ends when the certified timeframe has elapsed.

PENDING REGULATORY APPROVAL

Primary Care Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with one of the contracted Independent Practice Associations, Medical Groups, or Blue Shield as a Primary Care Physician to provide primary care to Members and to refer, authorize, supervise, and coordinate the provision of all Benefits to Members in accordance with the contract.

Primary Care Physician Service Area — that geographic area served by the Member's Primary Care Physician's Medical Group or IPA.

Physical Therapy — treatment provided by a physical therapist, occupational therapist or other appropriately licensed Health Care Provider.. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

Plan — the Blue Shield Access + HMO Health Plan.

Plan Hospital — a Hospital licensed under applicable state law contracting specifically with Blue Shield to provide Benefits to Members under the Plan.

Note: This definition does not apply to Mental Health and Substance Use Disorder Services. See above for MHSA Participating Providers for Mental Health and Substance Use Disorder Services,

Plan Non-Physician Health Care Practitioner — a health care professional who is not a Physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals, or Blue Shield to provide Covered Services to Members when referred by a Primary Care Physician. For all Mental Health and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Plan Provider — a provider who has an agreement with Blue Shield to provide Plan Benefits to Members and an MHSA Participating Provider.

Plan Service Area — that geographic area served by the HMO Plan.

Plan Specialist — a Physician other than a Primary Care Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide Covered Services to Members either according to an authorized referral by a Primary Care Physician, or according to the Access+ Specialist program, or for OB/GYN Physician services. For all Mental Health and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Premium (Dues) — the monthly prepayment that is made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Group Health Service Contract.

Preventive Health Services — primary preventive medical services, including related laboratory services, for early detection of disease as specifically described in the Principal Benefits and Coverages section of this combined Evidence of Coverage and Disclosure Form.

Prosthesis(es) (Prosthetic) — an artificial part, appliance or device used to replace a missing part of the body.

Psychological Testing — testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

Reasonable and Customary Charge —

1) In California: The lower of: (a) the provider's billed charge, or (b) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a non-Plan provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered.

2) Outside of California: The lower of: (a) the provider's billed charge, or, (b) the amount, if any, established by the laws of the state to be paid for Emergency Services.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.

Rehabilitative Services — Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual's ability to function to the maximum extent practical. Rehabilitative services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care — Mental Health or Substance Use Disorder Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

Respiratory Therapy — treatment, under the direction of a Physician and provided by a certified respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — a minor under the age of 18 years who:

- 1) has one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms; and
- 2) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

- a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, Family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
- b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing — services performed by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Public Health as a “Skilled Nursing Facility” or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.

Special Enrollment Period – a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this health plan outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee’s Dependent has a 30-day Special Enrollment Period, except as otherwise stated in items 5 and 6, if any of the following occurs:

- 1) The eligible Employee or Dependent meets all of the following requirements:
 - a) The Employee or Dependent was covered under another employer health benefit plan or had other health insurance

coverage at the time he was offered enrollment under this plan;

- b) The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health plan or other health insurance was the reason for declining enrollment provided that, if he was covered under another employer health plan or had other health insurance coverage, he was given the opportunity to make the certification required as was notified that failure to do so could result in later treatment as a Late Enrollee;
 - c) The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan’s coverage, exhaustion of COBRA continuation coverage, cessation of an employer’s contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership.
 - d) The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
- 2) A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee’s health benefit Plan. The health Plan shall enroll such a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
 - 3) For eligible Employees or Dependents who fail to elect coverage in this Plan during their

initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of up to 12 months, unless he or she meets the criteria specified in paragraphs 1 or 2 above; or

- 4) For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
- 5) For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or
- 6) For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Special Food Products — a food product which is both of the following:

- 1) Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a

- 2) Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment under the direction of a Physician and provided by a licensed speech pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by diagnosed illness or injury.

Subacute Care — Skilled Nursing or skilled Rehabilitative Services provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, Physical, Occupational or Speech Therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber — an eligible Employee who is enrolled and maintains coverage under the Group Health Service Contract.

Substance Use Disorder Condition — drug or alcohol Use Disorder or dependence.

Substance Use Disorder Services — services provided to treat a Substance Use Disorder Condition.

Terminal Disease or Terminal Illness (Terminally Ill) — a medical condition resulting in a life expectancy of one year or less, if the disease follows its natural course.

Total Disability (or Totally Disabled) —

- 1) In the case of an Employee or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

- 2) in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Urgent Services — those Covered Services rendered outside of the Primary Care Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Primary Care Physician Service Area.

This combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of the Blue Shield Access+ HMO Plan.

Should you have any questions, please call the Blue Shield of California Customer Service Department at the number provided on the back page of this combined Evidence of Coverage and Disclosure Form.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198 번으로 문의해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Tagalog

Անվճար Լեզվախոս Ծառայություններ: Դուք կարող եք թարգմանն ձեր բերել և փաստաթղթերը ընթերցել սալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ գանգադարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

خدمات جانی مربوط به زبان. می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شود. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و با این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਆਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាសនៈសម្រាប់អ្នកជា ភាសាខ្មែរ ។ សម្រាប់ព័ត៌មាន សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដៃលេខាស បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Key Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

Outpatient Prescription Drug Rider

San Francisco Health Service System Custom Access + Rx

Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:

Rx Ultra

Drug Formulary:

Plus

Calendar Year Pharmacy Deductible (CYPD)¹

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

When using a Participating Pharmacy²

Calendar Year Pharmacy Deductible

Per Member \$0

Prescription Drug Benefits^{3,4}

Your payment

When using a Participating Pharmacy² CYPD¹ applies

Retail pharmacy prescription Drugs

Per prescription, up to a 30-day supply.

Contraceptive Drugs and devices	\$0
Formulary Generic Drugs	\$10/prescription
Formulary Brand Drugs	\$25/prescription
Non-Formulary Brand Drugs	\$50/prescription

Mail service pharmacy prescription Drugs

Per prescription, up to a 90-day supply.

Contraceptive Drugs and devices	\$0
Formulary Generic Drugs	\$20/prescription
Formulary Brand Drugs	\$50/prescription
Non-Formulary Brand Drugs	\$100/prescription

Specialty Pharmacies

Per prescription. Specialty Drugs are covered and only when dispensed by a Network Specialty Pharmacy.

20% up to \$100/prescription

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has any Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✓) in the Benefits chart above.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✓) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting <https://www.blueshieldca.com/wellness/drugs/formulary#heading2>.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this Benefit plan's prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Formulary Generic Drug Copayment. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable Formulary or Non-formulary Drug Copayment. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug Copayment.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Benefit designs may be modified to ensure compliance with State and Federal requirements.

Outpatient Prescription Drug Benefits

The following Prescription Drug Benefit is separate from the Health Plan coverage. The Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Benefit Supplement; however, the general provisions and exclusions of the Health Plan contract shall apply.

Benefits are provided for Outpatient Prescription Drugs which meet all of the requirements specified in this supplement, are prescribed by the Member's Physician and, except as noted below, are obtained from a Participating Pharmacy. All Drugs covered under this Benefit, including over-the-counter items, must be prescribed by a Physician.

Blue Shield's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Blue Shield Outpatient Prescription Drug Benefit. Non-Formulary Drugs may be covered subject to higher Copayments. Select Drugs and Drug dosages and most Specialty Drugs require prior authorization by Blue Shield for Medical Necessity, including appropriateness of therapy and efficacy of lower cost alternatives. You or your Physician may request prior authorization from Blue Shield.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantify limits require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section. You, your Physician or Health Care Provider may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs.

Blue Shield's Formulary is established by Blue Shield's Pharmacy and Therapeutics Committee. This Committee consists of physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, health benefit based on the medical evidence, and comparative cost. They review new Drugs, dosage forms, usage and clinical data to update the Formulary during scheduled meetings four times a year. Note: Your Physician or Health Care Provider might prescribe a Drug even though the Drug is not included on the Formulary.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

You must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs under the Outpatient Prescription Drug benefit. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. You can locate a retail Participating Pharmacy by visiting <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service at the number listed on the Identification Card. If you obtain Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny your claim, unless it is for an Emergency Service.

Blue Shield negotiates contracted rates with Participating Pharmacies for covered Drugs. If your plan has a Pharmacy Deductible, you are responsible for paying the full contracted rate for Drugs until you meet the Member Calendar Year Pharmacy Deductible. Generic Drugs are not subject to, and will not accrue to the Calendar Year Pharmacy Deductible.

You must pay the applicable Copayment or Coinsurance for each prescription Drug when you obtain it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than your Copayment or Coinsurance, you only pay the contracted rate. There is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See *Prior Authorization/Exception Request Process/Step Therapy* section.

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you must pay the difference in cost, plus your Generic Drug Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Generic Drug Copayment or Coinsurance. For example, you select Brand Drug "A" when there is an equivalent Generic Drug "A" available. The Participating Pharmacy's contracted rate for Brand Drug "A" is \$300, and the contracted rate for Generic Drug "A" is \$100. You would be responsible for paying the \$200 difference in cost, plus your Generic Drug Copayment or Coinsurance. This difference in cost does not apply to the

Member Calendar Year Pharmacy Deductible or the Calendar Year Out-of-Pocket Maximum.

If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you can request an exception to paying the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity. See the section on Prior Authorization/Exception Request Process below for more information on the approval process. If the request is approved, you pay only the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

When you obtain Drugs from a Non-Participating Pharmacy for a covered emergency:

- You must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim form for reimbursement to:

Blue Shield of California
Argus Health Systems, Inc.
P.O. Box 419019,
Dept. 191
Kansas City, MO 64141

- Blue Shield will reimburse you based on the price you paid for the Drug, minus any applicable Deductible and Copayment or Coinsurance.

Claim forms may be obtained by calling Customer Service or visiting www.blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

You have an option to use Blue Shield's Mail Service Prescription Drug Program when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of your maintenance Drugs and may help you to save money. You may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. Your Physician or Health Care Provider must indicate a prescription quantity equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

You must pay the applicable Mail Service Prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit www.blueshieldca.com or call Customer Service to get additional information about the Mail Service Prescription Drug Program.

Obtaining Specialty Drugs through the Specialty Drug Program

Specialty Drugs are Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

Specialty Drugs are available exclusively from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, upon your request, will transfer the Specialty Drugs to an associated retail store for pickup. See *Exceptions Process for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA. To select a Network Specialty Pharmacy, you may go to <http://www.blueshieldca.com> or call Customer Service.

Go to <http://www.blueshieldca.com> for a complete list of Specialty Drugs. Most Specialty Drugs require prior authorization for Medical Necessity by Blue Shield, as described in the *Prior Authorization/Exception Request Process* section.

Prior Authorization/Exception Request Process/Step Therapy

Some Drugs and Drug quantities require prior approval for Medical Necessity before they are eligible for coverage under the Outpatient Prescription Drug Benefit. This process is called prior authorization.

The following Drugs require prior authorization:

- Some Formulary, Non-Formulary, compound Drugs, and most Specialty Drugs require prior authorization.
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.
- Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance.

Blue Shield covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug,

- There are no FDA-approved, commercially available, medically appropriate alternative,
- The compounded medication is self-administered, and
- Medical literature supports its use for the diagnosis.

You must pay the Non-Formulary Brand Drug Copayment or Coinsurance for covered compound Drugs.

You, your Physician or Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, we will provide prior authorization approval or denial, based upon Medical Necessity, 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

Prior authorization decisions are based on the following:

1. The requested Drug, dose, and/or quantity is both safe and Medically Necessary for the specified use.
2. You have tried and failed Formulary alternative(s), or they are inappropriate.
3. You are stable on treatment, and changing to an alternative may cause immediate harm.
4. You have tried and failed Drug(s) recommended as initial treatment, or they are inappropriate.
5. Relevant clinical information supports the use of the requested medication over Formulary Drug alternatives.

To request coverage for a Non-Formulary Drug, you, your representative or Health Care Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If step therapy coverage requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, you, your Physician or Health Care Provider can file a grievance with Blue Shield, as described in the Grievance Process section.

Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment will be assessed for each 30 day supply except as otherwise stated below. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity.

2. Designated Specialty Drugs may be dispensed for a 15-day trial at a pro-rated Copayment or Coinsurance for an initial prescription, and with the Member's agreement. This Short Cycle Specialty Drug Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Specialty Drug before obtaining the complete 30-day supply, and therefore helps save the Member out-of-pocket expenses. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the Short Cycle Specialty Drug Program, which the Member can elect at that time. At any time, either the Member, or Provider on behalf of the Member, may choose a full 30-day supply for the first fill.

If the Member has agreed to a 15-day trial, the Network Specialty Pharmacy will also contact the Member before dispensing the remaining 15-day supply to confirm if the Member is tolerating the Specialty Drug. To find a list of Specialty Drugs in the Short Cycle Specialty Drug Program, the Member may visit <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or call the Customer Service number on the Blue Shield Member ID card.

3. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.
4. Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
5. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

No Benefits are provided under the Outpatient Prescription Drug Benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of your combined Evidence of Coverage and Disclosure Form – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage and Drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible;
2. Any drug provided or administered while the Member is an Inpatient, or in a Physician's office, Skilled Nursing Facility, or Outpatient Facility (see the Professional Services and Hospital Services sections of your combined Evidence of Coverage and Disclosure Form);
3. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facility (see the Hospital Services and Skilled Nursing Facility Services sections of your combined Evidence of Coverage and Disclosure Form);
4. Except as specifically listed as covered under this Outpatient Prescription Drug Supplement, drugs which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
6. Drugs that are considered to be experimental or investigational;
7. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment, Prosthetic Appliances and the Orthoses section of your combined Evidence of Coverage and Disclosure Form). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
8. Blood or blood products (see the Hospital Services section of your combined Evidence of Coverage and Disclosure Form);
9. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
10. Dietary or Nutritional Products (see the Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy section of your combined Evidence of Coverage and Disclosure Form);
11. Any Drugs which are not self-administered. These medications may be covered under the Other Outpatient Services, Hospice Program Services Benefits, and the Family Planning and Infertility Services Benefits of the health plan;
12. All Drugs for the treatment of infertility.
13. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
14. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) require a Physician's prescription, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: refer to your medical Benefits for coverage of other contraceptive methods;
15. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and, (4) medical literature supports its use for requested diagnosis;
16. Replacement of lost, stolen or destroyed prescription Drugs;
17. For Members enrolled in a Hospice Program through a Participating Hospice Agency only pharmaceuticals that are medically necessary for the palliation and management of terminal illness and related conditions are excluded from coverage under the Outpatient Prescription Drug Benefits, and are covered under the Hospice Program Benefits;
18. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection, medications prescribed to treat pain, or drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;
19. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered Emergency;
20. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;

PENDING REGULATORY APPROVAL

21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
22. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

See the Grievance Process portion of your combined Evidence of Coverage and Disclosure Form for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Definitions

Anticancer Medications — Drugs used to kill or slow the growth of cancerous cells.

Brand Drugs — Drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which has the same brand as that of the manufacturer with the original FDA approval.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips and test tablets), (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B, (6) contraceptive Drugs and devices, including female OTC contraceptive drugs and devices, including diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives and emergency contraceptives, including female OTC contraceptive products when ordered by a Physician, (7) inhalers and inhaler spacers for the management and treatment of asthma.

Note: To be considered for coverage, all Drugs require a valid prescription by the Member's Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically.

Generic — Drugs that (1) are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent or authorized generic to the Brand Drug, (2) contain the same active ingredient as the Brand Drug, and (3) typically cost less than the Brand Drug equivalent.

Network Specialty Pharmacy— select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs.

To select a Specialty Pharmacy, you may go to <http://www.blueshieldca.com> or call the toll-free Member Services number on your Blue Shield Identification Card.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary Drug alternatives.

Non-Participating Pharmacy — a pharmacy which does not participate in the Blue Shield Pharmacy Network.

Participating Pharmacy — a pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members. Note: the Mail Service Pharmacy is a Participating Pharmacy.

To select a Participating Pharmacy, you may go to <http://www.blueshieldca.com> or call the toll-free Member Services number on your Blue Shield Identification Card

Specialty Drugs - Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available exclusively at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost

Acupuncture and Chiropractic Services Rider

Summary of Benefits

HMO

This Summary of Benefits shows the amount you will pay for Covered Services under this acupuncture and chiropractic services Benefit.

Benefits

Your payment

<i>Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.</i>	When using an ASH Participating Provider	When using a Non-Participating Provider
Acupuncture Services		
Office visit		
<i>30 Acupuncture visits per Member, per Calendar Year</i>	\$15/visit	Not covered
Chiropractic Services		
Office visit		
<i>30 Chiropractic visits per Member, per Calendar Year</i>	\$15/visit	Not covered
Chiropractic appliances, per Calendar Year	All charges above \$50	Not covered

Benefit designs may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Co-payment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders, nausea and pain.

Benefits include an initial examination, subsequent office visits and Acupuncture treatment.

Acupuncture Services that are Covered Services include but are not limited to the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues (e.g. Carpal Tunnel, Tennis Elbow);
- stroke rehabilitation;
- menstrual cramps;
- back and neck pain; and
- nausea.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders, and pain.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- laboratory tests;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

PENDING REGULATORY APPROVAL

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

Exclusions

Acupuncture services Benefits do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your Evidence of Coverage for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
 American Specialty Health Plans of California, Inc.
 P.O. Box 509002
 San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Services to Members.
Nausea	An unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative Nausea and vomiting, and Nausea of pregnancy
Musculoskeletal and Related Disorders	Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your Evidence of Coverage.

Infertility Services Rider
Summary of Benefits

Group Rider
HMO

This Summary of Benefits shows the amount you will pay for Covered Services under this Infertility services Benefit.

Benefits	Your payment	
	When using a Participating Provider	When using a Non-Participating provider
Infertility Services	50% of the Allowed Charges	Not covered
<i>Services are not subject to any applicable Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.</i>		

Assisted Reproductive Technology (ART) Procedures and Associated Services

Lifetime Benefit Maximums

Natural artificial inseminations <i>Without ovum [oocyte or ovarian tissue (egg)] stimulation</i>	6/lifetime
Stimulated artificial inseminations <i>With ovum [oocyte or ovarian tissue] stimulation</i>	3/lifetime
Gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), or Zygote intrafallopian transfer (ZIFT);	2/lifetime
Intracytoplasmic sperm injection (ICSI);	
Elective single embryo transfer, including preparation of embryo for transfer	
Preimplantation genetic screening for embryo biopsy preimplantation genetic diagnosis (PGD);	
Cryopreservation of sperm, oocytes, embryos <i>When retrieved from a Subscriber, spouse or Domestic Partner. Includes one retrieval and a year of storage per person</i>	1/lifetime

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

Benefit designs may be modified to ensure compliance with State and Federal requirements.

Introduction

Only the Subscriber, spouse or Domestic Partner is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, and ancillary services and injectable drugs when authorized by the Primary Care Physician, to a Subscriber, spouse or Domestic Partner covered for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth.

Benefits

Benefits are provided for a Subscriber, spouse or Domestic Partner who has a current diagnosis of Infertility for a medically appropriate diagnostic work-up and ART procedures.

Benefits include cryopreservation services for a condition which the treating Physician anticipates will cause Infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). The Subscriber, spouse or Domestic Partner is responsible for the Copayment listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered or prescribed by the provider during a course of treatment to induce fertilization. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

Exclusions

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the EOC;
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Subscriber, spouse or Domestic Partner;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above;
- Covered Services in excess of the lifetime Benefit maximums; or
- Services for or incident to a condition which the Subscriber, spouse, or Domestic Partner anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of sperm/oocytes/ovarian tissue/embryos.

Benefits are limited to a Subscriber, spouse, or Domestic Partner covered hereunder who has diagnosed Infertility as defined at the time services are provided.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC

PENDING REGULATORY APPROVAL

Handy Numbers

If your Family has more than one Blue Shield HMO Primary Care Physician, list each Family member's name with the name of his or her Physician.

Family Member _____

Primary Care Physician _____

Phone Number _____

Family Member _____

Primary Care Physician _____

Phone Number _____

Family Member _____

Primary Care Physician _____

Phone Number _____

Important Numbers:

Hospital _____

Pharmacy _____

Police Department _____

Ambulance _____

Poison Control Center _____

Fire Department _____

General Emergency _____ *911* _____

*HMO Customer Service
Department (See back page of this combined Evidence of Coverage and Disclosure Form)*

For Mental Health Services and information, call the MHSA at 1-877-263-9952.

Contacting Blue Shield of California

For information contact your appropriate Blue Shield of California location.

Members may call Customer Service toll free at 1-855-256-9404

The hearing impaired may call Blue Shield's Customer Service Department through Blue Shield's toll-free TTY number at 1-800-241-1823.

Please direct correspondence to:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

W0051448 (1/19)

201901HMOEOC

PENDING REGULATORY APPROVAL