Added Advantage POS Plan℠

Evidence of Coverage

California Association of Professional Employees Benefit Trust

Classic Option

Group Number: W0052320-M0009179

Effective Date: January 1, 2016

Blue Shield of California

Evidence of Coverage

Added Advantage POS Plan

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

This Evidence of Coverage (EOC) 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 EOC, 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 EOC. The Summary of Benefits sets forth the Member's share-of-cost for Covered Services under the benefit plan.

Please read this EOC 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 EOC that apply to any special health care needs.

For questions about this plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this EOC.

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 EOC .

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 EOC, 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 EOC 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**.

Grandfathered Health Plan Notice

Blue Shield believes this plan/policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy is not required to include certain consumer protections of the Affordable Care Act that apply to other plans; however, even though they are not required to be included, all of the protections of the Affordable Care Act are included in your current plan/policy.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the Customer Service Department number on your identification card. If you obtain this plan/policy through your Employer and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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 Personal 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 Personal 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 Personal 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 EOC 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 EOC.
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 Personal 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 Personal 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 Abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for non-emergency Mental Health and Substance Abuse Hospital admission and Non-Routine Outpatient Mental Health and Substance Abuse Services.

Table of Contents

POS Summary of Benefits

The Summary of Benefits is provided with, and is incorporated as part of, the EOC. It sets forth the Member's share-of-costs for Covered Services under the benefit plan. Please read both documents carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this benefit plan.

See the end of this Summary of Benefits for footnotes providing important benefit footnotes.

Summary of Benefits — Added Advantage POS Plan

Calendar Year Medical Deductible	Member Deductible Responsibility		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Calendar Year Medical Deductible	None	$300 per Member/ $600 per Family [4]	

Calendar Year Out-of-Pocket Maximum [3]	Member Maximum Calendar Year Out-of-Pocket Amount[5]		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Calendar Year Out-of-Pocket	$1,500 per Member / $3,000 per Family	$4,000 per Member / $8,000 per Family	$6,000 per Member / $12,000 per Family

Maximum Lifetime Benefits	Maximum Blue Shield Payment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Lifetime Benefit Maximum	No maximum	No maximum	

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Allergy Testing and Treatment Benefits			
Allergy serum purchased separately for treatment	50%	50%	50%
Office visits (includes visits for allergy serum injections)	You pay nothing	10%	30%
Ambulance Benefits			
Emergency or authorized transport	$50	10%	10%
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.			
Ambulatory Surgery Center Outpatient Surgery facility services	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Ambulatory Surgery Center Outpatient Surgery Physician Services	You pay nothing	10%	30%
Bariatric Surgery All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.			
Bariatric Surgery Benefits for residents of designated counties in California Under Level II, all bariatric surgery Services for residents of designated counties in California must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See the Bariatric Surgery Benefits section, the paragraphs under Bariatric Surgery Benefits For Residents of Designated Counties in California, in the Plan Benefits section of the EOC for further details.			
Hospital Inpatient Services	You pay nothing	10%	Not covered
Hospital Outpatient Services	$50 per surgery	10%	Not covered
Physician bariatric surgery Services	You pay nothing	10%	Not covered

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Bariatric Surgery Benefits for residents of non-designated counties in California			
Hospital Inpatient Services	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Hospital Outpatient Services	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Physician bariatric surgery Services	You pay nothing	10%	30%
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits			
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Covered Services for Members who have been accepted into an approved clinical trial when prior authorized by Blue Shield. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.	You pay nothing	Not covered	Not covered
Diabetes Care Benefits			
Devices, equipment, and supplies	You pay nothing	You pay nothing	You pay nothing
Diabetes self-management training- office location	$10 per visit	$20 per visit (deductible waived)	30%
Dialysis Center Benefits			
Dialysis Services Note: Dialysis services may also be obtained from a Hospital. Dialysis services obtained from a Hospital will be paid at the Participating or Non-Participating level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	You pay nothing	10%	30% of up to $350 per day (Blue Shield payment not to exceed $210 per Member per day)
Durable Medical Equipment Benefits			
Breast pump	You pay nothing	You pay nothing	You pay nothing
Other Durable Medical Equipment	You pay nothing	You pay nothing	You pay nothing

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Emergency Room Benefits			
Emergency room Physician services Note: Under all Benefit Levels, after services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Participating and Non- Participating Provider levels as specified under Professional (Physician) Benefits, "Outpatient Physician services, other than an office setting" in this Summary of Benefits.	You pay nothing	You pay nothing	You pay nothing
Emergency room Services not resulting in admission Note: Under all Benefit Levels, after services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Participating and Non- Participating Provider levels as specified under Hospital Benefits (Facility Services), "Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies" in this Summary of Benefits.	$50 per visit	$50 per visit	$50 per visit
Emergency room Services resulting in admission (Billed as part of inpatient Hospital services)	You pay nothing	You pay nothing	You pay nothing

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Family Planning Benefits Note: Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the appropriate facility benefit in this Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), intrauterine device (IUD), and tubal ligation.			
Counseling and consulting (Including)	You pay nothing	$20 per visit (deductible waived)	30%
Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives	$10 per visit	$20 per visit (deductible waived)	30%
Diaphragm fitting procedure	You pay nothing	You pay nothing	You pay nothing
Implantable contraceptives	You pay nothing	$20 per visit	30%
Infertility Services	50%	$20 per visit	30%
Injectable contraceptives	You pay nothing	$20 per visit	30%
Insertion and/or removal of Intrauterine Device (IUD)	You pay nothing	$20 per visit	30%
Intrauterine device (IUD)	You pay nothing	$20 per visit	30%
Tubal ligation	You pay nothing	50%	50%
Vasectomy	$75 per surgery	50%	50%
Hearing Aid Benefits			
Hearing Aid Services with maximum payment of $1,000 per Member, every 24 months	You pay nothing	Not covered	Not covered
Home Health Care Benefits			
Home health care agency services (including home visits by a nurse; home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist) Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. If your benefit plan has a Calendar Year Medical Deductible, the number of visits start counting toward the maximum when services are first provided even if the Calendar Year Medical Deductible has not been met.	$10 per visit	10%	Not covered[6]
Medical supplies	You pay nothing	10%	Not covered[6]

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Home Infusion/Home Injectable Therapy Benefits			
Hemophilia home infusion services Services provided by a hemophilia infusion provider and prior authorized by Blue Shield. Includes blood factor product.	You pay nothing	10%	Not covered[6]
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit if selected as an optional Benefit by your Employer, and are described in a Supplement included with this booklet.	You pay nothing	10%	Not covered[6]
Home visits by an infusion nurse Home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation	$10 per visit	10%	Not covered[6]
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program. The Hospice Program Benefit must be prior authorized by Blue Shield and must be received from a Participating Hospice Agency.			
24-hour Continuous Home Care	You pay nothing	Not covered	Not covered
Short term Inpatient care for pain and symptom management	You pay nothing	Not covered	Not covered
Inpatient Respite Care	You pay nothing	Not covered	Not covered
Pre-hospice consultation	You pay nothing	Not covered	Not covered
Routine home care	You pay nothing	Not covered	Not covered

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Hospital Benefits (Facility Services)			
Inpatient Facility Services Semi-private room and board, services and supplies, including Subacute Care	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Inpatient skilled nursing services, including Subacute Care Up to a maximum of 100 days per Member, per Calendar Year, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your benefit plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Inpatient services to treat acute medical complications of detoxification	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Outpatient dialysis services	You pay nothing	10%	30% of up to $350 per day (Blue Shield payment not to exceed $210 per Member per day)
Outpatient Facility services	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Outpatient services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity.			
Ambulatory Surgery Center Outpatient Surgery facility services	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Inpatient Hospital services	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Office location	$10 per visit	$20 per visit (deductible waived)	30%
Outpatient department of a Hospital	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)

Mental Health Benefits Benefits and Member Copayments All Level I Non-Emergency Services must be referred or authorized by the Mental Health Service Administrator (MHSA)			
	LEVEL I Care authorized by the MHSA or provided by MHSA Participating Providers for "HMO Plan" level of Benefits	**LEVEL II** There are no separate Mental Health or Substance Abuse Benefit payments under Level II	**LEVEL III**[3] Member use of MHSA Non-Participating Providers for "Non-Preferred" Plan level of Benefits.
Mental Health and Substance Abuse Benefits[7] All Services provided through Blue Shield's Mental Health Service Administrator (MHSA).			
Inpatient Mental Health and Substance Abuse Services			
Inpatient Hospital Services	You pay nothing		30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Inpatient Professional (Physician) Services	You pay nothing		30%
Residential care for Mental Health Condition	You pay nothing		30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Residential care for Substance Abuse Condition	You pay nothing		30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Non-Routine Outpatient Mental Health and Substance Abuse Services			
Behavioral Health Treatment in home or other non-institutional setting	You pay nothing		30%
Behavioral Health Treatment - office location	You pay nothing		30%
Intensive Outpatient Program	You pay nothing		30%
Electroconvulsive therapy (ECT)[9]	You pay nothing		30%
Office-based opioid treatment: Outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment[9]	You pay nothing		30%
Partial Hospitalization Program[8]	You pay nothing		30% per episode of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Psychological Testing to determine mental health diagnosis (outpatient diagnostic testing)	You pay nothing		30%
Transcranial Magnetic Stimulation	You pay nothing		30%
Routine Outpatient Mental Health and Substance Abuse Services			
Professional (Physician) office visits	$10 per visit		30%

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Orthotics Benefits			
Office visits	$10 per visit	$20 per visit (deductible waived)	30%
Orthotic equipment and devices	You pay nothing	You pay nothing	You pay nothing
Outpatient Prescription Drug Benefits Outpatient Prescription Drug coverage if selected as an optional Benefit by your Employer, is described in a Supplement included with this booklet.			
Outpatient X-Ray, Pathology, Laboratory Benefits			
Mammography and Papanicolaou test	You pay nothing	10%	30%
Outpatient Diagnostic X-Ray, Pathology, Diagnostic Examination and Clinical Laboratory Services	You pay nothing	10%	30%
PKU Related Formulas and Special Food Products Benefits			
PKU	You pay nothing	10% of billed charges	10% of billed charges
Podiatric Benefits			
Podiatric Services -- office location	$10 per visit	$20 per visit (deductible waived)	30%
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Covered Services section of the EOC. Services will be covered as any other surgery as noted in this Summary of Benefits.			
Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Prenatal and preconception Physician office visit: initial visit	You pay nothing	$20 per visit (deductible waived)	30%
Prenatal and preconception Physician office visit: subsequent visits. See Outpatient X-Ray, Pathology, and Laboratory Benefits for prenatal genetic testing.	You pay nothing	$20 per visit (deductible waived)	30%
Postnatal Physician office visit	You pay nothing	$20 per visit (deductible waived)	30%
Abortion services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility coinsurance may apply.	You pay nothing	10%	30%

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Preventive Health Benefits			
Preventive Health Services See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the EOC, for more information.	You pay nothing	You pay nothing	You pay nothing
Professional (Physician) Benefits			
Inpatient Physician Services For bariatric surgery Services see the Bariatric Surgery section in this Summary of Benefits	You pay nothing	10%	30%
Outpatient Physician Services, other than an office setting	You pay nothing	10%	30%
Physician home visits	$25 per visit	10%	30%
Physician office visits For mammography and Papanicolaou test, a woman may self-refer to an OB/GYN or family practice Physician in the Personal Physician's Medical Group/IPA.)	$10 per visit	$20 per visit (deductible waived)	30%
Teladoc consultations Teladoc consultation Services provide confidential consultations using a network of board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. over secure video, 7 days a week. See the Principal Benefits and Coverages section, Professional (Physician) Benefits for detailed information.	$15 per visit	Not covered	Not covered
Prosthetic Appliances Benefits			
Office visits	$10 per visit	$20 per visit (deductible waived)	30%
Prosthetic equipment and devices	You pay nothing	You pay nothing	You pay nothing
Reconstructive Surgery Benefits For Physician services for these Benefits, see the "Professional (Physician) Benefits" section of the Summary of Benefits.			
Ambulatory Surgery Center outpatient surgery facility services	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Inpatient Hospital services	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Outpatient department of a Hospital	$50 per surgery	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.			
Office location	$10 per visit	10%	30%
Outpatient department of a Hospital	$10 per visit	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Skilled Nursing Facility (SNF) Benefits			
Skilled nursing services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing SNF. If your Plan has a Calendar Year Medical Deductible, the number of days start counting toward the day maximum even if the Calendar Year medical Deductible has not been met.	You pay nothing	10%	10%

Benefit	Member Copayment		
	LEVEL I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.	**LEVEL II[2]** Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits.	**LEVEL III[3]** Member use of non-Blue Shield Participating Provider for "Non-Preferred" Plan level of Benefits.
Speech Therapy Benefits Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.			
Office location	$10 per visit	10%	30%
Outpatient department of a Hospital	$10 per visit	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Transplant Benefits - Tissue and Kidney Organ Transplant Benefits for transplant of a cornea, kidney or skin.			
Hospital Services	You pay nothing	10%	30% of up to $600 per day (Blue Shield payment not to exceed $420 per Member per day)
Professional (Physician) Services	You pay nothing	10%	30%
Transplant Benefits - Special Blue Shield requires prior authorization for all Special Transplant Services, and all services must be provided at a Special Transplant Facility designated by Blue Shield.			
Facility Services in a Special Transplant Facility	You pay nothing	Not covered	Not covered
Professional (Physician) Services	You pay nothing	Not covered	Not covered
Urgent Services Benefits			
Urgent services inside the Personal Physician's Service Area and not rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	Not covered	$20 per visit	30%
Urgent services inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	$10 per visit	$20 per visit	30%
Urgent Services outside the Personal Physician's Service Area, within California	$10 per visit	N/A	N/A
Urgent Services outside the Personal Physician's Service Area, outside of California	$10 per visit	See Applicable Benefit	See Applicable Benefit

Summary of Benefits
Footnotes:

[1] Benefits under Level I must be provided or authorized by your Personal Physician (and/or the Medical Group/IPA associated with your Personal Physician or MHSA, except in an emergency, for Urgent Services outside your Personal Physician's Service Area, or as otherwise specified in this EOC. The Member is responsible for payment for services that are not authorized, when authorization is required.

[2] Benefits under Level II are accessed from Participating Providers (and MHSA Participating Providers), who have agreed to provide Covered Services to Members at a negotiated rate ("Allowable Amount"). Copayments under Level II benefits are calculated from the Allowable Amount. The Member may also be responsible for an additional payment for services from MHSA Participating Providers that are not referred or authorized, when referral or authorization for those services is required.

[3] Benefits under Level III are accessed from Non-Participating Providers (and MHSA Non-Participating Providers). The Member is responsible for any Copayments, Coinsurance, and any amounts in excess of the Allowable Amount for Covered Services provided by Non-Participating Providers (and MHSA Non-Participating Providers).

[4] The Covered Services listed below (as they appear in the Summary of Benefits) are not subject to, and will not accrue to, the Calendar Year Medical Deductible.

Bariatric surgery: covered travel expenses for bariatric surgery
Durable medical equipment: breast pump

[5] Under Level I Benefits, Copayments or Coinsurance for Covered Services accrue to the Calendar Year Out-of-Pocket Maximum, except Copayments or Coinsurance for Covered Services listed in the following sections of this Summary of Benefits:

Charges in excess of specified benefit maximums
Bariatric surgery: covered travel expenses for bariatric surgery,
Any optional Infertility Benefits
Any optional vision Benefits
Any optional hearing aid benefit
Any optional dental Benefits.

Copayments or Coinsurance for Emergency Services received from Non-Participating Providers accrue to the Calendar Year Out-of-Pocket Maximum established for Services by Participating Providers.

Note: Copayments, Coinsurance, and charges for services not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

[6] Services from a Non-Participating Home Health Care/Home Infusion Agency are not covered unless prior authorized. When Services are authorized, the Level II Copayment applies.

[7] Prior authorization from the MHSA is required for all non-Emergency or non-Urgent Inpatient Services, and Non-Routine Outpatient Mental Health and Substance Abuse Services. No prior authorization is required for Routine Outpatient Mental Health and Substance Abuse Services – Professional (Physician) Office Visit.

[8] For Non-Routine Outpatient Mental Health and Substance Abuse Services - Partial Hospitalization Program Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.

[9] The Member's Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.

The Blue Shield Added Advantage POS Health Plan

Introduction to the Blue Shield Added Advantage POS Health Plan

The Added Advantage POS Health Plan offers a wide choice of Physicians, Hospitals and Non-Physician Health Care Practitioners. Members have 3 Benefit options called "Levels" to choose from when obtaining medical care. The choice made at the time a Member needs medical care will determine the out-of-pocket costs.

This Blue Shield of California (Blue Shield) EOC 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 EOC.

Please read this EOC 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 Personal Physician in the coordination and authorization of Covered Services; Member responsibilities such as payment of Copayments, Coinsurance and Deductibles; and obtaining prior authorization for certain services (see the *Benefits Management Program* section).

Capitalized terms in this EOC 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 EOC.

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.

Under the Added Advantage POS Plan, each Member will have a personal physician. Deciding whether to obtain medical care from or through a Personal Physician will determine the level of Benefits received and the out-of-pocket costs.

Three Levels of Benefits

The following three Benefit levels (or options) are available under the Blue Shield POS Plan when a Member seeks medical care:

Level I

Level I is the "HMO Plan" level of Benefits. This Level provides the highest level of Benefits — i.e., HMO Plan Benefits at the lowest out-of-pocket cost. Members will be covered under Level I only when care is provided by (1) the Member's Personal Physician, (2) any provider authorized by the Member's Personal Physician (3) a Mental Health Service Administrator (MHSA) Participating Provider or (4) any provider for Emergency Services as defined in the Plan Benefits section. Members will only be responsible for the Level I Copayments.

To determine whether a Level I provider is an HMO Plan Provider, access Blue Shield's Internet site at http://www.blueshieldca.com, or call Customer Service at the telephone number provided on the back page of this EOC . Note: A Level I HMO Plan Provider's status may change. Members are obligated to verify whether the chosen provider is a still an HMO Plan Provider.

Level II

Level II is the Participating Provider "Preferred Plan" level of Benefits. Level II provides Members with the second highest level of Benefits. Benefits under Level II are provided when a Member chooses to receive medical care from a Blue Shield Participating Provider. Referral or authorization by the Member's Personal Physician is not required, but Services are subject to the prior authorization requirements of the Benefits Management Program. Members will be responsible for the Level II Copayments of the Plan. However, Members will not be required to pay any difference between the Participating Provider's actual charges and the Allowable Amount, except as set forth in the section on Reductions - Third Party Liability.

To determine whether a Level II provider is a Participating Provider, access Blue Shield's Internet site at http://www.blueshieldca.com, or call Customer Service at the telephone number provided on the back page of this EOC. Note: A Level II Participating Provider's status may change. Members are obligated to verify whether the chosen provider is a still a Participating Provider.

Level III

Level III is the non-Participating/non-Preferred level of Benefits. A Member may choose any provider who is not a Blue Shield or MHSA Participating Provider, at a higher out-of-pocket cost to the Member. Services are subject to the prior authorization requirements of the Benefits Management Program and a Member will be responsible for the Level III deductibles and Copayments of the POS Plan (which are higher than under Level I or Level II), and any payments as set forth in the section on Reductions - Third Party Liability.

When services are rendered by a Blue Shield or MHSA non-Participating Provider, Members are also responsible for any difference between the provider's actual charges and the Allowable Amount.

Please review this booklet, which summarizes the general provisions and operation of your POS Plan.

If you have any questions regarding the information, you may contact the Blue Shield POS Customer Service Department at the number provided on the back page of this EOC.

Role of the Personal Physician

To receive Level I medical Benefits, the Personal Physician chosen by the Member at the time of enrollment must coordinate all Covered Services including primary care, preventive services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological Physician services and Mental Health and Substance Abuse Services), Hospice admission through a Participating Hospice Agency, Emergency Services, Urgent Services and Hospital admission. The Personal Physician will also manage prior authorization when needed. When services are not coordinated with the Member's Personal Physician, the Member is responsible for payment of Covered Services under Level II or Level III Benefits.

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.

Selecting a Personal Physician

Each Member must select a general practitioner, family practitioner, internist, obstetrician/gynecologist, or pediatrician as their Personal Physician at the time of enrollment. Individual Family members must also designate a Personal Physician, but each may select a different provider as their Personal Physician. A list of Added Advantage POS 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 EOC for assistance in selecting a Personal Physician.

The Member's Personal 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 Personal Physician at the time of enrollment, Blue Shield will designate a Personal Physician and the Member will be notified. This designation will remain in effect until the Member requests a change.

A Personal Physician must also be selected for a newborn or child placed for adoption within 90 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 Personal Physician. For the month of birth, the Personal Physician must be in the same Medical Group or Independent Practice Association (IPA) as the mother's Personal 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 Personal Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If a Personal Physician is not selected for the child within 90 days following the birth or placement for adoption, Blue Shield will designate a Personal Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first 90 days following the birth or when placement for adoption occurred.

To change the Personal Physician for the child after the first 90 days following the birth or placement for adoption, see the section below on *Changing Personal Physicians or Designated Medical Group or IPA.*

Remember that if you want your child covered beyond the 90 days from the date of birth or placement for adoption, you must inform your Employer who will notify Blue Shield as explained in the Plan Service Area and Eligibility section of this EOC.

The child must be enrolled with Blue Shield to continue coverage without lapse, beyond the first 31 days from the date of birth or placement for adoption. See the *Eligibility and Enrollment* section for additional information.

Personal Physician Relationship

The Physician-patient relationship is an important element of a POS Plan. The Member's Personal 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 Personal 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 EOC for assistance in selecting a new Personal Physician.

If a Member is not able to establish a satisfactory relationship with his or her Personal Physician, Blue Shield will provide access to other available Personal Physicians.

Obstetrical/Gynecological (OB/GYN) Physician Services (Benefit is Provided Only under Level I)

Under Level I, 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 Personal Physician without a referral from the Personal 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 Personal 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.

Referral to Specialty Services

To receive specialty services under Level I, Members must have the Specialty services provided or arranged by their Personal Physician.

When the Personal 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 Personal 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 Personal 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 Personal 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 EOC.

Level II: Use of Blue Shield Participating Providers

Under Level II, a Member may choose to receive Covered Services from any Blue Shield Participating Provider without referral or authorization by the Member's Personal Physician, subject to the prior authorization requirements of the *Benefits Management Program*.

Level III: Use of Non-Blue Shield Participating Providers

Under Level III, a Member may choose to receive covered medical services, including second medical opinions, from a Blue Shield non-Participating Provider without referral or authorization by the Member's Personal Physician, subject to the prior authorization requirements of the *Benefits Management Program*.

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

Role of the Medical Group or IPA

Most Blue Shield HMO Personal Physicians contract with a Medical Group or IPA to share administrative and authorization responsibilities (some Personal Physicians contract directly with Blue Shield). The Personal 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 Personal 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 Personal Physician to authorize Covered Services and ensure that Covered Services are performed by Plan Providers.

The Member's Personal Physician and Medical Group/IPA are listed on the Member's identification card.

Changing Personal Physicians or Designated Medical Group or IPA

Members may change their Personal Physician or Medical Group/IPA by calling Customer Service at the number provided on the back page of this EOC or by submitting a Member Change Request Form to the Customer Service Department. If the selected Medical Group/IPA does not have an affiliation with the Member's Personal Physician, a change in Medical Group/IPA may also require the Member to select a new Personal Physician.

Changes in Medical Group/IPA or Personal Physician are effective the first day of the month following notice of approval by Blue Shield. Once the change of Personal Physician is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN services 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 new authorizations must be obtained. Members may call Customer Service for assistance with Personal 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 Personal Physician or Medical Group/IPA during an on-going course of treatment may interrupt care. For this reason, while obtaining HMO Plan (Level I) Benefits, the effective date of a Personal 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 Personal 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 EOC.

If a Member's Personal Physician terminates participation in the Plan, Blue Shield will notify the Member in writing and designate a new Personal Physician who is immediately available to provide the Member's medical care. Members may also make their own selection of a new Personal Physician within 15 days of this notification. The Mem-

ber's selection must be approved by Blue Shield prior to receiving any Covered Services under the Plan.

Mental Health and Substance Abuse Services

Blue Shield contracts with a Mental Health Service Administrator (MHSA) to underwrite and deliver all Mental Health and Substance Abuse Services through a unique network of MHSA Participating Providers. All non-emergency Mental Health and Substance Abuse Hospital admissions and Non-Routine Outpatient Mental Health and Substance Abuse Services must be arranged through and authorized by the MHSA. Members are not required to coordinate Mental Health and Substance Abuse Services through their Personal Physician.

Level I: MHSA Participating Providers

For Level I, all Mental Health and Substance Abuse 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 Personal Physician, may also contact the MHSA directly at 1-877-263-9952 to obtain this information.

Mental Health and Substance Abuse Services received from an MHSA Non-Participating Provider will not be covered at Level I 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.

For coverage at Level I, all non-emergency Mental Health and Substance Abuse inpatient Hospital admissions including Residential Care, and Non-Routine Outpatient Mental Health and Substance Abuse Services must be prior authorized by the MHSA. For prior authorization of Mental Health and Substance Abuse 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 and Substance Abuse Hospital admission or for any Non-Routine Outpatient Mental Health and Substance Abuse 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 and Substance Abuse Hospital admission.

Level III: MHSA Non-Participating Provider

Under Level III, you may choose to receive covered Mental Health and Substance Abuse Services from an MHSA Non-Participating Provider

Prior authorization for all non-emergency Mental Health and Substance Abuse inpatient Hospital admissions including Residential Care, and Non-Routine Outpatient Mental Health and Substance Abuse Services is still required under Level III. See the Benefits Management Program, the *Prior Authorization for Mental Health and Substance Abuse Hospital Admissions and Non-Routine Outpatient Services* section, for complete information..

Continuity of Care by a Terminated Provider (Applies to Level I and Level II only)

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.

Financial Responsibility for Continuity of Care Services (does not apply to Level I)

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Preferred Provider in the same geographic area.

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 Personal Physician to another Physician for a second medical opinion. The Member's Personal Physician may also offer a referral to another Physician for a second opinion.

If the second opinion involves care provided by the Member's Personal 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 Specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the Medical Group/IPA.

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 Services Department at the number provided on the back page of this EOC.

Level I Urgent Services While Traveling

The Blue Shield POS Plan provides coverage for you and your family for your urgent service needs when you or your family are temporarily traveling outside of your Personal Physician Service Area.

Urgent Services are defined as those Covered Services rendered outside of the Personal 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 Personal 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 Personal Physician Service Area

If you require urgent care for a condition that could reasonably be treated in your Personal 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 Personal 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 Personal Physician Service Area.

Outside of California

The Blue Shield POS Plan provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described herein, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Level I Follow-up Services

Level I Out-of-Area Follow-up Care is covered and services may be received through the BlueCard Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. To receive Level I services, Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Customer Service 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 provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Follow-up care is also covered through a Blue Shield of California Provider and may also be received from any provider. However, when outside your Personal Physician Service Area 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 the Personal 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 Personal Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Personal 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 for Emergency Services received anywhere in the world for emergency care of an illness or injury.

For Emergency Services from a 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 Allowable Amount 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 Personal Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization.

An emergency means 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.

If a Member receives non-authorized services under circumstances that Blue Shield determines were not a situation in which a reasonable person would believe that an emergency condition existed, the services will not be covered under Level I. Benefits will be determined under Level II or Level III subject to the applicable deductible Copayments and Coinsurance.

Inpatient, Home Health Care, Hospice Program and Other Medical Services Under Level I

Under Level 1 of the Plan, a Member's Personal Physician is responsible for obtaining prior authorization before a Member is admitted to the Hospital or a Skilled Nursing Facility, or receives home health care and certain other services, or before a Member can be admitted into a Hospice Program through a Participating Hospice Agency.

If a Member's Personal Physician determines that a Member should receive any of these services, the Personal Physician will request authorization. If Blue Shield determines that the requested Service is Medically Necessary, then the Member's Personal Physician will arrange for the admission to the Hospital or Skilled Nursing Facility, including Subacute Care admissions, or to a Hospice Program through a Participating Hospice Agency, as well as for the provision of home health care and other services. See the Benefits Management Program for additional Level II and Level III information.

NurseHelp 24/7 SM

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 Personal 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.

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

Level I ("HMO Plan" Level of Benefits / MHSA Participating Providers)

There is no Calendar Year Medical Deductible under Level I.

Level II (PPO In Network)

There are no Mental Health or Substance Abuse Benefits under Level II.

For services provided under Level II the Calendar Year Medical Deductible is the amount an individual must pay for Covered Services from Participating Providers each year before Blue Shield begins payment in accordance with this EOC and Health Service Agreement. This Deductible does not accrue 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 Level II Calendar Year Medical Deductible applies to a particular Covered Service.

Once the individual Deductible is reached, Covered Level II Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

Level III (PPO Out of Network Level of Benefits / MHSA Non-Participating Providers)

For services provided under Level III, the Calendar Year Medical Deductible is the amount an individual must pay for Covered Services from Blue Shield and MHSA Non-Participating Providers each year before Blue Shield begins payment in accordance with this EOC and Health Service Agreement. This Deductible does not accrue 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 Level III Calendar Year Medical Deductible applies to a particular Covered Service.

Once the individual Deductible is reached, Covered Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

For Covered Services from PPO Out of Network Providers and MHSA Non-Participating Providers the Member is responsible for the applicable Copayment and Coinsurance and for any amounts billed in excess of the Allowable Amount. Charges in excess of the Allowable Amount do not accrue to the Calendar Year Medical Deductible.

Calendar Year Out-of-Pocket Maximum –

Level I ("HMO Plan" Level of Benefits / MHSA Participating Providers)

The Calendar Year Out-of-Pocket Maximum is the highest Copayment and Coinsurance amount an individual is required to pay for designated Covered Services each year. 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.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amount. When the individual maximum is reached, Covered Services will be paid at 100% of the Allowable Amount or contracted rate for the remainder of the Calendar Year.

Charges for services that are not covered and charges in excess of the Allowable Amount or 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.

Level II ("Preferred Plan" Blue Shield PPO Network Participating Provider Level of Benefits)

There are no Mental Health or Substance Abuse Benefits under Level II.

Under Level II, this is the maximum amount an individual is required to pay for Covered Services provided by Participating Providers. The Calendar Year Medical Deductible under Level II will not accumulate toward this 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 this Calendar Out-of-Pocket Maximum.

The Summary of Benefits provides the Level II individual Calendar Year Out-of-Pocket Maximum amount for Participating Providers. When the maximum is reached, Covered Services will be paid by Blue Shield at 100% of the Allowable Amount or contracted rate for the remainder of the Calendar Year.

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

Level III ("Non-Preferred Plan" Level of Benefits)

Under Level III, this is the maximum amount an individual is required to pay for Covered Services provided by Blue Shield and MHSA Non-Participating Providers. The Calendar Year Medical Deductible under Level III will not accumulate toward this 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 this Calendar Out-of-Pocket Maximum.

The Summary of Benefits provides the Level III Calendar Year Out-of-Pocket Maximum amount for Non-Participating Providers. When the maximum is reached, Covered Services will be paid at 100% of the Allowable

Amount or contracted rate for the remainder of the Calendar Year.

For Covered Services from PPO Out of Network Providers and MHSA Non-Participating Providers the Member is responsible for the applicable Copayment and Coinsurance and for any amounts billed in excess of the Allowable Amount. Charges for services that are not covered and charges in excess of the Allowable Amount or contracted rate do not accrue to the Level III Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Level III Calendar Year Out-of-Pocket Maximum is reached.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for Covered Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call Blue Shield of California at the Customer Service telephone number listed on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers or you can go on-line at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide".

Inter-Plan Programs

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. Blue Shield's payment practices in both instances are described in this booklet.

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, Blue Shield will remain responsible for fulfilling our contractual obligations. However the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member copayment and deductible amounts, if any, as stated in this EOC.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed covered charges for your covered services; or

2) The negotiated price that the Host Plan makes available to Blue Shield.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan 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 under-estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

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

Claims for Emergency and Out-of-Area Urgent Services

Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record for payment to the Plan, within one year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered under Level I, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. The services will be covered under Level II or Level III, subject to the applicable deductibles, Copayments and requirements of the Plan. In the event covered medical transportation services are obtained in such an emergency situation, the Blue Shield Health Plan shall pay the medical transportation provider directly.

Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating BlueCard Program provider, the Member must submit a complete claim with the Urgent Service record for payment to the Plan, within one year after the first provision of Urgent Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Urgent Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. If the Plan determines that the services would not have been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

If the Plan determines that the services are not covered as Urgent Services under Level I, the services will be covered under Level II or Level III subject to the applicable deductibles, Copayments and requirements of the Plan.

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 EOC to request a copy.

Benefits Management Program for Level II and Level III Benefits

This section does not apply if a Member receives Benefits from or through a Personal Physician under Level I.

The Benefits Management Program applies utilization management and case management principles to assist Members and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this health plan.

The Benefits Management Program includes prior authorization requirements for inpatient admissions, selected inpatient and outpatient services, office-administered injectable drugs, home-infusion-administered drugs, and PKU related formulas and Special Food Products as well as emergency admission notification, and inpatient utilization management. The program also includes Member services such as, discharge planning, case management and, palliative care services.

The following sections outline the requirements of the Benefits Management Program.

Prior Authorization

Prior authorization allows the Member and provider to verify with Blue Shield or Blue Shield's MHSA that (1) the proposed services are a Benefit of the Member's plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Member and provider when Benefits are limited to services rendered by Participating Providers or MHSA Participating Providers (See the Summary of Benefits).

A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Member and provider within two business days of the decision. For urgent services when the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Member's condition, not to exceed 72 hours from receipt of the request.

If prior authorization was not obtained, and 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 for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Member or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed within California on an outpatient, non-emergency basis:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedures utilizing nuclear medicine

For authorized services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained and the radiological or nuclear imaging 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 for Medical Services Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical services and Drugs that require prior authorization. Members are encouraged to work with their providers to obtain prior authorization. Members and providers may call Customer Service at the number provided on the back page of this EOC to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

Failure to obtain prior authorization for hemophilia home infusion products and services, home infusion/home injectable therapy, PKU related formulas and Special Food Products or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage.

To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back page of this EOC.

For authorized services and Drugs from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to services rendered by a Participating Provider. If prior authorization was not obtained and the medical services or Drugs provided to the Member are determined not to be a Benefit of the plan, were not medically necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, Special Transplant and bariatric surgery. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When inpatient Hospital admission is authorized to a Non-Participating Hospital, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained for an inpatient Hospital admission 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 Hospital admission; See the *Emergency Admission Notification* section for additional information.

Prior Authorization for Mental Health or Substance Abuse Hospital Admissions and Non-Routine Outpatient Services

Prior authorization is required for all non-emergency mental health or substance abuse Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Non-Routine Outpatient Mental Health and Substance Abuse Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Office-Based Opioid Treatment (OBOT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA.

If prior authorization was not obtained for an inpatient mental health or substance abuse Hospital admission or for any Non-Routine Outpatient Mental Health and Substance Abuse 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.

For an authorized admission to a Non-Participating Hospital or authorized Non-Routine Outpatient Mental Health and Substance Abuse Services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency mental health or substance abuse Hospital admission; See the *Emergency Admission Notification* section for additional information.

Emergency Admission Notification

When a Member is admitted to the Hospital for Emergency Services, Blue Shield, or Blue Shield's MHSA should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an inpatient Hospital stay may be extended or reduced as warranted by the Member's condition. When a determination is made that the Member no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Member. If discharge does not occur within 24 hours of notification, the Member is responsible for all inpatient charges accrued beyond the 24 hour time frame.

Maternity Admissions: the minimum length of the inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter inpatient stay is adequate.

Mastectomy: The length of the inpatient stay is determined post-operatively by the attending Physician in consultation with the Member.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield or Blue Shield's MHSA will work with the Member, the attending Physician and the Hospital discharge planners to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Member access necessary services and to make the most efficient use of plan Benefits. The Member's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Member, the provider, and Blue Shield or Blue Shield's MHSA, and will not exceed the standard Benefits available under this plan.

The approval of alternative benefits is specific to each Member for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this health plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other Member in any other instance.

Palliative Care Services

In conjunction with Covered Services, Blue Shield provides palliative care services for Members with serious illnesses. Palliative care services include access to physicians and nurse case managers who are trained to assist Members in managing symptoms, in maximizing comfort, safety, autonomy and well-being, and in navigating a course of care. Members can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Members may call the Customer Service Department to request more information about these services.

Principal Benefits and Coverages (Covered Services)

Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurances, charges in excess of Benefit maximums, Participating Provider provisions, and Benefits Management Program provisions

These services and supplies are covered only when Medically Necessary, and is subject to all terms, conditions, limitations and exclusions of the Contract, including any conditions or limitations set forth in the Benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions set forth in this EOC. 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 Personal 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 EOC. All services are provided under Levels I, II and III except as otherwise stated.

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 may be specifically indicated, for services received from Non-Participating Providers, Subscribers will be responsible for all charges above the Allowable Amount in addition to the indicated Copayment or Coinsurance amount.

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 from one medical facility to another.

Ambulatory Surgery Center Benefits

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

Bariatric Surgery Benefits

Benefits are provided for Hospital and professional services in connection with bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, from Blue Shield. Prior authorization is required for services received under Levels I, II and III for all Members, whether the Member is a resident of a designated or non-designated county.

Note: The following paragraphs do not apply to Members obtaining bariatric surgery services under Level I (HMO Plan Level) or to Members obtaining bariatric surgery services under Level II or Level III if those Members are residents of non-designated counties. (A list of designated counties is provided below.) Bariatric surgery services under Level I, or under Level II and III for residents of non-designated counties, will be paid as any other surgery as described elsewhere in this Plan Benefits section when:

1. services are consistent with Blue Shield's medical policy; and,
2. prior authorization is obtained, in writing, from Blue Shield's Medical Director.

For bariatric surgery services under Level I or under Levels II and III for residents of non-designated counties, travel expenses associated with bariatric surgery services are not covered.

Level II Bariatric Surgery Services for Residents of Designated Counties

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric services*, Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1) performed at a Hospital or Ambulatory Surgery Center and by a Physician, that have both (facility and Physician) contracted with Blue Shield as a Bariatric Surgery Services Provider to provide the bariatric surgery services; and,
2) the services are consistent with Blue Shield's medical policy; and,
3) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

*See the list of designated counties below.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric Benefits and to make a decision regarding Benefits based on: 1) the medical circumstances of each patient; and 2) consistency between the treatment proposed and Blue Shield medical policy.

For Members who reside in a designated county and obtain bariatric surgery services under Level II, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Hospital or Ambulatory Surgery Center and by a Physician participating as a Bariatric Surgery Services Provider will result in denial of claims for this Benefit.

Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must also be provided by a Physician participating as a Bariatric Surgery Services Provider.

The following are the designated counties in which Blue Shield has designated Bariatric Surgery Services Providers to provide bariatric surgery services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement For Level II Bariatric Surgery Services for Residents of Designated Counties

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric services at a Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider. All requests for travel expense reimbursement must be prior authorized by Blue Shield. Approved travel-related expenses will be reimbursed as follows:

1) Transportation to and from the facility up to a maximum of $130 per round trip:
   a) for the Member for a maximum of three trips:
      i) one trip for a pre-surgical visit,
      ii) one trip for the surgery, and
      iii) one trip for a follow-up visit.
   b) for one companion for a maximum of two trips:
      i) one trip for the surgery, and

ii) one trip for a follow-up visit.

2) Hotel accommodations not to exceed $100 per day:

   a) for the Member and one companion for a maximum of two days per trip,

      i) one trip for a pre-surgical visit, and

      ii) one trip for a follow-up visit.

   b) for one companion for a maximum of four days for the duration of the surgery admission.

      i) Hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3) Related expenses judged reasonable by Blue Shield not to exceed $25 per day per Member up to a maximum of four days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

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

Benefits are provided under Level I only 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 Personal Physician, and:

1) the clinical trial has a therapeutic intent and the Personal 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 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 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.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the *Outpatient Prescription Drug Benefits* section.

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 Personal 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, 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 professionally 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. For the lowest out-of-pocket expenses, covered non-Emergency Services and emergency room follow-up services (e.g., suture removal, wound check, etc.) should be authorized by Blue Shield or obtained through the Member's Personal Physician.

Emergency Services are services provided for an unexpected 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 (Benefit provided only under Level I)

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. In addition, if the non-Plan Hospital is unable to determine the contact information for Blue Shield in order to request prior authorization, the non-Plan Hospital may bill the Member for such services. Members should contact Customer Service at the number provided on the back page of the EOC for questions regarding improper billing for services received from a non-Plan Hospital.

Family Planning 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. (Benefits provided only under Level I)

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

The Level II /Level III Calendar Year Deductible applies only to sterilizations and benefits under Level III for Counseling and Consulting and Physician Office Visits.

Hearing Aid Benefits

1. Audiological Evaluation. To measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

2. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a one-year period following the provision of a covered hearing aid.

Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period and replacement of a hearing aid more than once in any period of 24 months. Also excludes surgically implanted hearing devices.

Benefits are limited to a combined maximum of $1,000 per Member during any 24 consecutive month period.

Home Health Care Benefits

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

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. 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 Personal 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, 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. When services are authorized, they are covered under Level II.

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. (Note: most Participating home health care and home infusion agencies are not Participating Hemophilia Infusion Providers.) 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 EOC.

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

Following evaluation by the Member's Personal 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, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

Hospice Program Benefits

Benefits are provided for services through a Hospice Agency when an eligible Member requests prior authorization, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by their Personal 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 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 personal 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 Personal 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 Personal Physician recertifies that the Member is Terminally Ill.

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 abuse 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 abuse detoxification is authorized through the Member's Personal 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 90 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized.

Covered Physical Therapy, Occupational Therapy and Speech Therapy services provided in an outpatient Hospital setting are described under the *Rehabilitation and Habilitation Benefits (Physical, Occupational and Respiratory Therapy)* and *Speech Therapy Benefits* 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 Abuse Benefits – Level I (HMO) Benefits

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

Routine Outpatient Mental Health and Substance Abuse Services

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

Non-Routine Outpatient Mental Health and Substance Abuse Services

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

1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including 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 Abuse 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 Abuse Conditions.

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

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

Mental Health and Substance Abuse Benefits – Level III (MHSA Non-Participating) Benefits*

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services and Substance Abuse Services for Blue Shield Members within California. See the *Out-Of-Area Program, Blue-Card Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health and Substance Abuse Services, including Residential Care, and Non-Routine Outpatient Mental Health and Substance Abuse Services are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the *Benefits Management Program* section for complete information.

Routine Outpatient Mental Health and Substance Abuse Services

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

Non-Routine Outpatient Mental Health and Substance Abuse Services

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

Non-Routine Outpatient Mental Health and Substance Abuse Services

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

1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including 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 Physician or licensed psychologist and provided under a treatment plan approved by the MHSA.

   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 Abuse 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 Abuse Conditions.

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

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

Benefits are provided for X-ray services, diagnostic testing, clinical pathology, and laboratory services.

Benefits are provided 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 prior authorized, 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.

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 90 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized.

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, as defined, are covered.

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*.

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 90 days of birth;

8) Office administered Injectable medications approved by the Food and Drug Administration (FDA) as prescribed or authorized by the Personal 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 consultation 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 Physician's office is closed or 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 urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

    This Teladoc service is only available to Members in California. 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 Physician but are a supplemental service. You do not need to contact your 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, the applicable Outpatient Prescription Drug Benefits Copayments and requirements will apply. Teladoc consultation services are not available for mental health and substance abuse services consultations.

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

Professional services by providers other than Physicians are described elsewhere under Covered Services.

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 Abuse 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. These contact lenses will not be covered under this plan if the Member has coverage for contact lenses through a Blue Shield vision plan;

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.

Rehabilitation and Habilitation 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* section.

See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitation 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 for services received under all Levels combined, 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

Benefits are provided for Medically Necessary Outpatient Speech Therapy services when ordered by a 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.

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, or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield, (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 Personal Physician Service Area, call your Personal 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 Personal Physician Service Area, Members may receive care for Urgent Services as follows:

Inside California

For Urgent Services within California but outside the Member's Personal 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 Obtaining Medical Care 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. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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 Program participating provider. When a BlueCard Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. If you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. See *Claims for Emergency and Out-of-Area Urgent Services* in the How to Use This Health Plan section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

For Level I services, 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. To receive Level I services, Blue Shield may direct the Member to receive the additional follow-up care from their Personal Physician.

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a Physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the How to *Use This Health Plan* section. See *BlueCard Program* in the *How to Use This Health Plan* section for additional information.

Members before traveling abroad may call their local Member Services office for the most current listing of providers or they can go on line at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide". However, a Member is not required to receive Urgent Services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

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 Infu-

sion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;

8) hearing aids, except as specifically provided under Hearing Aid Benefits;

9) 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;

10) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

11) 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;

12) 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 the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

13) 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);

14) for Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages).

15) 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.

16) for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

17) Level I only: For or incident to the treatment of Infertility, except the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

18) 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;

19) services incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits;

20) home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

21) genetic testing except as described in the sections on Outpatient X-ray, Pathology and Laboratory Benefits;

22) services performed in a Hospital by house officers, residents, interns, and others in training;

23) services performed by a Close Relative or by a person who ordinarily resides in the Member's home;

24) services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under *Mental Health and Substance Abuse Benefits*;

25) massage therapy that is not Physical Therapy or a component of a multimodality rehabilitation treatment plan;

26) 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;

27) 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 re-

quired by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

28) 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;

29) 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;

30) 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;

31) patient convenience items such as telephone, television, guest trays, and personal hygiene items;

32) 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 the Durable Medical Equipment Benefits, Home HealthCare, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

33) services for which the Member is not legally obligated to pay, or for services for which no charge is made;

34) 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; and

35) for spinal manipulation and adjustment, except as specifically provided under *Professional (Physician) Benefits* in the Plan Benefits section;

36) for transportation services other than provided under *Ambulance Benefits* in the Plan Benefits section;

37) for inpatient and Non-Routine Outpatient Mental Health and Substance Abuse Services unless authorized by the MHSA.

38) Drugs dispensed by a Physician or Physician's office for outpatient use; and

39) services not specifically listed as a Benefit.

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 (1) because the Member does not receive the full amount of damages that the Member claimed or (2) 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:

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.

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 that would have been considered the initial enrollment date, 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*, you must inform your Employer who will notify Blue Shield within 90

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.

*To continue coverage of a newborn or a child placed for adoption beyond the first 31 days without lapse in coverage, you must inform your Employer who will notify Blue Shield within 31 days from the date of birth or placement of a child for adoption.

Coverage is never automatic; you need to inform your Employer who will notify Blue Shield.

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 EOC 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 fails or refuses to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the plan, he or she will immediately lose eligibility to continue enrollment.

Subject to the requirements described under the Continuation of Group Coverage provision in this EOC , 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.

Dependents may be enrolled within 90 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 that would have been considered your initial enrollment date or at the Employer's next Open Enrollment Period. Blue Shield will not consider 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 90 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 45 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 12-month 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 of 30 days 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 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 45-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 your Employer does not notify Blue Shield within 90 days following the Dependent's effective date of coverage for a newborn or a child placed for adoption, Benefits under this Plan will be terminated for those Dependents on the 31st day 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 noti-

fied 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.

Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

3) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, 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.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

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.

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 102 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 EOC.

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, 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 – Level I

Blue Shield generally contracts with groups of Physicians to provide Level I services to Members. A fixed, monthly fee is paid to the groups of Physicians for each Member whose Personal 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 EOC or talk to their Plan Provider.

Payment of Providers – Level III

Under Level III, Members are reimbursed directly by Blue Shield for Covered Services rendered by a non-Blue Shield Participating Provider. Requests for payment must be submitted to Blue Shield within 1 year after the month services were provided. Special claim forms are not necessary, but each claim must contain the Member's name, home address, group contract number, Member number, a copy of the provider's billing showing the services rendered, dates of treatment, and the patient's name and relationship to the Member. Blue Shield will notify you of its determination within 30 days after receipt of the claim.

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

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 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 EOC, 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 the Blue Shield Plan at the telephone number as noted on the back page of this EOC. 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.

Blue Shield 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. 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.

Mental Health and Substance Abuse 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 EOC.

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 the Member has a grievance against their health plan, he or she should first telephone the health plan at **1-855-256-9404** and use the health 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 the Member. If the Member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the health plan, or a grievance that has remained unresolved for more than 30 days, the Member may call the Department for assistance. The Member may also be eligible for an Independent Medical Review (IMR). If the Member is 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.hmohelp.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 for the Subscriber or their Dependents and the Subscriber feels that such action was due to reasons of health or utilization of benefits, the Subscriber or their 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 EOC.

For all Mental Health and Substance Abuse Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and Substance Abuse Services, MHSA Participating Providers, or Mental Health and Substance Abuse 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

ERISA Information

The following information has been provided to Blue Shield of California by your employer and is being reprinted in your EOC booklet at the express request of your employer.

Blue Shield of California makes no representation of any kind that this information is accurate (other than clerical accuracy) or sufficient to meet requirements for disclosure of summary plan information under ERISA.

If you have any questions about this information, they should be directed to your employer.

Summary Plan Description

The Employee Retirement Income Security Act of 1974 (ERISA) requires that you be furnished certain information regarding your employee welfare benefit plan.

If this Summary Plan Description fails to answer your questions regarding any aspect of the plan, you should contact the Plan Administrator named below who will be pleased to help you understand fully your rights and obligations under the plan.

Employer's Name and Address:

County of Los Angeles
Chief Administrative Office
3333 Wilshire Blvd., 10th Floor
Los Angeles, CA 90010-4101

Employer's Identification Number (EIN):

95-6995453

Name of Plan:

California Association of Professional Employees Benefit Trust

Plan Number:

501

Plan Description:

Group health service plan.

Contract Year:

The plan year ends on December 31, 2016.

Type of Administration:

The Plan is administered by contract.

Plan Administrator:

California Association of Professional Employees Benefit Trust
3018 E. Colorado Blvd., Ste. 200
Pasadena, CA 91107

Service of legal process should be directed to the Plan Administrator.

Name of Trustee:

California Association of Professional Employees Benefit Trust
3018 E. Colorado Blvd., Ste. 200
Pasadena, CA 91107

Funding of Plan:

Employees who participate in the Plan or in one or more of the components of the Plan are required to make contributions to the Plan for coverage. The Employer, in its sole and absolute discretion, shall determine the amount of any required employee contributions under the Plan and may increase or decrease the amount of the required contribution at any time. The Employer may require different contribution levels for different classes of employees. The Employer will notify eligible employees annually as to what the employee contribution rates will be. Employer shall contribute the difference between the amount employees contribute and the rates for the group health plan coverage. Any experience credits or refunds under a group contract shall be applied first to reimburse the Employer for its contributions, unless otherwise provided in that group contract or required by applicable law. Voluntary coverages are entirely paid by employees.

Health Care Service Plan Issuer:

The medical benefits in this EOC are guaranteed under a contract issued by the issuer. The issuer provides various administrative services including claims administration. The issuer of the contract is Blue Shield of California, 50 Beale Street, San Francisco, California, 94105.

Eligibility:

Refer to the Eligibility provision of this booklet.

Termination of Benefits:

Refer to the Termination of Benefits provision of this booklet.

The Employer reserves the right to discontinue or change the plan at any time, subject to any applicable legal requirements for prior notice.

Benefits:

Refer to the Plan Benefits provision of this booklet.

To Claim Benefits:

Refer to the reimbursement provisions of this booklet.

Statement of ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following:

1. Receive Information About Your Plan and Benefits

    a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the plan, including Group Health Service Contracts, and a copy of the latest annual report (Form 5500 Series)filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

    b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including the Group Health Service Contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description.. The administrator may make a reasonable charge for the copies.

    c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

    a. Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

    b. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or Health Care Service Plan issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

    c. California law also limits the circumstances under which a group health plan may exclude coverage for medical conditions present before an individual enrolled. The California law applies only to in-

surance and HMO contracts issued, amended, delivered or renewed in California.

3. Prudent Actions by Plan Fiduciaries

   In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

   a. If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to this decision without charge, and to appeal any denial, all within certain time schedules.

   b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

   c. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

When the following terms are capitalized in this EOC, they will have the meaning set forth below:

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.

Allowable Amount (**Allowance)** — the total amount Blue Shield allows for Covered Service(s) rendered, or the provider's billed charge for those Covered Services, whichever is less. The Allowable Amount, unless specified for a particular service elsewhere in this EOC, is:

1) For a Participating Provider: the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.

2) For a Non-Participating Provider who provides Emergency Services, anywhere within or outside of the United States:

   a) Physicians and Hospitals – the amount is the Reasonable and Customary Charge; or

   b) All other providers – the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield Plan have agreed upon some other amount.

3) For a Non-Participating Provider in California (including an Other Provider), who provides services (other than Emergency Services): the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or

   a) Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable and Customary Charge.

4) For a provider outside of California (within or outside of the United States), that has a contract with the local Blue Cross and/or Blue Shield Plan: the amount that the provider and the local Blue Cross and/or Blue Shield Plan have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.

5) For a Non-Participating Provider outside of California (within or outside of the United States) that does not

contract with a local Blue Cross and/or Blue Shield Plan, who provides services (other than Emergency Services): the amount that the local Blue Cross and/or Blue Shield Plan would have allowed for a non-participating provider performing the same services. Or, if the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

Allowed Charges — the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan providers (except that Physicians rendering Emergency Services, Hospitals which are not Plan Providers rendering any services, and non-contracting dialysis centers rendering any services when authorized by the Plan will be paid based on the Reasonable and Customary Charge, as defined).

Alternate Care Services Provider —refers to a supplier of Durable Medical Equipment, or a certified orthotist, prosthetist, or prosthetist-orthotist.

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.

Bariatric Surgery Services Provider — a contracting Hospital, Ambulatory Surgery Center, or a Physician that has been designated by Blue Shield to provide bariatric surgery services to Members who are residents of designated counties in California (described in the Covered Services section of this EOC).

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.

Blue Shield of California – a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this EOC, 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) A state health benefits high risk pool.

8) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.

9) 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.

10) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).

11) 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, and who is not legally separated from the Subscriber.

2) A Dependent Domestic Partner is an individual is 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. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

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:

   i) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   ii) 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

   iii) thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:

      (1) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

      (2) 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.

Doctor of Medicine — a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

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 sex 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 Services — services provided for an emergency medical condition, including a psychiatric emergency medical condition, or active labor, 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 means the following with respect to 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) — the County of Los Angeles, Chief Administrative Office, 3333 Wilshire Blvd., 10th Floor, Los Angeles, CA 90010.

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.

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.

Habilitation Services – Medically Necessary services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health care condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Respite care, day care, recreational care, Residential Care, social services, Custodial Care, or education services of any kind are not considered Habilitative Services.

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 Level I Benefits ("HMO Plan" level of benefits) and for Mental Health and Substance Abuse 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.

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) the presence of a demonstrated bodily malfunction recognized by a licensed Physician as a cause of not being able to conceive; or

2) for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or

3) for women over age 35, failure to achieve a successful pregnancy (live birth) after six months or more of regular unprotected intercourse; or

4) failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (The initial six cycles are not a benefit of this Plan); or

5) three or more pregnancy losses.

Intensive Outpatient Program — an outpatient Mental Health or Substance Abuse 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.

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.

   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 Rehabilitation that can be provided on an outpatient basis.

4) 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 in 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 MHSA to underwrite and deliver Blue Shield's Mental Health and Substance Abuse Services through a separate network of MHSA 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 MHSA for the provision of Mental Health or Substance Abuse Services.

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

Non-Participating or Non-Preferred (Non-Participating Provider or Non-Preferred Provider) — refers to any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members.

This definition does not apply to providers of Mental Health and Substance Abuse Services, which is defined separately under the MHSA Non-Participating Provider definition.

Non-Routine Outpatient Mental Health and Substance Abuse Services – Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Abuse 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.

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.

Other Providers —

1) Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; licensed acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2) Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and outpatient clinics not MD-owned; portable X-ray companies; independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

Out-of-Pocket Maximum - the highest 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 and charges in excess of the Allowable Amount 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.

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 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 or Preferred (Participating Provider or Preferred Provider) – refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members.

This definition does not apply to providers of Mental Health Services and Substance Abuse Services, which is defined separately under the MHSA Participating Provider definition.

Period of Care – the timeframe the Personal 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.

Personal 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 Personal 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.

Personal Physician Service Area — that geographic area served by the Member's Personal 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. For Level II and Level III Benefits, the term Physician also includes a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Plan — the Blue Shield Added Advantage POS Health Plan and/or Blue Shield of California.

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

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 Personal Physician. For all Mental Health and Substance Abuse Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

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

Plan Specialist — a Physician other than a Personal 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 according to an authorized referral by a Personal Physician. For all Mental Health and Substance Abuse 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 EOC .

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.

Rehabilitation — 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. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care — Mental Health or Substance Abuse 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 thera-

pist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Routine Outpatient Mental Health and Substance Abuse Services – professional (Physician) office visits for the diagnosis and treatment of Mental Health and Substance Abuse Conditions, including the individual, Family or group setting.

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 and will be required to furnish Blue Shield written evidence of loss of coverage, 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 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 was the reason for declining enrollment provided that, if he was covered under another employer health plan, 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 90 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 food product that is specially formulated to have less than one gram of protein per serving;

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 rehabilitation 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 Abuse Condition — drug or alcohol abuse or dependence.

Substance Abuse Services — services provided to treat a Substance Abuse 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 Personal 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 Personal Physician Service Area.

This EOC should be retained for your future reference as a Member of the Blue Shield Added Advantage POS 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 booklet.

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 Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք 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 لغوية مجانية. يمكنك الحصول على مترجم شفهي للتحدث إلى وقراءة المستندات الخاصة بك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المطبوع على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

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ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ 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 និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន 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

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Outpatient Prescription Drug Benefits

Summary of Benefits

Member Calendar Year Brand Drug Deductible	Deductible Responsibility	
	Participating Pharmacy	**Non-Participating Pharmacy**
Per Member There is no Brand Drug Deductible requirement.	$0	

Benefit	Member Copayment	
	Participating Pharmacy[1]	**Non-Participating Pharmacy**
Retail Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Diabetic Testing Supplies	$0 per prescription	Not covered
Formulary Generic Drugs	$5 per prescription	Not covered
Formulary Brand Drugs	$15 per prescription	Not covered
Non-Formulary Brand Drugs	$30 per prescription	Not covered
Mail Service Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Diabetic Testing Supplies	$0 per prescription	Not covered
Formulary Generic Drugs	$10 per prescription	Not covered
Formulary Brand Drugs	$30 per prescription	Not covered
Non-Formulary Brand Drugs	$60 per prescription	Not covered
Specialty Pharmacies		
Specialty Drugs	20% - $100 maximum[3]	Not covered

[1] Coinsurance is calculated based on the contracted rate.

[2] There is no Copayment or Coinsurance for contraceptive drugs and devices, however, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. If the Brand contraceptive drug is Medically Necessary, it may be covered without a Copayment or Coinsurance with prior authorization. The difference in cost does not accrue to the Calendar Year Brand Drug Deductible, Medical Deductible, or Out-of-Pocket Maximum.

[3] Includes oral Anticancer Medications.

This plan's 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 plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more any time after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Outpatient Prescription Drug Benefits

In addition to the Benefits found in your Blue Shield EOC, your plan also provides coverage for Outpatient Prescription Drugs described in this supplement. 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.

Coverage for selected Drugs may be limited to a specific quantity as described in "Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most Generic Drugs. The fact that a Drug is listed on the Blue Shield Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

Benefits may be provided for Non-Formulary Drugs subject to higher Copayments.

Members may access the Drug Formulary at http://www.blueshieldca.com/bsca/pharmacy/home.sp. Members may also call Customer Service at the number provided on the back of the EOC to inquire if a specific drug is included in the Formulary or to obtain a printed copy.

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 — 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. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

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 — Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancer, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain Drugs at a Participating Pharmacy, the Member must present his Blue Shield Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Blue Shield Identification Card will be denied.

Benefits are provided for Specialty Drugs only when obtained from a Network Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Specialty Drugs that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.

The Member is responsible for paying the applicable Copayment for each prescription Drug at the time the Drug is obtained.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Participating Pharmacy at the time the Drug is obtained, until the Brand Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

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 the Member requests a Brand Drug when a Generic Drug equivalent is available, and the Brand Drug Deductible has been satisfied (when applicable), the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

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

Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency.

Reimbursement for covered emergency claims will be based upon the purchase price of the covered prescription Drug(s) less any applicable Copayment(s). Claims must be received within 1 year of the date of service to be considered for payment. Claim forms are available upon request from the Blue Shield Service Center. Submit a completed Prescription Drug Claim form noting "Emergency Request" on the form, to Blue Shield Pharmacy Services, P.O. Box 7168, San Francisco, CA 94120.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

When Drugs have been prescribed for a chronic condition, a Member may obtain the Drug through Blue Shield's Mail Service Prescription Drug Program by enrolling online or by phone or mail. Members should allow 14 days to receive the Drug. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

The Member is responsible for the applicable Mail Service Prescription Drug Copayment for each prescription Drug.

For more information about the Mail Service Prescription Drug Program or to determine applicable cost share,, Members may visit https://www.blueshieldca.com/bsca/pharmacy/home.sp or call the Customer Service number on your Blue Shield Member ID card.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy's contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Brand Drug to the Mail Service Pharmacy prior to your prescription being sent to you, until the Brand Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices). For more information about the Mail Service Prescription Drug Program or to determine applicable cost share, or to obtain information on deductible amounts, Members may visit https://www.blueshieldca.com/bsca/pharmacy/home.sp or call the Customer Service number on your Blue Shield Member ID card.

If the Member requests a Mail Service Brand Drug when a Mail Service Generic Drug is available, the Member is responsible for the difference between the contracted rate for the Mail Service Brand Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

If the prescribing Physician requests a Mail Service Brand Drug when a Mail Service Generic Drug equivalent is available, the Member is responsible for paying the applicable Mail Service Brand Drug Copayment.

Prior Authorization Process for Select Formulary, Non-Formulary and Specialty Drugs

Select Formulary Drugs, as well as Specialty Drugs may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compounded drugs are covered only if the requirements listed under the Exclusion section of this Supplement are met. If a compounded medication is approved for coverage, the Non-Formulary Brand Drug Copayment applies. You or your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within two business days.

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. Initial prescriptions for select Specialty Drugs may be limited to a quantity not to exceed a 15 day supply. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated based on the number of days' supply.
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 EOC – 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 EOC);
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 EOC);
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 EOC). 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 EOC);
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 EOC);
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) are ordered by a Physician, (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;
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 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 *Blue Shield EOC.*

Acupuncture and Chiropractic Services Benefits

Summary of Benefits

Benefit	Member Copayment
Covered Services as described in this Supplement and authorized by American Specialty Health Plans of California, Inc. (ASH Plans)	**LEVEL I** **Care by or authorized by Personal Physician for "HMO Plan" level of Benefits.**
Acupuncture Services	
Office Visit	$10 per visit[1]
Chiropractic Services	
Office Visit	$10 per visit[1]
Benefit	**Maximum Blue Shield Payment**
Chiropractic Appliances	$50 per Calendar Year[1]

[1] Chiropractic and acupuncture Services are only provided under Level I.
[2] Member is responsible for all charges above the maximum payment indicated.

Introduction

In addition to the Benefits listed in your *EOC*, your Plan provides coverage for acupuncture and chiropractic Services as described in this Supplement.

Benefits

Acupuncture Services

Benefits are provided for Medically Necessary acupuncture Services as shown on the Summary of Benefits for acupuncture care when received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. This Benefit includes an initial examination and subsequent office visits and acupuncture Services specifically for the treatment of Neuromusculo-skeletal Disorders, Nausea and Pain, as authorized by ASH Plans up to the Benefit maximum specified above. Acupuncture Services that are Covered Services include but are not limited to the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation, and tennis elbow. Covered Services do not include services for treatment of asthma or addiction (including without limitation, smoking cessation). Covered Services also do not include vitamins, minerals, nutritional supplements (including herbal supplements) or other similar products.

Benefits are only provided for Services received from Level I providers, except as noted below.

Services provided by other than Level I providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no Level I Participating Providers. A provider who is not a Level I provider is an acupuncturist or chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to Members.

Chiropractic Services

Benefits are provided for Medically Necessary chiropractic Services for routine chiropractic care when received from an ASH Plans Participating Provider. This Benefit includes an initial examination and subsequent office visits, adjustments, and conjunctive therapy specifically for the treatment of Neuromusculo-skeletal Disorders as authorized by ASH Plans up to the Benefit maximum specified above. Benefits are also provided for X-rays.

Chiropractic appliances are covered up to the maximum in a Calendar Year as shown on the Summary of Benefits as authorized by ASH Plans.

You will be referred to your Personal Physician for evaluation of conditions not related to a Neuromusculo-skeletal Disorder, and for evaluation for non-covered services such as diagnostic scanning (CAT Scans or MRIs).

Benefits are only provided for Services received from Level I providers, except as noted below.

Services provided by other than Level I providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no Participating Providers. A provider who is not a Level I provider is an acupuncturist or chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to Members.

These chiropractic and acupuncture Benefits as described above are separate from your health Plan; however, the general provisions, limitations and exclusions described in your EOC do apply. A referral from a Member's physician is not required. All Covered Services must be prior authorized by ASH Plans, except for (1) the Medically Necessary initial examination and treatment by a Participating Provider; and, (2) Emergency Services.

NOTE: ASH Plans will respond to all requests for prior authorization within 5 business days from receipt of the request.

If you have questions, you may call the ASH Plans Member Services Department at 1-800-678-9133, or write to: American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

Note: Members should exhaust the Covered Services (Benefits) listed and obtained through this Supplement before accessing and utilizing the same services through the "Alternative Care Discount Program". (Members may access the following web site for information on the Wellness Discount Programs: http://www.blueshieldca.com.)

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. ASH Plans should be contacted for questions about acupuncture and chiropractic Services, ASH Plans Participating Providers, or acupuncture and chiropractic Benefits. You may contact ASH Plans at the telephone number or address which appear below:

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.

Grievance Process

Members may contact the Blue Shield Member Services Department by telephone, letter or on-line to request a review of an initial determination concerning a claim or service. Members may contact the Plan at the telephone number as noted in the back of your EOC booklet. If the telephone inquiry to Member Services does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Member Services Representative will initiate on the Member's behalf.

The Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from Member Services. The completed form should be submitted to Member Services at the address as noted in the back of your EOC booklet. The Member may also submit the grievance online by visiting our web site at http://www.blueshieldca.com.

Blue Shield will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the following paragraph for information on the expedited decision process.

Note: Blue Shield of California has established a procedure for our Members to request an expedited decision. A Member, Physician, or representative of a Member may 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 within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Blue Shield of California's Member Services Department at the number provided in the back of your EOC booklet.

NOTE: If your employer's 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 your claim have been completed and your claim has not been approved.

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.

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.

Neuromusculo-skeletal Disorders – conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunc-

tion of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures) and related to neurological manifestations or conditions.

Pain – a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

Participating Provider (Level I) – a Participating chiropractor, Participating acupuncturist or other licensed health care provider under contract with ASH Plans to provide Covered Services to Members.

Please be sure to retain this document. It is not a contract but is a part of your *Blue Shield Added Advantage POS* EOC.

Handy Numbers

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

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*Family Member*_____

Personal Physician _____

Phone Number _____

*Family Member*_____

Personal Physician _____

Phone Number _____

*Family Member*_____

Personal Physician _____

Phone Number _____

Important Numbers:

*Hospital*_____

Pharmacy _____

Police Department _____

*Ambulance*_____

Poison Control Center _____

Fire Department _____

*General Emergency*_____*911*_____

*Blue Shield POS Member Services Department (See back page of this booklet)*_____

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.

For prior authorization:

Please call the Customer Service telephone number listed above.

For prior authorization of inpatient Mental Health and Substance Abuse Services:

Please contact the Mental Health Service Administrator at 1-877-263-9952.

Please refer to the *Benefits Management Program* section of this EOC for additional information on prior authorization.

Please direct correspondence to:

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