Blue Shield PPO

Provider Network: Exclusive

Evidence of Coverage and Health Service Agreement

Individual and Family Plans

An independent member of the Blue Shield Association

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Blue Shield of California

Blue Shield PPO

Evidence of Coverage and Health Service Agreement

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Premiums, Blue Shield agrees to provide the Benefits of this Agreement.

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

Please read this Evidence of Coverage and Health Service Agreement 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 that apply to any special health care needs.

Blue Shield provides a matrix summarizing key elements of this Blue Shield health plan at the time of enrollment. This matrix allows individuals to compare the health plans available to them. The Evidence of Coverage and Health Service Agreement is available for review prior to enrollment in the plan. For questions about the this plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this Evidence of Coverage.

Packaged Plan: This health plan is part of a package that consists of a health plan and a dental plan which is offered at a package rate. This Evidence of Coverage and Health Service Agreement describes the benefits of the health plan as part of the package

Notice About Plan Benefits: No person has the right to receive the Benefits of this plan for services or supplies furnished following termination of coverage. Benefits of this plan are available only for services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of this Agreement 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 the modification. There is no vested right to receive the Benefits of this Agreement.

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 Evidence of Coverage and Health Service Agreement 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 agreement may include incentives to manage all services for Members in an appropriate manner consistent with the contract. To learn more about this payment system contact Customer Service.

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

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

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

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

Blue Shield of California

Subscriber Bill of Rights

As a Blue Shield Subscriber, 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 your Blue Shield plan, the services we offer you, the Physicians and other practitioners available to care for you.

5) Have reasonable access to appropriate medical services.

6) 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.

7) A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

8) 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.

9) Receive preventive health services.

10) Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.

11) 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 Physician.

12) Communicate with and receive information from Customer Service that is in a language you can understand.

13) Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

14) Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.

15) Voice complaints or grievances about the Blue Shield plan or the care provided to you.

16) Participate in establishing Public Policy of the Blue Shield plan, as outlined in your Evidence of Coverage.

17) Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

Blue Shield of California

Subscriber Responsibilities

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

1) Carefully read all Blue Shield 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 plan membership as explained in the Evidence of Coverage and Health Service Agreement.

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 Blue Shield 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 your Physician ahead of time when you must cancel.

8) Communicate openly with the Physician you choose so that you can develop a strong partnership based on trust and cooperation.

9) Offer suggestions to improve the Blue Shield 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) Treat all Blue Shield personnel respectfully and courteously as partners in good health care.

13) Pay your Premiums, Copayments, Coinsurance, and charges for non-Covered Services on time.

14) For all Mental Health Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization as required.

15) Follow the provisions of the Blue Shield Benefits Management Program.

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Introduction to the Blue Shield of California PPO Plan

This Blue Shield of California (Blue Shield) Evidence of Coverage and Health Service Agreement is the contract between Blue Shield and the Subscriber for health care coverage. A Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage and Health Service Agreement.

Please read both this Evidence of Coverage and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about Member responsibilities, such as payment of applicable Copayments, Coinsurance and Deductibles and obtaining prior authorization for certain services (see the Benefits Management Program section).

Capitalized terms in this Evidence of Coverage have special meaning. Please see the Definitions section to understand these terms. Please contact Blue Shield with questions about Benefits. Contact information can be found on the last page of this Evidence of Coverage.

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.

Choice of Providers

This Blue Shield health plan is designed for Members to obtain services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members may choose to seek services from Non-Participating Providers for most services. Covered Services obtained from Non-Participating Providers will usually result in a higher share of cost for the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider.

Please be aware that a provider's status as a Participating Provider or an MHSA Participating Provider may change. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHSA Participating Provider prior to obtaining coverage.

Call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider. Call the MHSA to determine if a provider is an MHSA Participating Provider. See the sections below and the Summary of Benefits for more details. See the *Out-of-Area Programs* section for services outside of California.

Blue Shield Participating Providers

Blue Shield Participating Providers include primary care Physicians, specialists, Hospitals, and Alternate Care Services Providers that have a contractual relationship with Blue Shield to provide services to Members of this Plan. Participating Providers are listed in the Participating Provider directory.

Participating Providers agree to accept Blue Shield's payment, plus the Member's payment of any applicable Deductibles, Copayments, and Coinsurance or amounts in excess of specified Benefit maximums as payment-in-full for Covered Services, except as provided under the *Exception for Other Coverage* and the *Reductions-Third Party Liability* sections. This is not true of Non-Participating Providers.

If a Member seeks services from a Non-Participating Provider, Blue Shield's payment for that service may be substantially less than the amount billed. The Subscriber is responsible for the difference between the amount Blue Shield pays and the amount billed by the Non-Participating Provider.

Some services are covered only if rendered by a Participating Provider. In these instances, using a Non-Participating Provider could result in a

higher share of cost to the Member or no payment by Blue Shield for services received.

Payment for Emergency Services rendered by a Physician or Hospital that is not a Participating Provider will be based on Blue Shield's Allowable Amount and will be paid at the Participating level of Benefits. The Member is responsible for notifying Blue Shield within 24 hours, or as soon as reasonably possible following medical stabilization of the emergency condition.

The Member should contact Member Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Provider or MHSA Non-Participating Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Provider level.

Please call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider.

MHSA Participating Providers

For Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care, and will underwrite and deliver Blue Shield's Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

MHSA Participating Providers are those providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services to Members of this Plan. A Blue Shield Participating Provider may not be an MHSA Participating Provider. It is the Member's responsibility to ensure that the provider selected for Mental Health Services, Behavioral Health Treatment, and Substance Use Services is an MHSA Participating Provider. MHSA Participating Providers are identified in the Blue Shield Behavioral Health Provider Directory. Additionally, Members may contact the MHSA directly by calling 1-877-263-9952.

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-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 policy and procedure for requesting continuity of care from a terminated provider.

Second Medical Opinion Policy

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 make an appointment with another Physician for a second medical opinion. The Member's attending Physician may also offer a referral to another Physician for a second opinion.

The second opinion visit is subject to the applicable Copayment, Coinsurance, Calendar Year Deductible, and all plan contract Benefit limitations and exclusions.

Services for Emergency Care

The Benefits of this plan will be provided for Emergency Services received anywhere in the world for the emergency care of an illness or injury.

For Emergency Services from either a Participating Provider or a Non-Participating 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 use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

NurseHelp 24/7 SM

The NurseHelp 24/7SM 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 physicians.

Retail-Based Health Clinics

Retail-based health clinics are outpatient facilities, usually attached or adjacent to retail stores, and pharmacies that provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners, under the direction of a physician, and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Participating Provider directory or the online provider directory located at www.blueshieldca.com. See the Blue Shield Participating Providers section for information on the advantages of choosing a Participating Provider.

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

The Calendar Year Medical Deductible is the amount an individual or a Family must pay for Covered Services each year before Blue Shield begins payment in accordance with this

Evidence of Coverage and Health Service Agreement. The Calendar Year Medical Deductible does not apply to all plans. When applied, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. Information specific to the Member's plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Medical Deductible applies to a particular Covered Service.

There are individual and Family Calendar Year Medical Deductible amounts for both Participating Providers and Non-Participating Providers. Deductible amounts for Covered Services provided by Participating Providers accrue to both the Participating Provider and the Non-Participating Provider Medical Deductible. Deductible amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Medical Deductible.

There is an individual Deductible within the Family Calendar Year Medical Deductible. This means:

1) Blue Shield will pay Benefits for that individual Member of a Family who meets the individual Calendar Year Medical Deductible amount prior to the Family Calendar Year Medical Deductible being met.
2) If the Family has 2 Members, each Member must meet the individual Deductible amount to satisfy the Family Calendar Year Medical Deductible.
3) If the Family has 3 or more Members, the Family Calendar Year Medical Deductible can be satisfied by 2 or more Members.

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

For Covered Services received from Non-Participating Providers, the Member is responsible for the applicable Copayment and Coinsurance and for amounts billed in excess of Blue Shield's Allowable Amount. Charges in excess of Blue Shield's Allowable Amount do not accrue to the Calendar Year Medical Deductible.

The Calendar Year Medical Deductible also applies to a newborn child or a child placed for adoption who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the plan. While coverage for this child is being provided, the Family Medical Deductible will apply.

Note: If the Member is enrolled in an Individual Deductible Plan, and has a newborn or child placed for adoption, the child is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan. While the child's coverage is provided, the Member and this Dependent will be enrolled in the Family Coverage Deductible Plan. The Family Calendar Year Deductible amount is described in the Summary of Benefits and will apply to the Member and this Dependent.

Calendar Year Pharmacy Deductible

The Calendar Year Pharmacy Deductible is the amount a Member must pay each Calendar Year for covered Drugs before Blue Shield begins payment in accordance with the Evidence of Coverage and Health Service Agreement. The Calendar Year Pharmacy Deductible does not apply to all plans. When it does apply, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. There is an individual deductible within the Family Calendar Year Pharmacy Deductible. Information specific to the Member's plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Pharmacy Deductible applies to a particular Drug.

Drugs in Tier 1, and contraceptive drugs and devices are not subject to the Calendar Year Pharmacy Deductible. The Calendar Year Pharmacy Deductible applies to all other Drugs.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. There are separate maximums for Participating Providers and Non-Participating Providers. If a benefit plan has any Calendar Year Medical Deductible it will accumulate toward the applicable Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers. Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Participating Providers accrue to both the Participating Provider and the Non-Participating Provider Out-of-Pocket Maximum. Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers.

There is an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means:

1) The Out-of-Pocket Maximum will be met for that individual Member of a Family who meets the individual Calendar Year Out-of-Pocket Maximum amount prior to the Family Calendar Year Out-of-Pocket Maximum being met.

2) If the Family has 2 Members, each Member must meet the individual Out-of-Pocket Maximum amount to satisfy the Family Calendar Year Out-of-Pocket Maximum.

3) If the Family has 3 or more Members, the Family Calendar Year Out-of-Pocket Maximum can be satisfied by 2 or more Members.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amounts for Participating Providers and Non-Participating Providers at both the individual and Family levels. When the respective 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 Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Submitting a Claim Form

Participating Providers will submit claims for payment directly to Blue Shield, however, there may be times when Members and Non-Participating Providers need to submit claims.

Except in the case of Emergency Services, Blue Shield will pay Members directly for Covered Services rendered by a Non-Participating Provider. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Blue Shield claim form to the Blue Shield address listed on the last page of this Evidence of Coverage.

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service. At a minimum, each claim submission must contain the Subscriber, name, home address, contract number, Subscriber's number, a copy of the

provider's billing showing the services rendered, dates of treatment and the patient's name.

Members should submit their claims for all Covered Services even if the Calendar Year Deductible has not been met. Blue Shield will keep track of the Deductible for the Member. Blue Shield also provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Out of Area Programs

Benefits will be provided for Covered Services received by Subscribers and their Dependent(s) who are temporarily traveling outside of California within the United States, Puerto Rico and U.S. Virgin Islands. (Temporarily traveling is defined as a Subscriber or Dependent(s) who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.) Blue Shield of California calculates the Subscriber's copayment as a percentage of the Allowable Amount, as defined in this booklet. When Covered Services are received in another state, the Subscriber's copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or to Blue Shield of California for payment. Blue Shield of California will notify you of its determination within thirty (30) days after the receipt of the claim. Blue Shield of California will pay you at the Non-Preferred Provider benefit level. Remember that your copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield of California and the amount billed.

Charges for services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Subscriber's responsibility and are not included in copayment calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require Covered Services while temporarily traveling outside of California:

1) call BlueCard Access® at 1-800-810-BLUE (2583) to locate physicians and hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,

2) visit the participating physician or hospital and present your membership card.

The participating physician or hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at 1-800-676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the participating physician or hospital is paid directly. You may be asked to pay for your applicable copayment and plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits, which will show your payment responsibility. You are responsible for the copayment and plan Deductible amounts shown in the Explanation of Benefits.

Pre-admission review is required for all inpatient hospital services and notification is required for inpatient emergency services. Prior Authorization is required for selected inpatient and outpatient services, supplies, and durable medical equipment. To receive pre-admission review from Blue Shield of California, the out-of-area provider should call the Customer Service telephone number indicated on the back of the Member's identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this plan will be provided for

Covered Services received anywhere in the world for the emergency care of an illness or injury.

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

Benefits will also be provided for Covered Services received while temporarily traveling 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 through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, and seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires pre-certification or prior authorization, you should also call Blue Shield of California at the Customer Service telephone number indicated on the back of the Member's 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 Blue 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 Evidence of Coverage.

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 underestimation 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 Emergency Services are paid based on the Allowable Amount as defined in this Evidence of Coverage.

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 the Customer Service Department at the number provided on the back page of this Evidence of Coverage to request a copy.

Benefits Management Program

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, and home-infusion-administered drugs, 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. (See the *Outpatient Prescription Drug Benefits* section for specific information about prior authorization for outpatient prescription drugs).

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 procedure 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 and Drugs 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 telephone number provided on the back page of this Evidence of Coverage 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 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 Evidence of Coverage and Health Service Agreement.

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 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, Behavioral Health, or Substance Use Disorder Hospital Admissions and Non-Routine Outpatient Services

Prior authorization is required for all non-emergency mental health, behavioral health, or substance use disorder 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 Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services, including but not limited to, Behavioral Health Treatment (BHT), Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Office-Based Opioid Treatment (OBOT), Post discharge ancillary care, 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, behavioral health, or substance use disorder Hospital admission or for any Non-Routine Outpatient Mental Services and Behavioral Health Treatment, or Outpatient Substance Use Disorder Service, 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 Services, Behavioral Health Treatment, and Outpatient Substance Use Disorder Services from a Non-Participating Provider, the Member is 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, behavioral health, or substance use disorder 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 case 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 person 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 at the number provided on the back page of this Agreement 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, Coinsurance, and charges in excess of Benefit maximums, Participating Provider provisions and Benefits Management Program provisions. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Evidence of Coverage and Health Agreement, including but not limited to, any conditions or limitations set forth in the Benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this Evidence of Coverage. All Benefits must be Medically Necessary to be covered. 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.

The Copayment and Coinsurance amounts for Covered Services, if applicable, are shown on the Summary of Benefits. The Summary of Benefits is provided with, and is incorporated as part of, this Evidence of Coverage and Health Service Agreement.

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.

Acupuncture Benefits

Benefits are provided for acupuncture services for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. These services must be provided by a Doctor of Medicine, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.

Allergy Testing and Treatment Benefits

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

Ambulance Benefits

Benefits are provided for (1) ambulance services (ground 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) authorized ambulance transportation to or from Covered Services.

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, whether the Member is a resident of a designated or non-designated county. See the *Benefits Management Program* section for more information.

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 (see the list of designated counties below), Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1) performed at a Participating Hospital or Ambulatory Surgery Center, and by a Participating Physician, that have both contracted with Blue Shield as a Bariatric Surgery Services Provider to provide the procedure;
2) the services are consistent with Blue Shield's medical policy; and

Prior authorization is obtained, in writing, from Blue Shield's Medical Director.

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, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Participating Hospital or Ambulatory Surgery Center by 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 services:

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

Bariatric Travel Expense Reimbursement 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 3 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.

   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.

Services for Residents of Non-Designated Counties

Bariatric surgery services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this 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 Members who reside in non-designated counties, travel expenses associated with bariatric surgery services are not covered.

Chiropractic Benefits

Benefits are provided for chiropractic services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, adjustments, conjunctive therapy, and X-ray services.

Benefits are limited to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Covered X-ray services provided in conjunction with this Benefit have an additional Copayment or Coinsurance as shown on the Summary of Benefits under Outpatient X-ray, Imaging, Pathology and Laboratory Benefits.

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

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition when prior authorized by Blue Shield, and:

1) the clinical trial has a therapeutic intent and a Participating Provider 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 Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

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

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

1) the investigational item, device, or service, itself;
2) drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
3) services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
4) any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
5) services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
6) services customarily provided by the research sponsor free of charge for any enrollee in the trial;
7) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

1) federally funded and approved by one or more of the following:

   a) one of the National Institutes of Health;

   b) the Centers for Disease Control and Prevention;

   c) the Agency for Health Care Research and Quality;

   d) the Centers for Medicare & Medicaid Services;

   e) a cooperative group or center of any of the entities in a) to d) above; or the federal Departments of Defense or Veterans Administration;

   f) a 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

Diabetic 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 Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes 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 Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pumps and the 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 Durable Medical Equipment 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 Durable Medical Equipment 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 Benefit* section for benefits for asthma inhalers and inhaler spacers);

3) breast pump rental or purchase when obtained from a Non-Participating Provider;

4) repair or replacement due to loss or misuse;

5) 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 D*iabetes 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 received in a Participating Physician's office.

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.

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

No Benefits are provided for family planning services from Non-Participating Providers.

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

For plans with a Calendar Year Deductible for services by Participating Providers, the Calendar Year Deductible applies only to male sterilizations.

Home Health Care Benefits

Benefits are provided for home health care services from a Participating home health care agency when the services are ordered by the attending Physician, and included in a written treatment plan

Services by a Non-Participating home health care agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by Blue Shield.

Covered Services are subject to any applicable Deductibles, Copayments and Coinsurance. Visits

by home health care agency providers will be payable up to a 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 (including all home health and home infusion 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 of 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 and/or a Home Infusion 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 Participating 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 Participating home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit, medications injected or administered intravenously, related laboratory services, when prescribed by a Doctor of Medicine and provided by a Participating 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 Benefit, 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.

Skilled services provided by a home health agency and/or a home infusion 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.

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.) To find a Participating Hemophilia Infusion Provider, consult the Participating Provider directory. Members may also verify this information by calling Customer Service at the telephone number shown on the last page of this Evidence of Coverage.

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

Following Member evaluation by a Doctor of Medicine, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once prior 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.

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 Non-Participating Hemophilia Infusion Provider; 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 Participating Hospice Agency when an eligible Member requests admission to, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by his or her Participating Provider's certification and must receive prior approval from Blue Shield for the admission. Members with a Terminal Disease or Terminal Illness who have not yet elected to enroll in a Hospice program may receive a pre-hospice consultative visit from a Participating Hospice Agency.

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

1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.

2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:

a) Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;

b) Home Health Aide services to provide 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 Doctor of Medicine acting as a consultant to the interdisciplinary Hospice team and to the Member's Participating Provider 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, durable medical equipment, and supplies.

4) Continuous home care when medically necessary to achieve palliation or management of acute medical symptoms including the following:

a) 8 to 24 hours per day of continuous skilled nursing care (8-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 either a 30 or 60-day period, depending on their diagnosis. The care continues through another Period of Care if the Personal Physician recertifies that the Member is Terminally Ill.

Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

1) Semi-private room and board unless a private room is Medically Necessary.

2) General nursing care, and special duty nursing.

3) Meals and special diets.

4) Intensive care services and units.

5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.

6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.

7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.

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) Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.

13) Subacute Care.

14) Medical social services and discharge planning.

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

16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder detoxification is prior authorized by Blue Shield.

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

1) Dialysis services.

2) Care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which an inpatient admission is planned.

3) Surgery.

4) Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.

5) Routine newborn circumcision performed within 18 months of birth.

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 (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;

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; and

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, Behavioral Health, and Substance Use Disorder Benefits

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

All Non-Emergency inpatient Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, including Residential Care, and Non-Routine Outpatient Mental Health Services, Behavioral Health Treatment, and Outpatient Substance Use Disorder 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.

Mental Health and Behavioral Health-Routine Outpatient Services

Benefits are provided for professional (Physician) office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health

Conditions in the individual, family or group setting.

Mental Health and Behavioral Health-Non-Routine Outpatient Services

Benefits are provided for Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions. These services may also be provided in the office, home, or other non-institutional setting. Non-Routine Outpatient Mental Health services and Behavioral Health Treatment 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 and behavioral health 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) 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.

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

6) Transcranial Magnetic Stimulation - a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

8) Post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.

Outpatient Substance Use Disorder Services

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

1) Intensive Outpatient Program - an outpatient substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

2) Office-Based Opioid Treatment - outpatient opioid detoxification and/or maintenance therapy including Methadone maintenance treatment.

3) 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.

4) Post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.

Inpatient Services

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

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

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

Orthotics Benefits

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

1) shoes only when permanently attached to such appliances;

2) special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;

3) knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;

4) functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;

5) initial fitting and adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

No Benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet not listed above. No Benefits are provided for backup or alternate items, or replacement due to loss or misuse.

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

Outpatient Prescription Drug Benefits

This Plan provides benefits for outpatient prescription Drugs as specified in this section.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. Members must obtain all Drugs from a Participating Pharmacy, except as noted below.

Some drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process* section. The Member or his/her Physician or

Health Care Provider may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs. Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when prior authorized by Blue Shield.

Blue Shield's Formulary is established by Blue Shield's Pharmacy and Therapeutics (P&T) Committee. This committee consists of physicians and pharmacists responsible for evaluating drugs for relative safety, effectiveness, health benefit based on the medical evidence, and comparative cost. They also review new drugs, dosage forms, usage and clinical data to update the Formulary four times a year. Note: The Member's Physician or Health Care Provider might prescribe a drug even though the drug is not included on the Formulary.

The Formulary is categorized into drug tiers as described in the chart below. The Member's Copayment or Coinsurance will vary based on the drug tier.

Drug Tier	**Description**
Tier 1	Most Generic Drugs and low cost Preferred Brands
Tier 2	1. Non-preferred Generic Drugs or; 2. Preferred Brand Name Drugs or; 3. Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
Tier 3	1. Non-preferred Brand Name Drugs or; 2. Recommended by P&T committee based on drug safety, efficacy and cost or; 3. Generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	1. Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2. Self administration requires training, clinical monitoring or; 3. Drug was manufactured using biotechnology or; 4. Plan cost (net of rebates) is >$600.

Members can find the Drug Formulary at www.blueshieldca.com/bsca/pharmacy/home.sp. Members can also contact Customer Service at the number provided on the back page of this Evidence of Coverage to ask if a specific drug is included in the Formulary, or to request a printed copy of the Formulary.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can locate a Participating Pharmacy by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service. If the Member obtains Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny the claim, unless it is for an Emergency Service.

Blue Shield negotiates contracted rates with Participating Pharmacies for Drug. If the Member's Plan has a Calendar Year Pharmacy Deductible, the Member is responsible for paying the contracted rate for Drugs until the Calendar Year Pharmacy Deductible is met. Drugs in Tier

1 are not subject to, and will not accrue to, the Calendar Year Pharmacy Deductible.

The Member must pay the applicable Copayment or Coinsurance for each prescription when the Member obtains it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when Medically Necessary and when prior authorized by Blue Shield. If prior authorized, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment or Coinsurance (refer to the Drug Tier table in the *Outpatient Drug Formulary* section of this Evidence of Coverage.). For all other Drugs, the Tier 3 Copayment or Coinsurance applies when prior authorization is obtained. If prior authorization is not obtained, the Member is responsible for paying 100% of the cost of the Drug(s).

If the Member, his/her Physician or Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, the Member pays the difference in cost, plus the Tier 1 Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Tier 1 Copayment or Coinsurance. For example, the Member selects Brand Drug A when there is an equivalent Generic Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300, and the contracted rate for Generic Drug A is $100. The Member would be responsible for paying the $200 difference in cost, plus a Tier 1 Copayment or Coinsurance. This difference in cost does not accrue to the Member's Calendar Year Pharmacy Deductible or Out-of-Pocket Maximum responsibility.

If the Member or his/her Physician or Health Care Provider believes the Brand Drug is Medically Necessary, they can request an exception to 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. If the request is approved, the Member pays the applicable tier Copayment or Coinsurance for the Brand Drug.

The prior authorization process is described in the *Prior Authorization/Exception Request Process* section of this Evidence of Coverage.

Emergency Exception for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

When the Member obtains Drugs from a Non-Participating Pharmacy for Emergency Services:

- The Member must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim Form to

  Blue Shield of California
  Argus Health Systems, Inc.
  P.O. Box 419019,
  Dept 191
  Kansas City, MO 64141
- Blue Shield will reimburse the Member based on the price the Member paid for the Drugs, minus any applicable Deductible and Copayment or Coinsurance.

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

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

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

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

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

Obtaining Specialty Drugs through the Specialty Drug Program

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

Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or upon the Member's request, at an associated retail store for pickup. For access at other Participating Pharmacies, the Member may call the Customer Service number on the back of his/her ID card. If a Participating Pharmacy is not reasonably accessible, the Member may obtain Specialty Drugs from a Non-Participating Pharmacy (see *Emergency Exception for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*).

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

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

Prior Authorization/Exception Request Process

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

The following Drugs require prior authorization:

1) Some preferred, non-preferred, compound Drugs, and most Specialty Drugs; Drugs to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy.

2) Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;

3) Some Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance;

4) When a Brand Drug is Medically Necessary, prior authorization is required if the Member, Physician or Health Care Provider is requesting an exception to the difference in cost between the Brand Drug and the Generic Drug Equivalent;

5) Drugs not listed on the Formulary may be covered if prior authorization is obtained from Blue Shield.

Blue Shield covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug, as defined,
- There are no FDA-approved, commercially available, medically appropriate alternative(s),
- The compounded medication is self administered, and
- Medical literature supports its use for the requested diagnosis.

The Member pays the Tier 3 Copayment or Coinsurance for covered compound Drugs.

The Member, his/her Physician or Health Care Provider may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within two business days. Coverage requests for Non-Formulary Drugs in standard or normal circumstances will have a determination provided within two business days or 72 hours, whichever is earlier; the same requests in exigent circumstances will have a determination provided within 24 hours.

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

1) Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

2) Blue Shield has a Short Cycle Specialty Drug Program. With the Member's agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows the Member to receive a 15-day supply of the Specialty Drug and determine whether the Member will tolerate it before he or she obtains the full 30-day supply. This program can help the Member save out of pocket expenses if the Member cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the program, which the Member can elect at that time. The Member or his/her Physician may choose a full 30-day supply for the first fill.

   If the Member agrees to a 15-day trial, the Network Specialty Pharmacy will contact the Member prior to dispensing the remaining 15-day supply to confirm that the Member is tolerating the Specialty Drug. The Member can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service.

3) You may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount

and you are responsible for the applicable Mail Service Copayment or Coinsurance. 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) The Member may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

Blue Shield does not provide coverage in the Outpatient Prescription Drug Benefit for the following. The Member may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Evidence of Coverage to determine if the Plan covers Drugs under that Benefit.

1) Any Drug the Member receives while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional Benefits and Hospital Benefits (Facility Services)* sections of this Evidence of Coverage.

2) Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the Hospital Benefits and Skilled Nursing Facility Benefits sections of this Evidence of Coverage.

3) Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug.

4) Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary and prior authorization is obtained from Blue Shield. See the *Prior Authorization/Exception Request Process* section of this Evidence of Coverage.

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 listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits,* and the *Orthotics Benefits* sections of this Evidence of Coverage

8) Blood or blood products (see the *Hospital Benefits (Facility Services)* section of this Evidence of Coverage).

9) Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.

10) Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.

11) Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, Hospice Program Benefits,* or *Family*

Planning Benefits sections of this Evidence of Coverage.

12) All Drugs for the treatment of infertility.

13) Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases prior authorization by Blue Shield is required.

14) Contraceptive drugs or devices which do not meet all of the following requirements:
    - Are FDA-approved.
    - Are ordered by a Physician or Health Care Provider
    - Are generally purchased at an outpatient pharmacy, and
    - Are self-administered.

    Other contraceptive methods may be covered under the *Family Planning Benefits* section of this Evidence of Coverage.

15) Compounded medication(s) which do not meet all of the following requirements:
    - The compounded medication(s) include at least one Drug
    - There are no FDA-approved, commercially available, medically appropriate alternatives
    - The compounded medications is self-administered, and
    - Medical literature supports its use for the requested diagnosis.

16) Replacement of lost, stolen or destroyed Drugs.

17) If the Member is enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice Program Benefits* section of this Evidence of Coverage.

18) Drugs prescribed for treatment of dental conditions. This exclusion does not apply to
    - antibiotics prescribed to treat infection,
    - Drugs prescribed to treat pain, or
    - Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.

19) Except for a covered emergency, Drugs obtained from a pharmacy:
    - Not licensed by the State Board of Pharmacy, or
    - Included on a government exclusion list.

20) Immunizations and vaccinations 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 convenience items. 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).

Outpatient X-ray, Imaging, Pathology and Laboratory Benefits

Benefits are provided to diagnose or treat illness or injury, including:

1) diagnostic and therapeutic imaging services, such as X-ray and ultrasounds

(certain imaging services require prior authorization;

2) clinical pathology; and

3) laboratory services.

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention.

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

Radiological and Nuclear Imaging

The following radiological procedures, when performed on an outpatient, non-emergency basis, require prior authorization under the Benefits Management Program. See the *Benefits Management Program* section for complete information.

1) CT (Computerized Tomography) scans;

2) MRIs (Magnetic Resonance Imaging);

3) MRAs (Magnetic Resonance Angiography);

4) PET (Positron Emission Tomography) scans; and

5) cardiac diagnostic procedures utilizing Nuclear Medicine.

See the *Pregnancy and Maternity Care Benefits* section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

PKU-Related Formulas and Special Food Products Benefits

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

Podiatric Benefits

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

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

1) prenatal care;

2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy;

3) outpatient maternity services;

4) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);

5) inpatient hospital maternity care including labor, delivery and post-delivery care;

6) Abortion services; and

7) outpatient routine newborn circumcision within 18 months of birth.

See the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section for information on coverage of other genetic testing and diagnostic procedures.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother,

determines a shorter Hospital length of stay is adequate.

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

Preventive Health Benefits

Preventive Health Services are only covered when rendered by a Participating Provider. These services include primary preventive medical screening and laboratory testing 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 paragraph 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 paragraphs 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 Benefits.

Professional Benefits

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

1) Office visits.
2) Services of consultants, including those for second medical opinion consultations.
3) Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
4) 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.

5) Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room.

6) Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay.

7) Surgical procedures.

8) Chemotherapy for cancer, including catheterization, and associated drugs and supplies.

9) Extra time spent when a Physician is detained to treat a Member in critical condition.

10) Necessary preoperative treatment.

11) Treatment of burns.

12) Outpatient routine newborn circumcision performed within 18 months of birth.

13) Diagnostic audiometry examination.

A Participating 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 Participating Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found online at www.blueshieldca.com.

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

Covered lab and X-ray services provided in conjunction with these professional services listed above are described under the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section.

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 Prosthetic appliances equally appropriate for a condition, Benefits will be based on the most cost-effective Prosthetic appliance. Benefits include:

1) blom-Singer and artificial larynx prostheses for speech following a 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 aphakia following cataract surgery when no intraocular lens has been implanted. ;

5) supplies necessary for the operation of prostheses;

6) initial fitting and replacement after the expected life of the item; and

7) repairs, except for loss or misuse.

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: (1) to improve function, or (2) to create a normal appearance to the extent

possible. Benefits include dental and orthodontic services that are an integral part of this 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/Habilitation services rendered in the home.

Skilled Nursing Facility Benefits

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

Speech Therapy Benefits

Benefits are provided for Medically Necessary outpatient Speech Therapy services when ordered by a Physician 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 *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

Transplant Benefits

Tissue and Kidney Transplants

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 include services incident to obtaining the human

transplant material from a living donor or a tissue/organ transplant "bank."

Special Transplants

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 through the Benefits Management Program and (3) the recipient of the transplant is a Subscriber or Dependent.

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 provision:

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.
9) 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.

Pediatric Dental Benefits

Blue Shield has contracted with a dental plan administrator (DPA). All pediatric dental plans will be administered by the DPA. Pediatric dental benefits are available for Members through the end of the Calendar Year in which the Member turns 19. Dental services are delivered to our Members through the DPA's network of participating providers. The DPA also serves as the claims administrator for processing claims received from Non-Participating Dentists.

If the Member purchased a Family dental plan that includes a supplemental pediatric dental plan on the Health Benefits Exchange, embedded pediatric dental benefits covered under this plan will be paid first. For purposes of coordinating benefits the medical plan is the primary dental benefit plan and the family pediatric dental plan is the secondary dental benefit plan.

If the Member has any questions regarding the information in this booklet, need assistance, or have any problems, he/she may contact the dental Member Services Department at: 1-800-286-7401.

Before Obtaining Dental Services

The Member is responsible for assuring that the Dentist he/she chooses is a Participating Dentist. Note: A Participating Dentist's status may change. It is the Member's obligation to verify whether the Dentist the Member chooses is currently a Participating Dentist in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located

in the Member's area, can be obtained by contacting the DPA at 1-800-286-7401. The Member may also access a list of Participating Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. The Member is also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

NOTE: The DPA will respond to all requests for pre-certification and prior authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, the DPA will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of benefits. However, by following the Pre-certification process both the Member and the Dentist will know in advance which services are covered and the benefits that are payable.

Participating Dentists

The Blue Shield of California Dental PPO Plan is specifically designed for Members to use Participating Dentists. Participating Dentists agree to accept the DPA's payment, plus the Member's payment of any applicable deductible and coinsurance amount, as payment in full for covered services. This is not true of Non-Participating Dentists.

If the Member goes to a Non-Participating Dentist, the Member will be reimbursed up to a pre-determined maximum amount, for covered services. The Member's reimbursement may be substantially less than the billed amount. The Member is responsible for all differences between the amount the Member is reimbursed and the amount billed by Non-Participating Dentists. It is therefore to the Member's advantage to obtain dental services from Participating Dentists.

Participating Providers submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. The Member or his/her Non-Participating Providers submits claims for reimbursement after services have been rendered. If the Member receives services from Non-Participating Providers, the Member has the option of having payments sent directly to the Non-Participating Provider or sent directly to the Member. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

The Member may access a Directory of Participating Dentists through Blue Shield of California's Internet site located at http://www.blueshieldca.com. The names of Participating Dentists in the Member's area may also be obtained by the DPA at 1-800-286-7401.

Continuity of Care by a Terminated Provider

Persons who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a the DPA's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

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 Participating Dentist in the same geographic area.

Pre-certification of Dental Benefits

Before any course of treatment expected to cost more than $250 is started, the Member should obtain Pre-certification of Benefits. The Member's Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to the DPA. The DPA will review the dental treatment plan to determine the benefits payable under the plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, the Member's claim form should be submitted to the DPA for payment determination. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

The dental plan provides benefits for covered services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this plan will in most cases provide benefits based on the most cost-effective procedure. The benefits provided under this plan are based on these considerations but the Member and his/her Dentist make the final decision regarding treatment.

Failure to obtain Pre-certification of Benefits may result in a denial of benefits. If the Pre-certification process is not followed, the DPA will still determine payment by taking into account alternative procedures; services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the Pre-certification process both the Member and his/her Dentist will know in advance which services are covered and the benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material which meets professionally recognized standards of quality dental care and is the most cost effective as determined by the DPA. If the Member and his/her Dentist decide on a more costly procedure, service or material than the DPA determined is payable under the plan, then benefits will be applied to the selected treatment plan up to the benefit maximum for the most cost effective alternative. The Member will be responsible for any charges in excess of the benefit amount. The DPA reserves the right to use the services of dental consultants in the Pre-certification review.

Example:

1) If a crown is placed on a tooth which can be restored by a filling, benefits will be based on the filling;

2) If a semi-precision or precision partial denture is inserted, benefits may be based on a conventional clasp partial denture

3) If a bridge is placed and the patient has multiple unrestored missing teeth, Benefits will be based on a partial denture.

Participating Dentists

When the Member receives covered dental services from a Participating Dentist, the Member will be responsible for a coinsurance amount as outlined in the section entitled Summary of Benefits. Participating Dentists will file claims on the Member's behalf.

Participating Dentists will be paid directly by the plan, and have agreed to accept the DPA's payment, plus the Member's payment of any applicable deductible or coinsurance amount, as payment in full for covered services.

If the covered Member recovers from a third party the reasonable value of covered services rendered by a Participating Dentist, the Participating Dentist who rendered these services is not required to accept the fees paid by the DPA as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by the DPA and the amount collected by the covered Member for these services.

Non-Participating Dentists

When the Member receives covered services from a Non-Participating Dentist, the Member will be reimbursed up to a specified maximum amount as outlined in the section entitled Summary of Benefits and Member Coinsurance. The Member will be responsible for the remainder of the Dentist's billed charges. The Member should discuss this beforehand with his/her Dentist if he is not a Participating Dentist. Any difference between a contracted Dental Plan Administrator's or Blue Shield of California's payment and the Non-Participating Dentist's charges are the Member's responsibility. Members are expected to follow the billing procedures of the dental office.

If the Member receives covered Services from a Non-Participating Dentist, either the Member or his/her provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

1-800-286-7401

Claims for all Covered California services should be sent to:

Blue Shield of California
Dental Plan Administrator
P O Box 400
Chico, CA 95927

Procedure for Filing a Claim

Claims for covered dental Services should be submitted on a dental claim form which may be obtained from the DPA or at blueshieldca.com. Have the Dentist complete the form and mail it to the DPA Service Center as shown in the Pediatric Dental Benefits Customer Services section.

The DPA will provide payment in accordance with the provisions of this Agreement. The Member will receive an explanation of benefits after the claim has been processed.

All claims for reimbursement must be submitted to the DPA within one (1) year after the month in which the service is rendered. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

Coordination of Dental Benefits

All individual and family medical plans include an embedded pediatric dental benefit. For purposes of coordinating benefits the medical plan is the primary dental benefit plan and the family pediatric dental plan is the secondary dental benefit plan.

Pediatric Dental Benefits General Exclusions and Limitations

Unless exceptions to the following general exclusions are specifically made elsewhere under this plan, this plan does not provide Benefits for:

1) Dental services not appearing on the Summary of Benefits;
2) Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage.
3) Services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Dental Provider and authorized by the Plan, or when required in a covered emergency;
4) Any dental services received or costs that were incurred in connection with any dental procedures started prior to Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to Member's effective date of coverage;
5) Any dental services received subsequent to the time the Member's coverage ends;

6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;

7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;

8) Procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits;

9) Cosmetic dental care;

10) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit under the Summary of Benefits or is given by a Dentist for a covered oral surgery;

11) Hospital charges of any kind;

12) Major surgery for fractures and dislocations;

13) Loss or theft of dentures or bridgework;

14) Malignancies;

15) Dispensing of drugs not normally supplied in a dental office;

16) Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;

17) The cost of precious metals used in any form of dental benefits;

18) Surgical removal of implants;

19) Services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Dental Provider or treatment is Dentally Necessary or his or her Dental Provider is a pedodontist/pediatric Dentist.

20) Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;

21) Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;

22) Treatment for which payment is made by any governmental agency, including any foreign government;

23) Charges for second opinions, unless previously authorized by the DPA;

24) Charges for saliva testing when caries management procedures D0601, D0602 and D0603 are performed;

25) Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.

Pediatric Dental Benefits Orthodontic Limitations & Exclusions

Medically necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. Initial orthodontic examination (D0140) called the Limited Oral Evaluation must be conducted. This examination includes completion and submission of the completed HLD Score Sheet with the Specialty Referral Request Form. The HLD Score Sheet is the preliminary measurement tool used in determining if the patient qualifies for medically necessary orthodontic services.

Those immediate qualifying conditions are:

1) Cleft lip and or palate deformities
2) Craniofacial Anomalies including the following:
   - Crouzon's syndrome,
   - Treacher-Collins syndrome,
   - Pierre-Robin syndrome,
   - Hemi-facial atrophy, Hemfacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3) Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
4) Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5) Severe traumatic deviation must be justified by attaching a description of the condition.
6) Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.

   The remaining conditions must score 26 or more to qualify (based on the HDL Index).

Excluded are the following conditions:

- Crowded dentitions (crooked teeth)
- Excessive spacing between teeth
- Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies
- Treatment in progress prior to the effective date of this coverage.
- Extractions required for orthodontic purposes
- Surgical orthodontics or jaw repositioning
- Myofunctional therapy
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Dental Necessity Exclusion

All services must be of Dental Necessity. The fact that a dentist or other plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental necessity.

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the contracted Dental Plan will pay benefits based upon the less costly service.

General Limitations

The following services, if listed on the Summary of Benefits, will be subject to Limitations as set forth below. Services identified as optional are not covered. If a Member chooses to receive an optional service, the Member will be responsible for the difference in cost between the Covered Service and the optional service, unless otherwise specified below:

1. Roentgenology (x-rays) are limited as follows:
   a) Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

b) Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

c) Panoramic film x-rays are limited to once every 24 consecutive months.

2. Prophylaxis services (cleanings) cannot exceed two in a twelve month period.

3. Dental sealant treatments are limited to permanent first and second molars only.

4. Restorations are limited as follows:

a) Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

b) Composite resin or acrylic restorations in posterior teeth are optional services and if rendered, will be paid at the equivalent amalgam restoration fee.

c) Micro filled resin restorations which are non-cosmetic.

d) Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is Dentally Necessary.

5. Oral Surgery is limited as follows:

a) Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.

6. Endodontics: Retreatment of root canals is a Covered Service only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a Covered Service.

7. Peridontics: Periodontal scaling and root planing and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months.

8. Crowns and Fixed Bridges. Five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction.

a) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

i. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan Administrator.

ii. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

iii. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

iv. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

b) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

i. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily

restore the case, it is considered optional treatment.

ii. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

iii. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

iv. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

v. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

9. Removable Prosthetics.

a) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

i. Partial dentures are not to be replaced within 36 consecutive months, unless 1) it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) the denture is unsatisfactory and cannot be made satisfactory.

ii. Benefits for partial dentures are limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the Dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

iii. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

iv. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

v. Benefits for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the Dentist, the applicant will be responsible for all additional charges.

b) Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months.

c) Tissue conditioning is limited to two per denture.

d) Implants are considered an optional service; however, the Member, not the Plan, pays for the entire cost.

e) Stayplates are a Covered Service only when used as anterior space maintainers for children.

Pediatric Dental Benefits Customer Services

Questions about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that the Member has experienced should be directed to your Dental

Customer Service at the phone number or address which appear below:

1-800-286-7401

Blue Shield of California

Dental Plan Administrator

425 Market Street, 15th Floor

San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

Note: Dental Benefit Providers has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. Dental Benefit Providers shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. 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 the Dental Customer Service Department at the number listed above.

Pediatric Dental Benefits Grievance Process

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Dental Member Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Member Service Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member 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 Dental Member Service Department. If the Member wishes, the Dental Member Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to the DPA at the address provided below. The Member may also submit the grievance to the Dental Member Service Department online by visiting http://www.blueshieldca.com.

1-800-286-7401

Blue Shield of California

Dental Plan Administrator

PO Box 30569

Salt Lake City, UT 84130-0569

The DPA will acknowledge receipt of a written 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 previous Member Service section for information on the expedited decision process.

Pediatric Dental Benefits Definitions –

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

Alternate Benefit Provision (ABP) — A provision that allows benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

Billed Charges — the prevailing rates of the Dental office.

Dental Allowable Amount — the Allowance is:

1) The amount a contracted Dental Plan Administrator has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as evaluation of the

value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or

2) Such other amount as the Participating Dentist and a contracted Dental Plan Administrator have agreed will be accepted as payment for the Service(s) rendered; or

3) If an amount is not determined as described in either 1. or 2. above, the amount a contracted Dental Plan Administrator determines is appropriate considering the particular circumstances and the Services rendered.

Dental Care Services — Necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Necessity (Dentally Necessary) — Benefits are provided only for Services that are Dentally Necessary as defined in this Section.

1. Services which are Dentally Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards which, as determined by a contracted Dental Plan Administrator, are:

   a. Consistent with the symptoms or diagnosis of the condition; and

   b. Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and

   c. Furnished in a setting appropriate for delivery of the Service (e.g., a dentist's office).

2. If there are two (2) or more Dentally Necessary Services that can be provided for the condition, Blue Shield will provide benefits based on the most cost-effective Service.

Dental Plan Administrator (DPA) — Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims received from Non-Participating Dentists.

Dentist — a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Elective Dental Procedure — any dental procedures which are unnecessary to the dental health of the patient, as determined by a contracted Dental Plan Administrator.

Emergency Dental Care Services — Services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1) placing the patient's health in serious jeopardy;

2) serious impairment to bodily functions;

3) serious dysfunction of any bodily organ or part.

Experimental or Investigational in Nature Dental Care Services — 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/dental 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/dental 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.

Maximum Plan Payment — the maximum amount that the Member will be reimbursed for services obtained from a Non-Participating Dentist.

Participating Dentist — a Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with a contracted Dental Plan Administrator to provide dental services to Members.

Pedodontics — Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

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

Prosthodontics — Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Treatment in Progress — Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken.

VPA Participating Provider – For purposes of this pediatric vision Benefit, participating provider refers to a provider that has contracted with the VPA to provide vision services to Blue Shield Members.

Pediatric Vision Benefits

Principal Benefits and Coverages for Pediatric Vision Benefits –

For Covered Services rendered by Non-Participating Providers, Blue Shield will pay up to the Allowable Amount as shown in the Summary of Benefits. Members will be responsible for all charges in excess of those amounts.

The following is a complete list of Covered Services provided under this pediatric vision Benefit:

1) One comprehensive eye examination in a Calendar Year. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, a determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in the presence of trauma or severe inflammation.
2) One of the following in a Calendar Year:
   a) One pair of spectacle lenses,
   b) One pair of Elective Contact Lenses up to the Benefit allowance (for cosmetic reasons or for convenience), or
   c) One pair of Non-Elective (Medically Necessary) Contact Lenses, which are lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus, 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) astigmatism (over 3 diopters), or other conditions as listed in the definition of Non-Elective Contact Lenses, once every Calendar Year interval if the examination indicates a prescription change.

A report from the provider and prior authorization from the contracted VPA is required.

3) One frame in a Calendar Year.

4) The need for supplemental Low Vision Testing is triggered during a comprehensive eye exam. These supplemental services may only be obtained from Participating Providers and only once in a consecutive two Calendar Year period. A report from the provider conducting the initial examination and prior authorization from the VPA is required. Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200.

5) One diabetic management referral per calendar year to a Blue Shield disease management program. The contracted VPA will notify Blue Shield's disease management program subsequent to the annual comprehensive eye exam, when the Member is known to have or be at risk for diabetes.

Important Information on the Pediatric Vision Benefits –

Pediatric vision services are covered when provided by a vision provider and when necessary and customary as determined by the standards of generally accepted vision practice. Coverage for these services is subject to any conditions or limitations set forth in the Benefit descriptions above, and to all terms, conditions, limitations and exclusions listed in this Evidence of Coverage and Health Service Agreement.

Payments for pediatric vision services are based on Blue Shield's Allowable Amount and are subject to any applicable Deductibles, Copayments, Coinsurance and Benefit maximums as specified in the Summary of Benefits. Vision providers do not receive financial incentives or bonuses from Blue Shield or the VPA.

Exclusions and Limitations for Pediatric Vision Benefits

Unless exemptions are specifically made elsewhere in this Evidence of Coverage and Health Service Agreement, these pediatric vision Benefits exclude the following:

1) Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;

2) Replacement or repair of lost or broken lenses or frames, except as provided under this Evidence of Coverage and Health Service Agreement;

3) Any eye examination required by the employer as a condition of employment;

4) Medical or surgical treatment of the eyes (see the *Ambulatory Surgery Center Benefits*, *Hospital Benefits (Facility Services)* and *Professional Benefits* sections of the Evidence of Coverage and Health Service Agreement);

5) Contact lenses, except as specifically provided in the Summary of Benefits;

See the *Principal Limitations, Exceptions, Exclusions and Reductions* section of this Evidence of Coverage and Health Service Agreement for complete information on plan general exclusions, limitations, exceptions and reductions.

Payment of Benefits for Pediatric Vision Benefits

Prior to service, the Subscriber should review his or her Benefit information for coverage details. The Subscriber may identify a Participating Provider by calling the VPA's Customer Service Department at 1-877-601-9083 or online at www.blueshieldca.com. When an appointment is made with a Participating Provider, the

Subscriber should identify the Member as a Blue Shield /VPA Member.

The Participating Provider will submit a claim for Covered Services online or by claim form obtained from the VPA after services have been received. The VPA will make payment on behalf of Blue Shield directly to the Participating Provider. Participating Providers have agreed to accept Blue Shield's payment as payment in full except as noted in the Summary of Benefits.

When services are provided by a Non-Participating Provider, a Vision Service Report (claim form C-4669-61) should be submitted to the VPA. This form may be obtained at www.blueshieldca.com and must be completed in full and submitted with all related receipts to:

Blue Shield of California

Vision Plan Administrator

P O Box 25208

Santa Ana, CA 92799-5208

Information regarding the Member's Non-Participating Provider Benefits is available in the Summary of Benefits or by calling Blue Shield / VPA Customer Service at 1-877-601-9083.

When the Member receives Covered Services from a Non-Participating Provider, the Subscriber or the provider may submit a claim for payment after services have been received. The VPA will make payment directly to the Subscriber. The Subscriber is responsible for any applicable Deductible, Copayment and Coinsurance amounts and for amounts billed in excess of the Allowable Amount. The Subscriber is also responsible for making payment to the Non-Participating Provider.

A listing of Participating Providers may be obtained by calling the VPA at the telephone number listed in the *Customer Service* section of this Endorsement.

Payment of Claims for Pediatric Vision Benefits

Participating Providers will submit a claim for Covered Services on line or by claim form obtained from the VPA and are paid directly by Blue Shield of California.

If the Member receives services from a Non-Participating Provider, payment will be made directly to the Subscriber, and the Member is responsible for payment to the Non-Participating Provider.

Choice of Providers for Pediatric Vision Benefits

Members may select any licensed ophthalmologist, optometrist, or optician to provide Covered Services under this pediatric vision Benefit, including providers outside of California. However, Members will usually pay more for services from a Non-Participating Provider. A list of Participating Providers in the Member's local area can be obtained by contacting the VPA at 1-877-601-9083. The Subscriber may also obtain a list of Participating Providers online at www.blueshieldca.com.

Customer Service for Pediatric Vision Benefits

For questions about these pediatric vision Benefits, information about pediatric vision providers, pediatric vision services, or to discuss concerns regarding the quality of care or access to care experienced, the Subscriber may contact:

Blue Shield of California

Vision Plan Administrator

Customer Service Department

P. O. Box 25208

Santa Ana, CA 92799-5208

The Subscriber may also contact the VPA at the following telephone numbers:

1-714-619-4660 or

1-877-601-9083

The VPA has established a procedure for Subscribers to request an expedited authorization decision. A Subscriber, 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. The VPA shall make a decision and notify the Subscriber and Physician as soon as possible to accommodate the Member's condition, not to exceed 72 hours following the receipt of the request. For additional information regarding the expedited decision process, or if the Subscriber believes a particular situation qualifies for an expedited decision, please contact the VPA Customer Service Department at the number listed above.

Grievance Process for Pediatric Vision Benefits

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

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the Vision Customer Service Department. If the Subscriber wishes, the Vision Customer Service staff will assist in completing the grievance form. Completed grievance forms should be mailed to the VPA at the address provided below. The Subscriber may also submit the grievance to the Vision Customer Service Department online at www.blueshieldca.com.

1-877-601-9083

Vision Plan Administrator

P. O. Box 25208

Santa Ana, CA 92799-5208

The VPA will acknowledge receipt of a written grievance within five (5) 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 Subscriber's dissatisfaction. See the previous *Customer Service* section for information on the expedited decision process.

Definitions for Pediatric Vision Benefits

Elective Contact Lenses — prescription lenses that are chosen for cosmetic or convenience purposes. Elective Contact Lenses are not medically necessary

Non-Elective (Medically Necessary) Contact Lenses — lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Contact lenses may also be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Prescription Change – any of the following:

1) Change in prescription of 0.50 diopter or more; or
2) Shift in axis of astigmatism of 15 degrees; or
3) Difference in vertical prism greater than 1 prism diopter; or
4) Change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

Vision Plan Administrator (VPA) – Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered under this Benefit through a network of Participating Providers.

VPA Participating Provider – For purposes of this pediatric vision Benefit, participating provider refers to a provider that has contracted with the VPA to provide vision services to Blue Shield Members.

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) 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; treatment (other than surgery) of chronic conditions of the foot (e.g., weak or fallen arches); flat or pronated foot; pain or cramp of the foot; special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;

4) services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;

5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or domiciliary care, except as provided under *Hospice Program Benefits*;

6) services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;

7) prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;

8) hearing aids;

9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, 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) 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, Pediatric Dental Benefits, and Hospital Benefits (Facility Services);

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

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

17) for or incident to the treatment of Infertility, including 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, 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, Imaging, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;

22) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Participating Providers;

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

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

25) 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, Behavioral Health, and Substance Use Disorder Benefits;

26) massage therapy that is not Physical Therapy or a component of a multiple-modality rehabilitation treatment plan;

27) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; 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;

28) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

29) 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;

30) 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;

31) 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;

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

33) 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 Health Care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

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

35) 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;

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

37) services not specifically listed as a Benefit.

See the *Grievance Process* section 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 health 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.

Limitation for Duplicate Coverage

Medicare Eligible Members

1) After this coverage in this plan has begun, Blue Shield will provide benefits if the Member is enrolled under Medicare but Medicare will be the primary payor and Blue Shield will:

   a) Estimate what Medicare would have paid for services received (based upon the reasonable value or Blue Shield's Allowable Amount) and

   b) Provide the Member's Blue Shield Benefits as if the Member was enrolled to receive benefits from Medicare.

The combined benefits from Medicare and the Blue Shield plan will equal but not exceed what Blue Shield would have paid if the Member were not eligible to receive Medicare benefits. Payment will be based on an amount that may be lower but will not exceed the Medicare allowed amount. The Blue Shield plan applicable Deductible, Copayments, and Coinsurance will be applied before plan Benefits are provided.

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 Allowable Amount for Covered Services provided to 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 Allowable Amount for Covered Services provided to 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 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 Allowable Amount).

Exception for Other Coverage

Participating Providers may seek reimbursement from other third party payers for the balance of their 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 limitations apply, and may use the services of Physician consultants, peer review committees of professional societies or hospitals, and other consultants.

Reductions – Third Party Liability

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the plan and have an equitable right to restitution, reimbursement or other available to recover the amounts Blue Shield paid for services provided to the Member on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield's right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code section 3040.

The Member is required to:

1) Notify Blue Shield in writing of any actual or potential claim or legal action which the Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party;
2) Cooperate with Blue Shield to execute any forms or documents needed to enable Blue Shield to enforce its right to restitution, reimbursement or other available remedies;
3) Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage;
4) Provide Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5) Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

A Member's failure to comply with items one (1) through five (5) above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

Further, if the Member received 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.

Conditions of Coverage

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Eligibility and Enrollment

To enroll and continue enrollment, a Subscriber must meet all of the eligibility requirements of this plan. Subscribers must reside in a Blue Shield service area for this plan within California to be eligible to enroll in coverage.

A Subscriber or Dependent may enroll during the annual Open Enrollment Period. Under certain circumstances, an individual or Dependent may qualify for a Special Enrollment Period. Other than during the annual Open Enrollment Period, or a Special Enrollment Period, a Subscriber or Dependent may not enroll in this heath plan.

Blue Shield will provide the Subscriber with a notice of the annual Open Enrollment Period each year. For additional information on enrollment periods, please contact Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be eligible immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their coverage under this health plan solely because of age, may continue to be eligible for coverage if they continue to meet the definition of Dependent in this Evidence of Coverage and Health Service Agreement. See the Definition of Dependent for additional information.

Effective Date of Coverage

Blue Shield will notify the Subscriber of the Effective Date of coverage for the Subscriber and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the Effective Date.

Other than during the annual Open Enrollment Period, a Subscriber or Dependent may not enroll in health coverage in the individual market unless the Subscriber or Defendant qualifies for a Special Enrollment Period. If an individual qualifies for a Special Enrollment Period, he or she must apply within the time limits applicable to the event that qualified the applicant for a Special Enrollment Period. If a Subscriber enrolls mid-year during a Special Enrollment Period, his or her plan benefit year will end December 31.

Effective dates will vary based on the circumstances of the Special Enrollment Period according to the guidelines established by federal and state law. In general, if a Subscriber or Dependent qualifies for a Special Enrollment Period (see Definitions), and the Subscriber submits a premium payment that is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first of the month after receipt of payment. If the Subscriber submits a premium payment that is delivered or postmarked after the 15th of the month, coverage will be effective on the first of the second month after receipt of payment.

However, if the Subscriber qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage, or Domestic Partnership, and enrollment is requested within 60 days of the event, the Subscriber may request enrollment for those Dependents within 60 days. 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)

Monthly Premiums are as stated in the Appendix and are set for a rating period that runs for the Calendar Year. Blue Shield offers a variety of options and methods by which Members may pay Premiums. Please call Customer Service to discuss these options or visit www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield of California

P.O. Box 51827

Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield a tax or license fee which is calculated upon base Premiums or Blue Shield of California's gross receipts or any portion of either. Premiums may also increase from time to time as determined by Blue Shield in accordance with federal and state law and regulations. Relocating to a different geographic rating area may lead to a change in Premium based on rating differences between geographic areas. Blue Shield will provide 60 days written notice of any changes in the monthly Premiums for this plan.

Term of the Agreement

This Agreement shall be renewed upon receipt of prepaid Premiums by Blue Shield unless otherwise terminated as described herein. Renewal is subject to Blue Shield's right to amend this Agreement. Any change in Premiums or Benefits is effective after 60 days notice to the Subscriber's address of record with Blue Shield of California.

This Agreement has a benefit year that runs for the Calendar Year. Subscribers and their Dependents will have an annual Open Enrollment Period from October 15 through December 7 each year to select a different or new plan. Covered California will give notice of the annual Open Enrollment Period.

Blue Shield will offer to renew the Agreement except in the following instances:

1) Non-payment of Premiums;
2) Fraud, misrepresentations, or omissions;
3) Termination of plan type by Blue Shield;
4) Blue Shield determines that the individual is no longer eligible for coverage in this plan; or
5) Subscriber relocates outside of California.

Termination of Benefits (Cancellation and Rescission of Coverage)

Cancellation at Member Request

A Subscriber may cancel this Agreement by providing Blue Shield 30 days' written notice.

Cancellation of Member's Enrollment by Blue Shield

Blue Shield may cancel a Member's coverage in this plan in the following circumstances:

1) The Member is no longer eligible for coverage in the plan.
2) Non-payment of premiums following expiration of any grace periods for payment.
3) Termination of this Blue Shield plan.
4) The Subscriber changes from one health plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

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:

1) Providing false or misleading material information on the enrollment application or otherwise to 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 Agreement by means of false, materially misleading, or fraudulent information, acts or omissions.

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents terminates at 11:59 p.m. Pacific Time on a date as determined by the reason for termination.

1) For non-payment of premiums, see Cancellation for Subscriber's Nonpayment of Premiums provision.

2) For termination by Blue Shield if Subscriber moves out of service area:

   Blue Shield may cancel this Agreement upon thirty (30) days written notice if the Subscriber moves out of California.

   Within 30 days of the notice of cancellation, Blue Shield shall refund the Premiums, if any, that Blue Shield determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such Premium refund any amounts paid by Blue Shield for benefits paid or payable by Blue Shield after the termination date.

3) Termination by Blue Shield due to withdrawal of the Agreement from the market:

   Blue Shield may terminate this Agreement together with all like Agreements to withdraw it from the market. In such instances the Subscriber will be given 90 days written notice and the opportunity to enroll on any other individual agreement.

4) For changes from one plan to another during the annual Open Enrollment or a Special Enrollment Period, the Subscriber's last day of coverage will be the day before the effective date of coverage in his or her new plan.

Even if a Subscriber remains covered, his or her Dependent's coverage may end if a Dependent becomes 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 terminates 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 terminates 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 day before his or her 26th birthday, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent.

In addition, if a request for the addition of a newborn or a newborn child placed for adoption or adopted is not submitted to and received by Blue Shield within the 60 days following that Dependent's birth, Benefits under this health plan for that newborn child will be terminated on the 31st day at 11:59 p.m. Pacific Time.

Cancellation for Subscriber's Nonpayment of Premiums

Blue Shield may cancel this Agreement for failure to pay the required Premiums when due:

1) If the Agreement is being cancelled because the Subscriber failed to pay the required

Premiums when due, then coverage will end 30 days after the date for which the Premiums are due. Subscriber will be liable for all Premiums accrued while this Agreement continues in force including those accrued during this 30 day grace period.

2) Notice. Within five business days of canceling or not renewing the Agreement, the Plan will mail Subscriber a Notice Confirming Termination of Coverage, which will inform of the following:

   a) That the Agreement has been cancelled, and the reasons for cancellation;

   b) The specific date and time when coverage for the Subscriber and all Dependents ended.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield has the right to rescind this Agreement if the information contained in the application or otherwise provided to Blue Shield by the Subscriber or anyone acting the Subscriber's behalf in connection with the application was intentionally and materially inaccurate or incomplete. This Agreement also may be rescinded if the Subscriber or anyone acting on his or her behalf failed to disclose to Blue Shield any new or changed facts arising after the application was submitted but before this Agreement was issued, when those facts pertained to matters inquired about in the application. However, after 24 months following the issuance of the Agreement, Blue Shield will not rescind the Agreement for any reason. If after enrollment, Blue Shield investigates the application information, Blue Shield will not rescind this Agreement without first notifying the Subscriber of the investigation and offering an opportunity to respond.

If this Agreement is rescinded, it means that the Agreement is voided retroactive to its inception as if it never existed. This means that the Subscriber and Dependents will lose coverage back to the original Effective Date. If the Agreement is properly rescinded, Blue Shield will refund any Premium payments made, but, to the extent permitted by applicable law, may reduce that refund by the amount of any medical expenses that Blue Shield paid under the Agreement or is otherwise obligated to pay. In addition, Blue Shield may, to the extent permitted by California law, be entitled to recoup from the Subscriber all amounts paid by Blue Shield under the Agreement.

If this Agreement is rescinded, Blue Shield will provide a 30-day advance written notice that will: (1) explain the basis of the decision and appeal rights, including the right to request assistance from the California Department of Managed Health Care; (2) clarify that those Members whose application information was not false or incomplete are entitled to new coverage, and will explain how those Members may obtain this coverage; and (3) explain that the monthly Premiums for those Members will be determined based on the number of individuals that remain Blue Shield Members.

Transfer of Coverage

1) If a Subscriber moves out of California, coverage under this Agreement will terminate. If a Subscriber moves to an area served by another Blue Cross and/or Blue Shield plan and notifies Blue Shield of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.

2) The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to subscribers who leave a group and apply for new coverage as individuals.

3) Conversion policies provide coverage without a medical examination or health statement.

4) If the Subscriber accepts the conversion policy, the new plan will credit the

Subscriber for the length of his enrollment in this plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.

5) The required Dues or premium amount and benefits available from the new plan may vary significantly from this plan.

6) In addition, the new plan may offer other types of coverage outside the transfer program which may:

   a) Require a medical examination or health statement to exclude coverage for pre-existing conditions; and

   b) Not credit the time enrolled in this Agreement.

General Provisions

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 Participating Providers stipulates that the Subscriber shall not be responsible to the Participating Provider for compensation for any services to the extent that they are provided in the Member's Agreement. Participating Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments, and Coinsurance, amounts in excess of specified Benefit maximums, or as provided under the *Exception for Other Coverage* and *Reductions - Third Party Liability* sections.

If services are provided by a Non-Participating 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.

No Maximum Aggregate Payment Amount

There is no maximum limit on the aggregate payments by Blue Shield for Covered Services provided under the Agreement.

No Annual Dollar Limit on Essential Health Benefits

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

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.

Assignability

Coverage or any Benefits of this Agreement may not be assigned without the written consent of Blue Shield.

Possession of a Blue Shield ID card confers no right to Covered Services or other Benefits of this Agreement. To be entitled to services, the Member must be a Subscriber who has been enrolled by Blue Shield and who has maintained enrollment under the terms of this Agreement.

Participating Providers are paid directly by Blue Shield.

If the Member receives Covered Services from a Non-Participating Provider, Blue Shield at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third party beneficiary or other legal relationship between Blue Shield and the Non-Participating

Provider. In addition, whether Blue Shield pays the Subscriber of the Non-Participating Provider, the Subscriber remains responsible for all charges up to the Non-Participating Provider's billed amount.

Plan Interpretation

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

Public Policy Participation Procedure

This procedure enables Members to participate in establishing the public policy of Blue Shield. 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 patients who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield 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 your letter.
2) Please include name, address, phone number, and Subscriber 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 your 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 Evidence of Coverage, 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 Agreement. 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 the Member's 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.

Legal Process

Legal process or service upon Blue Shield must be served upon Blue Shield's Registered Agent for Service of Process or upon Blue Shield at Blue Shield's corporate offices at 50 Beale Street, San Francisco, California 94105.

Organ and Tissue Donation

Many residents in the state of California are eligible to become organ and tissue donors. Donors can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at www.ctdn.org or Donate Life California's internet site at www.donatelifecalifornia.org. Potential donors can also call the regional organ procurement agency in the nearest city nearest for additional information on organ and tissue donation.

Notice of Participating Provider Inability to Perform, Breach, or Termination

If the inability to perform by a Participating Provider, the breach of the Agreement to furnish services by a Participating Provider, or the termination of a Participating Provider's contract with Blue Shield materially and adversely affects the Member, Blue Shield will, within a reasonable time, advise the Member in writing of such inability to perform, breach, or termination.

Entire Agreement: Changes

This Agreement, including the appendices, constitutes the entire agreement between parties. Any statement made by a Member shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by a corporate officer of Blue Shield and a written endorsement issued. No representative has authority to change this Agreement or to waive any of its provisions. The terms of this Agreement, including but not

limited to Benefits, Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximums and Premiums are subject to change at any time. Blue Shield will provide at least 60 days written notice of changes relating to premium rates or coverage.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain Benefits.

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.

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are appendices pertaining to Deductibles and Premiums. Endorsements may be issued from time to time subject to the notice provisions in the section entitled Duration of the Agreement. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield and notice to Blue Shield may be mailed to:

Blue Shield of California

50 Beale Street

San Francisco, CA 94105

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Identification Cards

Identification cards will be issued by Blue Shield to all Subscribers.

Statutory Requirements

This Agreement is subject to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

Blue Cross and Blue Shield Association Disclosure

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue

Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the plan's obligations created under this Agreement. This paragraph shall not create any additional obligations to the Subscriber whatsoever on the part of the Plan, other than those obligations created under other provisions of this Agreement.

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 Evidence of Coverage.

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

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 plan at the telephone number as noted on the back page of this Evidence of Coverage and Health Service Agreement. 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 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, Behavioral Health, and Substance Use Disorder Services

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

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

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.

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the

Friedman-Knowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law.

Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service.

The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review.

The Member and the Member's physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-200-3242 and use your 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 you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://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 you or your Dependents and you feel that such action was due to reasons of health or utilization of benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

Definitions

When the following terms are capitalized in this Evidence of Coverage and Health Service Agreement, they will have the meaning set forth below:

Accidental Injury — a definite trauma, resulting from a sudden, unexpected and unplanned event, occurring by chance, and 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.

Agreement (Evidence of Coverage and Health Service Agreement) — this contract, including this Evidence of Coverage and Health Service Agreement, Summary of Benefits, all endorsements, and all applications for coverage.

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 Evidence of Coverage, 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.

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 providing outpatient services 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.

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

Bariatric Surgery Services Provider — a Participating 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 Agreement).

Behavioral Health Treatment – 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.

Benefits (Covered Services) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to this Agreement.

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

Brand Drugs — Drugs which are FDA approved after a new drug application and/or registered under a brand or trade name by its manufacturer.

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 services and supplies which a Member is entitled to receive pursuant to the terms of this Agreement.

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 insurance, 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 Medi-Cal 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 Care 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 or supervisory care by a Doctor of Medicine); or care furnished to a person 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 individual to live outside an institution providing such care; or

2) when, despite such 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 this Agreement.

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 who meets the definition of Domestic Partner as defined in this Agreement.

3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. 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:

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

   b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of Blue Shield's request; and

   c) thereafter, certification of continuing disability and dependency from a

Physician must be submitted to Blue Shield on the following schedule:

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

(ii) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

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 registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Drugs — Drugs are:

1) FDA-approved medications that require a prescription either by California or Federal 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:
   - diaphragms,
   - cervical caps,
   - contraceptive rings,
   - contraceptive patches,
   - oral contraceptives,
   - emergency contraceptives, and
   - female OTC contraceptive products when ordered by a Physician or Health Care Provider;
7) Inhalers and inhaler spacers for the management and treatment of asthma.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1) placing the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) 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.

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.

Formulary — A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

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

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.

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 a home health agency licensed pursuant to California Health and Safety Code Sections 1726 and 1747.1 which 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;

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.

Infertility — the Member is actively trying to conceive and has:

1) the presence of a demonstrated condition recognized by a licensed Doctor of Medicine as a cause of not being able to conceive;

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

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

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, behavioral health, or substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

Medical Necessity (Medically Necessary) -

Benefits are provided only for services that are Medically Necessary.

1) Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:

   a) consistent with Blue Shield medical policy;

   b) consistent with the symptoms or diagnosis;

   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 the 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 that 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; and

   e) for inpatient Rehabilitation that can be provided on an outpatient basis.

4) Blue Shield reserves the right to review all claims to determine whether services 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 plan pursuant to this Agreement as either a Subscriber or a Dependent.

Mental Health Condition — mental disorders listed in the "Diagnostic & Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)", 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 Services, Behavioral Health Treatment, and Substance Use Disorder 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 Services, Behavioral Health Treatment, or Substance Use Disorder Services to Members of this Plan.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services to Members of this Plan.

Network Specialty Pharmacy – select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.

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

Non-Participating or Non-Preferred (Non-Participating Provider or Non-Preferred Provider) — refers to any provider who has not contracted with Blue Shield's Exclusive Provider Network 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 of this Plan.

This definition does not apply to providers of Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services,

which is defined separately under the MHSA Non-Participating Provider definition.

Non-Preferred 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-Preferred Drugs and are always subject to the Non-Preferred Copayment or Coinsurance.

Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment– Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including but not limited, to the following:

1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
4) Transcranial Magnetic Stimulation
5) Behavioral Health Treatment
6) Psychological Testing
7) Other outpatient items and services

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

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

1) Partial Hospitalization
2) Intensive Outpatient Program
3) Office-Based Opioid Treatment
4) Post-discharge ancillary care services.

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

Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by an occupational therapist or other appropriately licensed or certified 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 – the yearly period during which an individual may enroll or change coverage. The Open Enrollment Period is October 15 to December 7. For 2014, the initial Open Enrollment Period will run from October 1, 2013 to March 31, 2014.

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; nurse practitioners; licensed psychiatric nurses; licensed clinical social worker; marriage and family therapist; applied behavior analyst, acupuncture practitioners; registered dieticians and other nutrition advisors; certified nurse midwives; licensed occupational therapists; physical therapist; licensed acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech and language therapists or pathologists; dental technicians lab technicians, and any other practitioners included in (28 CCR 1300.50(I)(1)).

2) A provider who does not participate with this Plan's network, but does have a contract with Blue Shield to participate in the network for another Blue Cross and/or Blue Shield plan or plans.

3) 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-Pocket Maximum - the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, 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 acute inpatient care following stabilization.

Participating or Preferred (Participating Provider or Preferred Provider) – refers to a provider who has contracted with Blue Shield's Exclusive Provider Network 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 of this Plan.

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

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

Period of Care – the timeframe the Participating Provider 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.

Physical Therapy — treatment provided by a physical therapist, occupational therapist, or other appropriately licensed or certified 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 — 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 – this Blue Shield PPO Plan.

Preferred Drugs – Drugs listed on Blue Shield's Formulary and determined by Blue Shield's Pharmacy and Therapeutics Committee as products that have a clear advantage over Non-Formulary Drug alternatives.

Premium (Dues) — the monthly prepayment made to Blue Shield on behalf of each Member by the Contractholder for coverage under this Agreement.

Preventive Health Services — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically described in the *Preventive Health Benefits* section of this Evidence of Coverage.

Prosthesis(es) (Prosthetics) — 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-Participating 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; 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, in order 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.

Resident of California - an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

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

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

Routine Outpatient Mental Health Services and Behavioral Health Treatment – professional office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including the individual, family, or group setting.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1) have 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) meet 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 6 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 in 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, a health plan outside of the Open Enrollment Period. An individual and/or his or her Dependents has a 60-day Special Enrollment Period if any of the following occurs:

1) An individual or Dependent loses minimum essential coverage for a reason other than failure to pay premiums on a timely basis.

2) An individual or Dependent has lost or will lose coverage under an employer health benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan's coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an employer's contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.

3) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The health benefit plan shall enroll such a Dependent child within 60 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.

4) An individual or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility.

5) An individual or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal premium assistance program and requests enrollment within 60 days of the notice of eligibility for these premium assistance programs.

6) An individual acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption or placement for adoption.

7) An individual's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of Covered California, HHS, or any of their instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

8) An individual or Dependent demonstrates to the department that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

9) An individual or Dependent adequately demonstrates that the health plan in which he or she is enrolled substantially violated a

material provision of its contract in relation to the individual or Dependent

10) An individual or Dependent gains access to new health plans as a result of a permanent move;

11) An individual or Dependent is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions.

12) An individual or Dependent has been released from incarceration.

13) An individual or Dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the health benefit plan.

14) An individual or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

15) An individual or Dependent is enrolled in an eligible employer-sponsored plan that is not qualifying coverage in an eligible employer-sponsored plan and is allowed to terminate existing coverage. Such an individual must be permitted to access this special enrollment period 60 days prior to the end of his or her coverage through such eligible employer-sponsored plan.

16) An individual or Dependent experiences a qualifying event, as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended, including:

    a) With respect to the Subscriber:

        (1) the termination of employment (other than by reason of gross misconduct); or

        (2) the reduction of hours of employment to less than the number of hours required for eligibility.

    b) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children

        (1) the death of the Subscriber; or

        (2) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or

        (4) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or

        (5) the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or

        (6) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

        (7) a Dependent child's loss of Dependent status under this plan.

    c) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and De-pendent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

NOTE: Contact Blue Shield to determine when the Special Enrollment Period begins.

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.

Specialist - Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

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

Speech Therapy — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist or 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 a 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 that is primarily a rest-home, convalescent facility, or home for the aged is not included.

Subscriber — an individual who is a Resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield, and has maintained Blue Shield membership in accord with this Agreement.

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

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

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

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 សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

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

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

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Officer, to take effect on the Subscriber's Effective Date.

Jeff Smith, Vice President and General Manager
Individual and Family Plans
Blue Shield of California

Contacting Blue Shield of California

For information, including information about claims submission:

Members may call Customer Service toll free at 1-800-200-3242.

The hearing impaired may call Customer Service 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 Benefits Management Program radiological services:

Please call 1-888-642-2583.

For prior authorization of inpatient Mental Health, Behavioral Health, and Substance Use Disorder Services:

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

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

Please direct correspondence to:

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

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