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Blue Shield of California Health Benefits

Your benefits

How to use your plan

Evidence of Coverage

Contents

Dear valued member,

Welcome, and thank you for choosing Blue Shield.

We've been working hard to make health coverage easy to understand and easy to use. You can depend on access to the quality care you deserve from the health plan you trust from our broad provider network and helpful service representatives.

Use this book to get the most from your HMO plan. We've organized and streamlined the information you need for easy reference. We begin by covering the important details, from choosing doctors and other providers and obtaining prescription drugs to accessing care when you're away from home.

Discover how we complement your coverage with an array of tools, programs and services – including Wellvolution,® Teladoc, NurseHelp 24/7,℠ the *Find a Doctor* tool and more – for improving and maintaining your best health.

Members can now access even more of their health plan information anytime, anywhere with the Blue Shield mobile app available for iPhone® and Android.™ Download the mobile app to access your digital Blue Shield member ID card, view claims and benefit information, find a doctor or urgent care center and more!

Please let us know if you have any questions.

- Check out our online resources at **blueshieldca.com**.
- Give us a call. If you have questions or need assistance in a language other than English, our service representatives can help you. Call us at the number on your Blue Shield ID card or at **(888) 319-5999** for companies with 1-100 employees or at **(888) 256-1915** for companies with 101+ employees. Our TTY line for hearing-impaired service is **711**.
- Submit claims and other correspondence to: Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540.

Thank you again for choosing Blue Shield. We look forward to serving you and helping you meet your healthcare coverage needs.

Sincerely,

Your Blue Shield Support Team

A17564 (10/16)

Your health notes

Use this page for personal health and support information and any other notes.

Healthcare information

Provider's name	Specialty	Telephone number
	Primary care physician	( )
	Pediatrician	( )
	Dentist	( )
	Ophthalmologist	( )
	Cardiologist	( )
		( )
		( )
		( )
		( )

Prescriptions

Family member's name	Drug name	Generic or brand	Prescription number	Copay

Pharmacy information

Name of local pharmacy	Address	Telephone number
		( )
		( )

Drug allergies

Family members experiencing allergic reaction	Drug name

Other information/emergency contacts

Urgent care facility	( )
Day care	( )
Baby sitter	( )
Veterinarian	( )
NurseHelp 24/7℠	(877) 304-0504
Teladoc	(800) 835-2362
LifeReferrals 24/7℠	(800) 985-2405
Others	( )

your coverage

This section summarizes your Blue Shield plan benefits.

blue of california

Chiropractic Services

Supplement to Your Blue Shield
Access+ HMO EOC

Summary of Benefits

Benefit	Member Copayment
Covered Services as described in this Supplement and authorized by American Specialty Health Plans of California, Inc. (ASH Plans)	
Chiropractic Services	
Office Visit	$10 up to a maximum of 30 visits per Calendar Year[1]
Benefit	**Maximum Blue Shield Payment**
Chiropractic Appliances	$50 per Calendar Year[2]

[1] The 30 visits maximum is a per Member per Calendar Year maximum for all chiropractic Services.
[2] Member is responsible for all charges above the maximum payment indicated.

Introduction

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

Benefits

Benefits are provided for Medically Necessary chiropractic Services up to the maximum visits per Calendar Year as shown on the Summary of Benefits for routine chiropractic care when received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. This Benefit includes an initial examination and subsequent office visits, adjustments, and conjunctive therapy as authorized by ASH Plans up to the Benefit maximum specified above. Benefits are also provided for X-rays.

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

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

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

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

Services provided by Non-Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no Participating Providers. A Non-Participating Provider is a chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to Members.

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

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

Member Services

For all chiropractic Services, Blue Shield of California (BSC) has contracted with ASH Plans to act as the Plan's chiropractic Services administrator. ASH Plans should be contacted for questions about chiropractic Services, ASH Plans Participating Providers, or chiropractic Benefits. You may contact ASH Plans at the telephone number or address which appear below:

1-800-678-9133

American Specialty Health Plans of California, Inc.

P.O. Box 509002

San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Grievance Process

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

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

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

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

NOTE: If your employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans) - ASH Plans is a licensed, specialized health care Service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of chiropractic Services.

Neuromusculo-skeletal Disorders – conditions with associated signs and symptoms related to the nervous, muscular, and / or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and / or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments / capsules, discs, and synovial structures) and related to neurological manifestations or conditions.

Participating Provider – a Participating Chiropractor or other licensed health care provider under contract with ASH Plans to provide Covered Services to Members.

Please be sure to retain this document. It is not a contract but is a part of your *Blue Shield Access+ HMO EOC.*

Enhanced Rx $10/25/40 - $20/50/80 with $0 Pharmacy Deductible

THIS DRUG COVERAGE SUMMARY IS ADDED TO BE COMBINED WITH THE HMO OR POS PLANS UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Outpatient Prescription Drug Coverage
(For groups of 101 and above)

Blue Shield of California

Highlight: $0 Calendar Year Pharmacy Deductible
$10 Tier 1 / $25 Tier 2 / $40 Tier 3 drug - Retail Pharmacy
$20 Tier 1 / $50 Tier 2 / $80 Tier 3 drug - Mail Service

Covered Services	Member Copayment
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible)	
Calendar Year Pharmacy Deductible	None
PRESCRIPTION DRUG COVERAGE [1, 2, 3, 4]	**Participating Pharmacy** [5]
Retail Prescriptions up to a 30-day supply)	
• Contraceptive drugs and devices [6]	$0 per prescription
• Tier 1 drugs	$10 per prescription
• Tier 2 drugs	$25 per prescription
• Tier 3 drugs	$40 per prescription
• Tier 4 drugs (excluding Specialty drugs)	20% (up to $200 copayment maximum per prescription)
Mail Service Prescriptions (up to a 90-day supply)	
• Contraceptive drugs and devices [6]	$0 per prescription
• Tier 1 drugs	$20 per prescription
• Tier 2 drugs	$50 per prescription
• Tier 3 drugs	$80 per prescription
• Tier 4 drugs (excluding Specialty drugs)	20% (up to $400 copayment maximum per prescription)
Specialty Pharmacies (up to a 30-day supply) [7]	
• Tier 4 - Specialty drugs [8]	20% (up to $200 copayment maximum per prescription)

1 Amounts paid through copayments and any applicable pharmacy deductible accrues to the member's medical calendar year out-of-pocket maximum. Please refer to the *Evidence of Coverage* and Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Drugs obtained at a non-participating pharmacy are not covered, unless Medically Necessary for a covered emergency.

3 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the Tier 1 drug copayment plus the difference in cost to Blue Shield between the brand drug and its generic drug equivalent.

5 When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

6 Contraceptive drugs and devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

7 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring 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.

8 Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup. Oral anticancer medications are not subject to the calendar year pharmacy deductible.

Note: This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the Federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 83 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you would be subject to a late enrollment penalty in addition to your Part D premium.

Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Evidence of Coverage*.
2. Go to https://www.blueshieldca.com/bsca/pharmacy/home.sp and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of https://www.blueshieldca.com/bsca/pharmacy/home.sp and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions•.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

Plan designs may be modified to ensure compliance with state and Federal requirements.

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blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin costo, por favor llame inmediatamente al teléfono de Servicios al Miembro/Cliente que se encuentra al reverso de su tarjeta de identificación dental de Blue Shield. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用 您所講的語言書寫。如需免費幫助，請立即撥打登列在您的 Blue Shield 牙科 ID卡背面上 的會員/客戶服務部的電話。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Trợ giúp miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng isang tao na makatutulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito sa iyong wika. Para sa tulong na walang gastos, mangyaring tumawag kaagad sa numero ng telepono ng Serbisyo sa Miyembro/Customer na nasa likod ng iyong Dental ID kard ng Blue Shield. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh íliníigó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá'. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

Access+HMO® Zero Admit 20

Benefit Summary (For groups of 101 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2017

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND *PLAN CONTRACT* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: A description of the prescription drug coverage is provided separately

Calendar Year Medical Deductible	None
Calendar Year Out-of-Pocket Maximum	$1,000 per individual / $2,000 per family
Lifetime Benefit Maximum	None
Covered Services	**Member Copayment**
OUTPATIENT PROFESSIONAL SERVICES	
Professional (Physician) Benefits	
Physician and specialist office visits (note: a woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)	$20 per visit
Teladoc consultation	$5 per consultation
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
Allergy Testing and Treatment Benefits	
Allergy testing, treatment and serum injections	$20 per visit
Access+ *Specialist*℠ Benefits [1]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$35 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT FACILITY SERVICES	
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	No Charge
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	No Charge
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	No Charge
Inpatient Skilled Nursing Benefits [2, 3] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Free-standing skilled nursing facility	No Charge
Skilled nursing unit of a hospital	No Charge
EMERGENCY HEALTH COVERAGE	
Emergency room services not resulting in admission (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit
Emergency room physician services	No Charge
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$100 per transport
PRESCRIPTION DRUG COVERAGE	
Outpatient Prescription Drug Benefits	
A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Member Services number on your identification card.	
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge

Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based on allowed charges)	50%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES [4, 5]	
Inpatient hospital services	No Charge
Residential care	No Charge
Inpatient physician services	No Charge
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$20 per visit
Non-routine outpatient mental health and substance use disorder services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, psychological testing and transcranial magnetic stimulation)	No Charge
HOME HEALTH SERVICES	
Home health care agency services [2] Coverage limited to 100 visits per member per calendar year.	$20 per visit
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and postnatal physician office visits (may be billed as part of global maternity fee including hospital inpatient delivery services)	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling, consulting, and education (Includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services (member cost share is based upon allowed charges) (diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$20 per visit
SPEECH THERAPY BENEFITS	
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$20 per visit
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see Outpatient Prescription Drug Benefits)	20%
Diabetes self-management training	$20 per visit
URGENT CARE BENEFITS	
Urgent care services outside your personal physician service area within California	$20 per visit
Urgent care services outside of California (BlueCard® Program)	$20 per visit
OPTIONAL BENEFITS Optional dental, vision, hearing aid, infertility, chiropractic or acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

1 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA.

2 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan deductible has been met.

3 Inpatient skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on inpatient skilled nursing services is a combined maximum between skilled nursing services provided in a hospital unit and skilled nursing services provided in a skilled nursing facility (SNF).

4 Mental health and substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using MHSA participating providers.

5 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers.

Plan designs may be modified to ensure compliance with state and Federal requirements.

A44602-Rev_(1/17)

blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

accessing health care

Use the information in this section to access care and make the most of your healthcare coverage.

HMO plans at a glance

An easier way to manage your health care and costs

HMO plans give you a wide range of benefits to help you achieve your health and wellness goals:

- Preventive care office visits with no extra copayment
- Laboratory, X-ray, and diagnostic testing
- Inpatient physician services (including pregnancy and maternity care)
- No or low drug and medical deductibles
- Access to one of the largest provider networks in California
- No lifetime maximums

Depending on your company's plan, you may also have benefit coverage for:

- Chiropractic services
- Acupuncture
- Infertility
- Substance use disorder

See your *Evidence of Coverage* (EOC) document at the end of this booklet, or check with your company's plan administrator for your specific benefit coverage.

Plus, as an HMO member, you get more choices and easier access to care with:

Access+ *Specialist*℠ – You have the option of going directly to a participating specialist in the same medical group or Independent Practice Association (IPA) as your primary care physician (PCP), without a referral. When you use this option (available to you if an A+ follows the PCP or IPA/medical group name on your Blue Shield member ID card), you pay a slightly higher office visit copayment.

Access+ *Satisfaction*® – If you are ever dissatisfied with the service you received during a covered office visit with an HMO network physician, you can request a refund of the standard office visit copayment.

Register now for quick and easy access to your plan details and more

You can register today on blueshieldca.com. Once you've registered, you can log in and click on *Member Log In* to:

- See highlights and details of your health plan coverage
- Understand your copayment and deductible amounts
- Check the status of your claims
- Access health and wellness programs
- Sign up for the *Health Update* monthly email newsletter
- Find a physician or hospital
- Change your PCP
- Get answers to pharmacy questions
- Order replacement ID cards
- Print temporary ID cards
- Download Summary of Benefits and Coverage forms

Blueshieldca.com and mobile apps

You can now get your health plan information anytime, anywhere. The Blue Shield website and mobile apps have been designed for faster navigation and easier access on the go. You can visit Blue Shield's mobile website by entering blueshieldca.com into the mobile device's browser or by downloading the Blue Shield of California mobile app on the App Store℠ or Google Play™.

Your Blue Shield ID card

We recommend that you carry your Blue Shield member ID card with you at all times. When you receive care, your physician or other healthcare provider will ask to see it. Call Member Services at **(800) 424-6521** or log in to the *Member Log In* section of blueshieldca.com if you lose your ID card, or need to order or print another one.

Finding a doctor

Search online

Go to blueshieldca.com and use the *Find a Doctor* search feature for physicians or hospitals, or download a copy of our directory. You can customize your search to specify gender, specialty, language preference, and location.

To determine the availability of translation and sign-language service during medical visits, please contact the healthcare provider.

Compare providers

Our Performance Profile feature helps you compare network providers, so you can make informed healthcare choices. Based on nationally recognized quality measures, Performance Profile provides easy, online access to quality scores and patient satisfaction scores for HMO medical groups and hospitals.

Find a Doctor quality indicators

Get easy, online access to quality scores and patient satisfaction scores with the Find a Doctor Performance Profile, within the *Find a Doctor* tool.

Request a provider directory

If you would like a printed copy of our *HMO Physician and Hospital Directory*, call Member Services at the telephone number listed on your ID card.

Choosing a primary care physician (PCP)

As an HMO member, you may choose a PCP from our network to be your primary healthcare provider. You will access most of your healthcare services through your PCP. When you do, you pay just your copayment amount.

It's likely you have already selected your PCP. You and your covered family members may choose to have the same or different PCPs. If you did not select a PCP or designate a PCP for each of your dependents, then Blue Shield has chosen one for you.

Healthcare services from your PCP

You can expect your PCP to:

- Provide and coordinate your medical care, including referrals to specialists
- Order lab tests, X-rays, and other medical tests
- Arrange your admission to a hospital, ambulatory surgery center, or skilled nursing facility
- Focus on improving and maintaining your health through preventive care services, including periodic exams, immunizations, and well-child and well-baby care
- Assist you in finding mental health and substance use disorder services
- Assist in applying for hospice care
- Arrange for home health care, if needed

Changing your physician

Your care is important to us. If you change your PCP during hospitalization, while you are pregnant, or during the course of treatment, the quality and continuity of your care may be interrupted. So, your selection of a new PCP or medical group/IPA will become effective on the first day of the month following your discharge from the hospital, the delivery of your baby, or when it is medically appropriate to transfer your care.

The regional Blue Shield medical director must approve exceptions. For information about requesting approval for an exception, please contact Member Services.

Selecting or changing PCPs

You may select a new PCP or designated medical group/IPA at any time, for any reason. You can either:

1. Go to blueshieldca.com, search for and choose a new PCP; or
2. Call a Member Services representative at the telephone number listed on your Blue Shield ID card to help you make the change.

In most cases, the change will be effective on the first day of the month following your request.

PCPs for your newborn and adopted children

Newborns must have a PCP in the same medical group as the mother's PCP. If the mother is not an HMO member, we will assign the newborn a PCP from the subscriber's PCP's medical group. Adopted children must have a PCP in the same medical group as the subscriber's PCP. You may select a new PCP for any of your children after their first month of coverage.

Member satisfaction

We want to hear what you have to say about our HMO network physicians and their staff. If you are ever dissatisfied with the service you received during a covered office visit with an HMO physician, we'll refund your standard office visit copayment.

Here's how it works:

- If you have a positive or negative comment about the service you received from an HMO physician or staff member during a covered office visit, call the Member Services number shown on your Blue Shield ID card.

Using your prescription drug coverage

Drug benefits and applicable prescription copayments and deductibles vary among different types of health plans. You can find details about your drug coverage three ways:

1. Check your EOC document at the end of this booklet or the benefit summary located in this book for information on your prescription drug coverage; or
2. Go to blueshieldca.com and log in at the top of the home page (registration required); or
3. Call the Member Services number shown on your Blue Shield ID card.

Then make the most of your prescription drug benefit and help to manage your costs by following these simple steps:

1. Check our formulary

The *Blue Shield Drug Formulary Plus*, a list of prescription drugs that are covered by the benefit plan, is just one of the ways we're managing treatment quality and keeping medication costs down for you.

You can review our formulary two ways:

Search online. Go to blueshieldca.com. Under *Be Well*, click on *Drugs* and then choose *Drug Formularies* to:

- Search for drugs and find out if they are included in our formulary
- Find generic equivalents for brand drugs (where available)
- Review coverage restrictions or prior authorization requirements
- See your copayment for prescription drugs (formulary, non-formulary, or specialty)

Get a printed copy. You can download a printable version of our formulary from blueshieldca.com. Just go to blueshieldca.com and click on the *Be Well* tab and then click on *Drugs*.

2. Get authorization, if needed

Prior authorization is when a prescriber must demonstrate medical necessity before a drug is covered. Prior authorization helps to promote patient safety and keep the cost of health care affordable.

- While your Blue Shield plan may cover the drugs listed in our formulary, some formulary and non-formulary drugs may require prior authorization for medical necessity.
- Most medications are covered by Blue Shield without requiring prior authorization. However, some select drugs require a physician to provide information about the patient's prescription and medical history to determine if the medication is a medical necessity. Drugs requiring prior authorization for medical necessity are listed in the formulary with "PA."
- If a pharmacy tries to process a prescription that requires prior authorization, we will notify them immediately, and they can assist in having your physician contact Blue Shield Pharmacy Services to begin the prior authorization process.

You may also contact Member Services at **(800) 443-5005** or **TTY (800) 241-1823** to request prior authorization.

3. Consider a generic alternative

Choosing generic drugs when they are available, instead of brand drugs, is one of the easiest ways to reduce your prescription costs. Generic drugs often have a lower copayment than brand-name drugs.

The Food and Drug Administration (FDA) requires that generic drugs have the same active ingredient(s) as well as the same quality, strength, purity, and potency as their brand-name counterparts. This means that generic drugs are just as safe and effective – and can cost you less money.

In some cases, a generic version of a brand-name drug may not be available. Once a brand-name drug has been approved by the FDA, it is protected under patent for many years. During this time, generic versions of the drug cannot be made.

Fortunately, generic drugs are available for most common medical conditions, including acid reflux, allergies, depression, diabetes, high blood pressure, high cholesterol, and insomnia, and can help you save money on prescription drug costs. Talk to your doctor or local pharmacist to learn more about available generic drugs.

4. Fill your prescription

At a network pharmacy

Our pharmacy network includes more than 5,800 pharmacies in California and 57,000 pharmacies nationally, including all major retail chains. To find a local network retail, mail, or specialty pharmacy, go to the *Be Well* section of blueshieldca.com. Click on *Drugs* to look up a retail pharmacy by name or location, or to find a specialty pharmacy. Or, call the Member Services number on your ID card.

Simply present your Blue Shield ID card at a retail network pharmacy to receive up to a 30-day supply of covered medications.

Mail service prescriptions

Blue Shield provides access to the mail service drug benefit through CVS Caremark Mail Service Pharmacy. It offers you the convenience of receiving up to a 90-day supply of covered maintenance drugs,* delivered to your home or office, with no charge for shipping.

How to receive your prescriptions by mail

Step 1: Register with CVS Caremark Mail Service Pharmacy
To receive covered medications from CVS Caremark Mail Service Pharmacy, you must first register and provide basic information. This includes your name, shipping address, payment method and drug allergies. You can register online, by phone or by mail.

Step 2: New prescriptions
Once you are registered, CVS Caremark will need your prescription. This can be sent electronically or by phone, fax or mail.

- **Electronically** – Ask your doctor to send an electronic prescription for a 90-day supply to CVS Caremark. This is called "e-prescribing" and is the simplest way to send a prescription.
- **By phone or fax** – Request your doctor to submit your prescription for a 90-day supply by phone or fax to CVS Caremark.
- **By mail** – Mail your prescription using the CVS Caremark mail order form. You can fill out and print the form online.

You can pay using an electronic check or a credit card (Visa, MasterCard, Discover or American Express). Or, you can pay by check or money order. Do not send cash.

Step 3: CVS Caremark delivers
Please allow 10 to 14 business days to receive your covered maintenance medications through CVS Caremark. Once your prescription is on file at CVS Caremark, please allow five to eight business days to receive refills of your covered medications.

Refilling your mail service prescriptions
Once your prescription has been filled by CVS Caremark, you may order a refill in one of the following ways:

- **Online** – Ordering refills is convenient, fast and easy at www.caremark.com. Register online to receive refill reminders and other important updates.
- **By phone** – Call the toll-free number on your prescription label for a fully automated refill service.
- **By mail** – You will receive an order form with every mail service order. Simply fill in the ovals for the refills you want to order. If you need a refill for a prescription not listed on the form, write the prescription number in the space provided. Send the form to CVS Caremark along with your payment.

Specialty pharmacy network
Specialty drugs are drugs requiring coordination of care, close monitoring, or extensive patient training 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, restriction to certain physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost. Specialty drugs may be self-administered by injection, by inhalation, orally, or topically. These drugs may also require special handling or manufacturing processes, or have limited prescribing or pharmacy availability.

Specialty drugs are available through our specialty pharmacy network. For more information, go to blueshieldca.com, click on *Be Well*, and then choose the *Locate a Pharmacy* link.

To find out more about your drug benefits, including copayments and deductibles, check your EOC document at the end of this booklet, log in to blueshieldca.com, or call Member Services at **(800) 443-5005** or TTY (800) 241-1823.

Medication and formulary contacts

Blue Shield online pharmacy information	blueshieldca.com
Blue Shield–contracted mail service pharmacy	**(866) 346-7200** **TTY (866) 346-7197**

Using your benefits

Preventive care

Preventive care can keep you on the road to good health. Routine physical exams, screenings, and immunizations are important steps in preventing illness and detecting it before symptoms arise.

With the HMO plan, you pay no copayment for preventive services. Call your PCP to make an appointment when you need:

- Immunizations
- Annual routine physical exam
- Annual gynecological exam and mammography screening for women
- Preventive lab tests ordered during routine health exams

You can chart your path to good health with our Preventive Health Guidelines located at the end of this section.

Specialist care

Direct access to a specialist
If your PCP's medical group/IPA is a participating Access+ *Specialist* provider (shown by an A+ after the PCP or group name on your ID card), you have access to a participating specialist in the same medical group or IPA without a referral.

Consult with your PCP if you need ongoing specialty care. You can continue to go directly to a specialist, but you'll need to pay a slightly higher copayment each time. If your PCP agrees that you should see the specialist on an ongoing basis, he or she can give you a referral. Then you'll pay a lower copayment.

There is no copayment due when you receive non-routine outpatient mental health and substance use disorder services. Please see a list of non-routine services in your *Evidence of Coverage* booklet.

Hospital care

Your PCP will arrange for your admission to a hospital when:

- You need inpatient hospital care
- You need surgery or other hospital treatment on an outpatient basis

Ambulatory surgical care

Your PCP can refer you to a network ambulatory surgery center (ASC)* for certain kinds of elective outpatient surgery. Our network ASCs provide quality care and may charge significantly less for the same outpatient procedures than a network hospital, because of its lower overhead costs. Whether or not surgery at an ASC is right for you depends on your medical condition and

* Generally, the drugs provided through mail service are drugs that you take on a regular basis for a chronic or long-term medical condition.

specific health needs. Talk to your physician if you think an ASC may be a good choice for you.

You can find a network ASC three ways:

1. Go to blueshieldca.com/fad. Click on *Facilities* and under "Facility type" select *Ambulatory Surgery Centers*.
2. Check your printed copy of our *HMO Physician, Hospital, Urgent Care, and Ambulatory Surgery Center Directory*.
3. Call Member Services at the telephone number listed on your Blue Shield ID card.

Urgent care

Urgent care centers (UCCs) offer non-emergency care when PCPs are not available, without incurring the higher expense of emergency room (ER) services.

While in your PCP's service area

HMO members are covered for urgent care services only when they visit UCCs contracted with their PCP's medical group or IPA. So they should talk to their PCP's office ahead of time about which center(s) to visit in case they need urgent care services.

If you require urgent care for a condition that could reasonably be treated in your PCP's office or in a UCC (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), you must first call your PCP. However, you may go directly to a UCC when your assigned medical group/IPA has provided you with instructions for obtaining care from a UCC in your PCP's service area.

Within California

If you are temporarily traveling within California, but are outside of your PCP's service area, if possible you should call Blue Shield Member Services at the number provided on the back page of this booklet for assistance in receiving urgent services through a Blue Shield of California plan provider. You may also locate a plan provider by visiting blueshieldca.com. However, you are not required to use a Blue Shield of California plan provider to receive urgent services; you may use any provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Emergency care

Emergency services are services provided for a 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. Serious jeopardy to the member's health
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

If you have an accident or medical condition that requires emergency care, call 911 or go directly to the nearest medical facility.

Notify Blue Shield

For emergency room visits that result in direct admission to the hospital, you or a family member must notify Blue Shield Medical Management within 24 hours of receiving inpatient emergency care, or by the end of the first business day following treatment, or as soon as it is reasonably possible to do so. Doing so ensures you receive coverage for medically necessary services and enables us to work closely with the hospital or physician so that you receive the care you need.

Emergency coverage reviews

We will review the services retrospectively to determine whether they were for a medical or mental health condition for which a reasonable person would have believed that he or she had an emergency. Services are not covered when it is determined that a reasonable person would not have believed that the condition represented an emergency.

Mental health emergencies

All network emergency services for mental health or substance use disorder are managed and reviewed by the Blue Shield mental health service administrator (MHSA). Contact Blue Shield's MHSA within 24 hours of emergency treatment, or as soon as reasonably possible. See the "Mental health or substance use disorder care" section for more details. For non-network mental health emergencies, please contact Blue Shield.

Emergency care contacts

Emergency medical help	**911**
Blue Shield Member Services	**(800) 424-6521**
Blue Shield's MHSA	**(877) 263-9952**
Mental health services outside California	**(800) 810-2583**

Accessing care outside California and abroad

When you're outside California or out of the country, the BlueCross BlueShield Association's BlueCard® Program connects you and your family to urgent and emergency care. The BlueCard Program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you'll be able to find the healthcare provider you need. Within the United States, you're covered whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in more than 230 countries and territories around the world through the BlueCard Worldwide® Network.

We recommend bringing a list of BlueCard providers to your travel destination, so you're prepared should you need urgent care. And always travel with your

* The ambulatory surgery center benefit is not available to all plans or in all areas of California. Please check your EOC document to see if your plan includes the benefit.

Blue Shield ID card because it contains information that a BlueCard provider will need.

Please note that you are not required to access a BlueCard provider for urgent or emergency care.

How to access BlueCard services

Step 1. Find a BlueCard provider:

- Call **(800) 810-BLUE (2583)** from within the United States, or call **(804) 673-1177** collect from outside the country; or
- Outside California, go to http://provider.bcbs.com.

Step 2. See the BlueCard provider nearest you for urgent or emergency services.

Step 3. Notify your PCP when you return to California, so he or she can provide any necessary follow-up care.

Away From Home Care for extended stays

If you or your covered dependents will be out of California for 90 to 180 days, you may be eligible for coverage under Away From Home Care® (AFHC). This program is designed to give students, long-term travelers, workers on extended out-of-state assignments, and families living apart the convenience and flexibility they need. AFHC offers coverage for extended periods across the country through a broad network of host HMO plans that deliver care at or near your travel destination. The coverage offered by the host plan is different from your Blue Shield of California coverage and typically includes preventive care, physician office visits, hospitalization services, immunizations, surgery, and more.

To learn more about AFHC and to find out if you are eligible, call the Member Services number on your ID card or **(800) 424-6521**. Please note that AFHC is not available in all areas and states.

Urgent care contacts

Emergency medical help	**911**
Member Services	**(800) 424-6521**
BlueCard Program	**(800) 810-BLUE (2583)**
Blue Shield website	blueshieldca.com

Obstetrics/gynecology care

You may arrange for obstetrical and gynecological care directly from any OB/GYN in your PCP's medical group or IPA without a referral.

Second medical opinions

Any time you want a second medical opinion, just ask your PCP for a referral. If the second opinion is regarding specialty care, contact Member Services for prior authorization for a second opinion outside your PCP's medical group or IPA.

Mental health or substance use disorder care

Blue Shield's mental health service administrator (MHSA) manages mental health and substance use disorder services for our members. These services are provided by Blue Shield's MHSA network of psychiatrists, psychologists, and other mental health professionals.

Follow these steps to access expert advice, guidance, counseling, and treatment for issues that affect your emotional health:

Step 1. Choose a participating provider by calling Blue Shield's MHSA toll-free at **(877) 263-9952**. When you call, you may be transferred to a clinically trained counselor who can consult with you and recommend one or more participating providers suited to your unique needs.

Or you can find a provider online. Go to blueshieldca.com/fad. Click on *Doctors* and under "Doctor type or specialty," select *Mental Health Caregivers*.

Step 2. Obtain prior authorization. All non-emergency mental health and substance use disorder inpatient admissions, including residential care, and non-routine outpatient mental health and substance use disorder services require prior authorization by the MHSA.

For prior authorization of mental health and substance use disorder services, the mhsa participating provider should contact the MHSA at **(877) 263-9952** at least five business days prior to the admission.

Step 3. Make an appointment for pre-authorized services with the network clinician you have selected. You have access to an urgent care appointment with your PCP, a specialist, a covering physician, or an urgent care provider that does not require prior authorization. The time standard of 24 hours must be met unless the treating health professional determines that a longer waiting time will not have a detrimental impact on you.

Mental health services contacts

Emergencies	**911**
Blue Shield's MHSA	**(877) 263-9952**
Blue Shield website	blueshieldca.com

See your EOC document at the end of this booklet for information regarding your rights and responsibilities, recourse for grievances, and our commitment to confidentiality.

Health and wellness resources

There's more to your Blue Shield health plan than broad healthcare coverage. You also have access to our Health & Wellness resources, a collection of tools and programs that give you lots of choices for improving your health. Just go to blueshieldca.com and select *Health & Wellness*.

Health & Wellness

Wellvolution®	The next generation in wellness programs to make wellness easy and fun. Find more information and register at mywellvolution.com.
NurseHelp 24/7℠	Registered nurses are on call to help you with medical support 24 hours a day, seven days a week, by phone or online.
LifeReferrals 24/7℠*	Around-the-clock professionals can assist with personal, family, and work issues, to help you meet life's challenges.
Decision-making resources	Access tools to help you compare providers and explore options for management of your condition.
***Health Update* newsletter**	This monthly email newsletter is filled with timely health and benefits information, on topics such as preventive health, heart health, disease prevention, and nutrition. Go to *Wellness Tools* and click on *Health Update Newsletter* to subscribe.
Wellness discount program	Alternative care discount program (for acupuncture, chiropractic, massage therapy, and health and wellness products), the Discount Vision Program, and wellness discounts provided through Weight Watchers and 24 Hour Fitness offer extra support for your well-being at discounted rates.
Prenatal Program	Our Prenatal Program is designed to optimize a woman's health and quality of care before and during pregnancy, and offer case management if extra support is needed.
Condition Management Program	Our Condition Management Program offers you support by showing you how to take an active role in managing your chronic condition or other complex conditions.
Shield Support	Our programs are designed to help you live better with illness, recover from acute conditions, and develop self-management skills.

Pharmacy

Drug formularies	Find information about drugs, coverage or formulary status, costs, and generic alternatives.
Drug interactions	Learn about interactions among prescription drugs, over-the-counter medications, dietary supplements, and herbal products.

You choose when and how to use these valuable wellness resources. Each one is available to you at no extra charge!

Health and wellness

Wellvolution

What is Wellvolution?

Wellvolution is a well-being solution for real people like you with real lives like yours. Using the latest online and mobile technologies Wellvolution is making wellness rewarding, easy, social, fun, and is designed to help you to create positive lifestyle choices that stick.

How does it work?

Once you receive your Blue Shield member ID card, you are eligible to register for Wellvolution at mywellvolution.com from a computer, tablet, or smartphone. Wellvolution is made up of wellness programs that are found on the Well-Being Tracker™, and includes two programs which are available to all our members: the Well-Being Assessment and Daily Challenge®.

Well-Being Assessment

First you'll take a confidential Well-Being Assessment to measure your sense of purpose, financial well-being, social support, community involvement, and physical health. The Well-Being Assessment is confidential and the answers you provide will not be shared with your employer. You'll receive a personal report with scores in each of these areas that show you how your well-being compares to others and give you a clear idea of which areas need additional focus.

Daily Challenge

Daily Challenge is a fun, easy, and social wellness program that introduces small daily actions and choices that are designed to improve your well-being. Each day you receive a message with one simple activity or "challenge" to complete and a reason why it will help improve your well-being. You can even invite family and friends to participate with you. Download the Daily Challenge app to complete your challenges on the go.

* LifeReferrals 24/7 is only available for group customers with 101+ employees.

What else does Wellvolution offer?

Your employer may offer additional programs such as those listed below:

Walkadoo

The Walkadoo® program adds more movement to your day. Using a wireless device and mobile app, this walking program challenges you to increase your activity with personalized, daily step goals and the added bonus of being able to invite friends to participate with you.

Rewards

Wellvolution administers a wide range of rewards. From our creative approach to cash incentives, to premium discounts and contributions to your HRA/HSA account, please check your programs page on the Wellvolution platform to learn more about which rewards are available to you.

Biometric screening

A biometric screening is a measurement of your health metrics and may include measurements of your height, weight, body mass index, blood pressure, smoking status, blood glucose, and/or a full lipid panel (cholesterol). You may also have the opportunity to get your annual flu shot.

QuitNet

QuitNet® uses the latest science and best practices to help individuals overcome their addiction to tobacco. QuitNet integrates many intervention modalities, including online and mobile support from experts and peers, telephone-based coaching from a tobacco treatment specialist, personalized email and SMS text support, and pharmaceutical quit aids.

Health Coach

The Health Coach program uses a whole-person, integrated approach to address your needs and behavioral risks. Primary topics for Health Coach include exercise, healthy eating, weight management, stress management, depression, tobacco cessation, medication adherence, appointment adherence, and self-care.

Take charge of your well-being

Stay engaged in your health and wellness with our fun and social Wellvolution programs! Visit us at mywellvolution.com and discover how easy it is to start making more positive lifestyle choices.

NurseHelp 24/7

Talk to a registered nurse any time day or night, seven days a week, at **(877) 304-0504** or online. Experienced nurses are ready to listen, answer questions, and provide you with information to help you make informed decisions and choose the care that's most appropriate. They offer:

- **Health information** – Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions, and suggestions for preparing for doctor appointments.
- **Healthcare assistance** – Guidance in understanding and choosing the most appropriate types of health care, such as hospital, home health, and long-term care, and help in evaluating services.
- **Self-care tips** – Helpful tips for taking care at home of minor injuries such as a twisted ankle, or common illnesses like colds and the flu.
- **Lifestyle counseling** – Resources and information about healthy habits, including diet and exercise.

You can also access NurseHelp 24/7 online and engage in a one-on-one Internet dialogue with a registered nurse, 24 hours a day, seven days a week. You can get immediate answers to your general health questions.

Following a chat, you have the option to receive a printed copy of your chat and the information exchanged. The online nurses can also refer you to health information, resources, and member programs on blueshieldca.com – just log in and select *Be Well*.

LifeReferrals 24/7

Everyone can use a hand sometimes, and LifeReferrals 24/7* offers convenient support to help you with a wide range of personal, family, and work issues. A phone call connects you to a team of experienced professionals ready to listen and help. You'll be guided to the appropriate professional, depending on your needs:

- **Legal and finance issues** – Connect with a financial adviser on money matters or an attorney on a variety of legal services.
- **Personal challenges including relationship problems or coping with grief** – Call for a personal phone consultation and set up a face-to-face session (three sessions in any six-month period) for counseling with a licensed therapist at no cost to you.
- **Child care, elder care, and chronic condition management** – Consult with a specialist who can provide useful information and referrals to a wide range of resources, such as day care, meal programs, transportation, and more.

The LifeReferrals 24/7 team is available to discuss your concerns and guide you to possible solutions anytime, day or night, at **(800) 985-2405**. All of the services and referrals to resources are confidential.

NurseHelp 24/7 and LifeReferrals 24/7 are designed to complement – not replace – your health care.

Contact information

NurseHelp 24/7	**(877) 304-0504**
LifeReferrals 24/7	**(800) 985-2405**
TTY	**711**

You can also log in to blueshieldca.com and select *Be Well* to get more information about these services.

* LifeReferrals 24/7 is only available for group customers with 101+ employees.

Decision-making resources

Use these powerful online tools to find relevant information about treatment options and medications at blueshieldca.com:

- **Symptom Checker** can help members pinpoint particular symptoms and then find information that helps to explain the cause.
- **Health Library** provides members with access to a comprehensive range of tools and information including health topics and conditions, decision points, treatment options, interactive tools, drug interactions, videos, community networking, and more.

Health Update newsletter

Subscribe to the monthly *Health Update* email newsletter by clicking on *Health Update* in the *Wellness Tools* section of blueshieldca.com. It's filled with timely health and benefits information, such as preventive health reminders and information about your plan, heart health, disease prevention, nutrition, and much more – to help you make intelligent, informed healthcare choices. Each edition features a hot topic of the month with links to our website, where you'll find comprehensive information relevant to that topic.

Wellness discount program

Blue Shield's wellness discount program[1] complements and enhances your covered benefits, and saves you money on services and supplies ranging from the traditional to the alternative. For more information or to access these discounts, please go to blueshieldca.com/wellnessdiscounts.

Weight Watchers

Receive a wide range of savings to help you lose extra pounds and maintain a healthy weight:

- **Online savings** – Special rates on three-month and 12-month subscription
- **At-home kits** – Special member pricing of $124.90 on the at-home kit
- **Monthly pass** – Special rates for unlimited local meetings each month and free eTools

24 Hour Fitness

Enjoy a variety of waived and discounted fees, including:

- Waived enrollment, processing, and initiation fees
- Discounted monthly dues as low as $24.99 per month

ClubSport and Renaissance ClubSport

Get discount options on membership dues and fees to help you increase wellness and stay fit:

- 60% off enrollment fees with a month-to-month membership
- $0 enrollment fee with a 12-month membership; a one-time $25 processing fee applies at the time of enrollment

Membership includes:

- Two complimentary personal training sessions for new members
- MicroFit testing and goal setting
- Access to online nutritional support
- Free wellness seminars
- Free club programs
- Three hours of complimentary child care with a family membership

Alternative care discount program

Relax and save on alternative healthcare services from participating American Specialty Health Systems Inc. (ASH Networks) practitioners. Just make an appointment with a participating provider, then simply show your Blue Shield ID card to get your discount. It's that easy!

Acupuncture services

Members receive 25% off the usual and customary fees for services including:

- Examinations
- Acupuncture or electro-acupuncture
- Adjunctive therapeutic procedures

Chiropractic services

Members receive 25% off the usual and customary fees for services including:

- Examinations
- Manipulative treatment
- Adjunctive therapeutic procedures

Massage therapy

Members receive 25% off the usual and customary fees for massage therapy visits. A variety of techniques may be used including:

- Swedish massage
- Deep-muscle massage
- Deep-tissue massage

Health and wellness products

Receive online discounts off the suggested manufacturer's retail price on a broad selection of quality health-improvement products, with free shipping on most items. This includes:

- Vitamins
- Herbal supplements
- Homeopathic remedies
- Diet and sports nutrition
- Yoga and fitness equipment
- Personal body care
- Health and wellness books, audio, and DVD products

Discount Vision Program

Discount Provider Network[2]

All Blue Shield members can save 20% on the following services and materials at participating providers whether or not you have vision care benefits through Blue Shield. Access participating providers on the *Find a Doctor* page at blueshieldca.com/fad.

- Routine eye exams
- Frames and lenses (including photochromic)
- Tints and coatings
- Extra pair of glasses
- Non-prescription sunglasses
- Hard contact lenses

MESVision Optics

MESVisionOptics.com features competitive prices on many contact lens brands[3] as well as a selection of sunglasses, reading glasses, and eye care accessories.

- Anyone can order discounted contact lenses, sunglasses, readers, and accessories. Blue Shield vision plan members can apply their eligible benefits to reduce their out-of-pocket cost for contact lenses.
- MESVision Optics stocks all major brands and types of contact lenses at a reduced price from other online retail sellers.
- Every lens is shipped in safe, sealed containers and is guaranteed to be the exact lens prescribed by your doctor.
- Free shipping is available for all orders over $50.
- Visit www.MESVisionOptics.com.

QualSight LASIK

Save on LASIK surgery at more than 45 surgery centers in California.

- Members in California saved an average of $950 per LASIK surgery and over $1,100 on procedures such as Custom Bladeless (all-laser) LASIK in 2014.
- Services include pre-screening, a pre-operative exam, and post-operative visits.
- Call (877) 437-6110 to find out if you are a potential candidate for this life-changing procedure today or visit our website at www.qualsight.com/-lasikca.

NVISION Laser Eye Centers

As a Blue Shield of California member, you are entitled to a 15% discount from NVISION Laser Eye Centers.

- NVISION Laser Eye Centers has some of the most experienced surgeons in the world, with offices in Southern California and Sacramento.
- Use your flexible spending account or ask about affordable financing options.
- Call NVISION at (877) 91 NVISION, or (877) 916-8474, or go online to www.NVISIONcenters.com to find a doctor or learn more about whether LASIK is right for you.

To find an alternative provider

Alternative care discount program	Go to blueshieldca.com/wellnessdiscounts, or call American Specialty Health Systems Inc. at (877) 335-2746
Weight Watchers, 24 Hour Fitness, ClubSport, Renaissance ClubSport, Discount Vision Program, and LASIK discount program	Go to blueshieldca.com/wellnessdiscounts

Important note about the discount programs:

1 These discount program services are not a covered benefit of Blue Shield health plans, and none of the terms or conditions of Blue Shield health plans apply.

Discount program services are available to all members with a Blue Shield medical, dental, vision, or life insurance plan. Life insurance plans are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

The networks of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy. Nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products. Some services offered through the discount program may already be included as part of the Blue Shield plan covered benefits. Members should access those covered services prior to using the discount program.

Members who are not satisfied with products or services received from the discount program may use Blue Shield's grievance process described in the Grievance. Process section of the Evidence of Coverage or Certificate of Insurance/Policy. Blue Shield reserves the right to terminate this program at any time without notice.

Discount programs administered by or arranged through the following independent companies:

- Alternative Care Discount Program – American Specialty Health Systems, Inc. and American Specialty Health Networks, Inc.
- Discount Provider Network and MESVisionOptics.com – MESVision
- Weight control – Weight Watchers North America
- Fitness facilities – 24 Hour Fitness, ClubSport, and Renaissance ClubSport
- LASIK – Laser Eye Care of California, LLC; QualSight, Inc.; and NVISION Laser Eye Centers

Note: No genetic information, including family medical history, is gathered, shared, or used from these programs.

2 The Discount Provider Network is available throughout California. Coverage in other states may be limited.

3 Requires a prescription from your doctor or licensed optical professional.

Condition Management Program

As a Blue Shield member, you can play an active role in managing your health with prevention and self-management programs – at no additional cost to you.

These programs offer up-to-date health and wellness information and strategies for self-management. Members receive a variety of printed education and self-management materials, as well as access to nurse support to help you manage your condition. Some members may be contacted by a care manager, a registered nurse who works with the member

consistently over the course of the program, focusing on education and self-management tools and techniques.

Please note that some group plans do not offer all of these programs. Be sure to check your EOC document to see if your plan includes a particular program.

As a Blue Shield member, you have access to mental health and substance use disorder benefits

- All services are provided through Blue Shield's mental health service administrator (MHSA).

Inpatient mental health and substance use disorder services

- Inpatient hospital services
- Inpatient professional (physician) services
- Residential care for mental health condition
- Residential care for substance use disorder condition

Non-routine outpatient mental health and substance use disorder services

- Behavioral health treatment in home or other non-institutional setting
- Behavioral health treatment in an office setting
- Electroconvulsive therapy (ECT)
- Intensive Outpatient Program
- Office-based opioid treatment: Outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment
- Partial Hospitalization Program
- Psychological testing to determine mental health diagnosis
- Transcranial magnetic stimulation

Routine outpatient mental health and substance use disorder services

- Professional (physician) office visits

Asthma Program

- Gives children and adults strategies for managing asthma with their doctors' help
- Offers a condition management handbook, educational materials, self-management tools and access to a secure and interactive Care Center website with personalized tools and information
- Provides preventive health guidelines to improve health

Prenatal Program

- Guides expectant moms during the pregnancy, and through postpartum with health information support, plus personalized coaching from a nurse for those who need extra support
- Provides materials on preconception, prenatal care, preparation for the baby's delivery, post-delivery care, postpartum health and caring for an infant, plus 24/7 access to nurse support through a 24/7 nurseline
- Offers choice of popular pregnancy or parenting book, including in eBook form.
- Includes information about enrollment in a mobile messaging service – text4baby℠ – which provides pregnant women and new moms with timely, helpful health information

Diabetes Program

- Develops skills needed for managing diabetes through educational materials and schedules for hemoglobin A1c and cholesterol screening
- Offers a condition management handbook, educational materials, self-management tools and access to a secure and interactive Care Center website with personalized tools and information
- Encourages you to follow your medication and treatment plan

Coronary Artery Disease (CAD) Program

- Helps you make lifestyle changes to reduce the risk of future heart problems
- Offers a condition management handbook, educational materials, self-management tools and access to a secure and interactive Care Center website with personalized tools and information
- Encourages you to follow your medication and treatment plan
- Provides practical tips to lower blood pressure and cholesterol, manage stress, control weight, and quit smoking

Chronic Obstructive Pulmonary Disease (COPD) Program

- Helps you make lifestyle changes to reduce the occurrence or lessen the severity of COPD episodes and upper-airway infections
- Offers a condition management handbook, educational materials, self-management tools and access to a secure and interactive Care Center website with personalized tools and information
- Encourages proper use of maintenance and/or exacerbation medications and encourages members to follow their medication and treatment plan

Heart Failure Program

- Offers a condition management handbook, educational materials, and self-management tools to assist you in managing heart-failure symptoms
- Encourages you to follow your medication and treatment plan

The Asthma, Diabetes, CAD, COPD and Heart Failure programs also offer in-person and online self-management workshops to members age 18 and over. The workshops are designed to help individuals gain self-confidence in their ability to manage their

Text4baby is a service mark of the National Healthy Mothers, Healthy Babies Coalition (text4baby.org). The National Healthy Mothers, Healthy Babies Coalition has agreements with most wireless service providers to waive applicable text charges.

symptoms and understand how their health status affects their lives.

Shield Support

Shield Support is Blue Shield's comprehensive, integrated care management program that includes member-focused clinical interventions to help members optimize benefits, health, and quality of life. Our experienced care teams include registered nurses, licensed clinical social workers, dietitians, physicians, and pharmacists who provide long- and short-term support, including:

- Case management for acute, long-term, and high-risk conditions, designed to help individuals live better with illness, recover from acute conditions, and develop self-management skills
- Care coordination services to help individuals navigate the healthcare system and access care, and to facilitate information sharing among the healthcare team involved in their care

Shield Support encompasses a broad spectrum of interventions for short-term care coordination, as well as ongoing complex case management, for:

- Complex, multiple conditions and diagnoses, care from multiple providers and specialists, as well as significant psychosocial and/or financial needs
- Newly diagnosed or advanced stage cancer, end-stage renal disease, stroke, septicemia, acute circulatory and digestive conditions, chronic pain, chronic respiratory conditions, HIV, amputation, and open wounds
- End-of-life care for members who are in the last 12 months of life due to a chronic or terminal illness, who are provided comprehensive management of their physical, psychological, social, spiritual, and existential needs
- Transplant (solid organ and bone marrow) with support by specialized transplant care managers. For more information on being a marrow or stem cell donor, go to Be the Match at https://bethematch.org or National Bone Marrow Transplant Link at www.nbmtlink.org
- Preterm infants in the Neonatal Intensive Care Unit (NICU) and post-NICU/pediatrics inpatient
- Catastrophic injury such as trauma, severe burns, spinal cord injury, and acquired brain injury
- Transitions to and from the hospital, to lower levels of care and home
- Care coordination to help members access care, find a specialist, or make informed decisions

Shield Support includes frequent telephonic outreach, online and mailed educational materials, as well as home visits.

Condition and case management program contacts

General information	Go to blueshieldca.com and click on *Health Conditions* in the *Be Well* section.
Contact information to apply for a condition or case management program	Call **(877) 455-6777**.

Pharmacy

Drug Formulary Database

Log in to blueshieldca.com. Under *My Plan & Claims*, click on *Benefits* and then select the *Pharmacy* tab to find information about drugs, coverage, or formulary status. You will also find information about generic alternatives and be able to compare brand-name and generic drug copayments, so you can manage your costs.

Drug Interaction Checker

Use our Drug Interaction Checker to learn about potential adverse interactions among the drugs you take, including prescription and over-the-counter medications, dietary supplements, and herbal products. Just log in to blueshieldca.com, go to the *My Plan & Claims* then *Pharmacy* section, and click on *Drug Interactions*.

Find a Pharmacy

It's easy to find a pharmacy near you. Use this online tool to search our large network of pharmacies by name or location for fast results. Choose from over 5,400 retail chain and independent pharmacies in California, many of which are open 24 hours a day. Log in to blueshieldca.com, go to the *Pharmacy* section, and click on *Find a Pharmacy*.

Get social

We're here and here for you

Join our social community and discover healthy places to eat, great places to hike, recipes with a uniquely California-healthy flair, and more.

Our Facebook and Twitter communities are all about healthy motivation, inspiration, and support wherever you are in California. Join the conversation to see what other members have to say and to share a tip of your own.

Plus, if you have questions about your Blue Shield plan, our Social Customer Service team can get you answers without making you hold on the phone.

Follow us on Facebook and Twitter and see what everybody's talking about.

Facebook: **BlueShieldCA**

Twitter: **@BlueShieldCA**

Get covered right down to your identity!

As a Blue Shield member, you can now get identity protection services such as identity repair assistance, identity theft insurance and credit monitoring for you and your covered family members. It makes good sense, and it's no charge.

You can access these services by calling **(855) 904-5733**, 6 a.m. to 6 p.m., Monday through Saturday or 24/7 at https://blueshieldca.allclearid.com/.

The power of prevention

Put our preventive health guidelines into practice. Your family's health could depend on it.

You've heard the old saying about an ounce of prevention. Your doctors know that preventive screenings and tests often are the best first steps in preventing illness. They also allow for rapid response at early onset of health problems, when treatments can be most effective.

To take advantage of the power of prevention, you and your entire family need to stay current with the recommended screenings and tests appropriate for your age, gender, medical history, current health and family history.

We have compiled the following guidelines to help you keep track of what's needed and when. It's just one more way we're working to make your health easier to maintain.

For children ages 0 to 2

Topics you may want to discuss with your doctor

Safety

- Use a checklist to "baby-proof" your home.
- Check your home for the presence of lead paint.

Nutrition

- Breast-feeding and iron-enriched formula and food for infants.

Dental health

- Do not put your baby or toddler to bed with a bottle containing juice, milk or other sugary liquid. Do not prop a bottle in a baby's or toddler's mouth. Clean your baby's gums and teeth daily.
- Use a clean, moist washcloth to wipe gums. Use a soft toothbrush with water only, beginning with eruption of first tooth.
- Age 6 months to preschool: Discuss with your dentist about taking an oral fluoride supplement if water is deficient in fluoride.
- Age 2: Begin brushing child's teeth with pea-size amount of fluoride toothpaste.

Autism

- Assessment at 18 and 24 months by your child's doctor.

Immunizations				
Shot number in a series	**1**	**2**	**3**	**4**
DTaP (diphtheria, tetanus, acellular pertussis)	2	4	6	15–18 months
Flu, annual	For children 6 months and older[2,18]			
Hepatitis A	12–23 months (second dose at least 6 months after first)			
Hepatitis B	0 (birth)	1–2	6–18 months	
Hib (Haemophilus influenzae type b)	2	4	6	12–15 months
IPV (inactivated poliovirus vaccine)	2	4	6–18 months	
MMR (measles, mumps, rubella)	First dose at 12–15 months, second dose at ages 4–6			
Pneumococcal (pneumonia)	2	4	6	12–15 months
RotaRix (rotavirus), *or*	2	4 months		
RotaTeq (rotavirus)	2	4	6 months	
Varicella (chicken pox)	12–15 months, second dose at ages 4–6			

Screenings/counseling/services	
Autism	Children 18–30 months old
Blood tests	24–48 hours after birth[1]
Flouride use	Discuss use or prescribe supplement for age 6 months and older[25]
Gonococcal ophthalmia	Topical eye medication administered during initial newborn care
Hearing loss	One- or two-step screening process for newborns
Height and weight	Periodically
Iron deficiency anemia	Children age 6–12 months at average or increased risk
Lead	Risk assessment and testing at age 12 and 24 months if risk identified
Sickle cell disease screening	Risk assessment and testing if risk identified
Tuberculosis	Risk assessment and testing if risk identified

Injury prevention for:

Infants and young children

A special message about SIDS. Sudden infant death syndrome (SIDS) is the leading cause of death for infants. Put infants to sleep on their backs to decrease the risk of SIDS.

Take these steps to "**baby proof**" your home and give your child a safe environment:

- Use the right car seat for your vehicle and for your child's weight. Read the car seat and vehicle manufacturer's instructions about installation and use. Use a rear-facing car seat until your child is at least 1 year old and weighs at least 20 pounds.
- Keep medicines, cleaning solutions and other dangerous substances in childproof containers, locked up and out of reach of children.
- Use safety gates across stairways (top and bottom) and guards on windows above the first floor.
- Keep hot-water heater temperatures below 120° F.
- Keep unused electrical outlets covered with plastic guards.
- Provide constant supervision for babies using a baby walker. Block the access to stairways and to objects that can fall (such as lamps) or cause burns (such as stoves or electric heaters).
- Keep objects and foods that can cause choking away from your child. This includes things like coins, balloons, small toy parts, hot dogs (unmashed), peanuts and hard candy.
- Use fences that go all the way around pools, and keep gates to pools locked.

For children ages 3 to 10

Topics you may want to discuss with your doctor

Safety

- Use a checklist to "child-proof" your home.
- Check your home for the presence of lead paint.

Exercise

- Ages 0–5: Participate in physical activity as a family, such as taking walks or playing at the playground. Limit television to less than two hours a day.
- Age 6 and up: Regular physical activity can reduce the risks of coronary heart disease, osteoporosis, obesity and diabetes.

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.

Dental health

- Ask your dentist when and how to floss child's teeth.
- Age 5: Talk to your dentist about dental sealants.

Other topics for discussion

- Well-child visits are a good time to talk to your doctor about any concerns you have with your child's health, growth or behavior.

Immunizations	
DTaP (diphtheria, tetanus, acellular pertussis)	Ages 4–6
Flu, annual	Recommended[2,18]
Hepatitis A	For children not previously vaccinated and risk factors are present
Hepatitis B	For children who did not complete the immunization series between 0–18 months
IPV (inactivated poliovirus vaccine)	Ages 4–6
MMR (measles, mumps, rubella)	Second dose at ages 4–6
Pneumococcal (pneumonia)	For children with risk factors[6] or an incomplete schedule (ages 2–5)
Varicella (chicken pox)	Second dose at ages 4–6

Screenings/counseling/services	
Height, weight, BMI and hearing	At annual exam
Flouride use	Discuss use or prescribe supplement for age 5 and younger[25]
Lead	Risk assessment for age 6 and under
Obesity	Screening, counseling and behavioral interventions for children age 6 and older
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for children age 10 and older at high risk
Tuberculosis	Risk assessment and testing if risk identified

Be aware of your child's recommended weight: Use our online tools to calculate your child's body mass index (BMI) by logging in to **blueshieldca.com** and searching for BMI.

Injury prevention for:

Older children

- Children should use a booster seat in the car's back seat until they are at least 8 years old or weigh at least 80 pounds.
- Older children should use car seat belts and sit in the back seat at all times.
- Make sure your child wears a helmet while rollerblading or riding a bicycle. Make sure your child uses protective equipment for rollerblading and skateboarding (helmet, wrist and knee pads).
- Warn your child of the dangers of using alcohol and drugs. Many driving and sports-related injuries are caused by the use of alcohol and drugs.

For all ages

- Use smoke detectors in your home. Change the batteries every year, and check once a month to see that they work.
- If you have a gun in your home, make sure that the gun and ammunition are locked up separately and kept out of children's reach.
- Never drive after drinking alcohol.
- Use car seat belts at all times.
- Teach your child traffic safety. Children under 9 years old need supervision when crossing streets.
- Teach your children how and when to call 911.
- Learn basic life-saving skills (CPR).
- Post the number for the Poison Control Center – (800) 222-1222 – near your phone. Also, write it in the space on your home "Important Information" list. The number is the same in every U.S. location. Do not try to treat poisoning until you have called the Poison Control Center.

For children ages 11 to 19

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day starting at age 11) can reduce the risks of coronary heart disease, osteoporosis, obesity and diabetes.

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
- Optimal calcium intake for adolescents and young adults is estimated to be 1,200 to 1,500 mg/day.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention;[6] practice safe sex (use condoms) or abstinence.
- Avoid unintended pregnancy; use contraception.

Substance abuse

- Use of alcohol, tobacco (cigarettes or chewing), inhalants and other drugs among adolescents is a major concern for parents. Let the doctor know if you have any concerns about your child.

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.

Other topics for discussion

- It is a good idea to let your teenager have private time with the doctor to ask any questions he or she may not feel comfortable asking you.

Immunizations	
Flu, annual	Recommended[2]
Hepatitis A	For individuals not previously vaccinated and risk factors are present
Hepatitis B	For individuals not previously vaccinated
HPV (human papillomavirus)	A three-shot series at pre-adolescent visit (ages 11–12); may also be given to females ages 9–26 and males ages 9–26
Meningococcal	At pre-adolescent visit (ages 11–12); administer to college-bound students living in a dorm if not previously immunized[8]
MMR (measles, mumps, rubella)	At pre-adolescent visit (ages 11–12) if missing second dose
Pneumococcal (pneumonia)	For children with risk factors[4]
Tdap booster (tetanus, diphtheria, pertussis)	For children ages 11–12 who have completed the recommended DTaP immunization series[17]
Varicella (chicken pox)	At pre-adolescent visit (ages 11–12) if missing second dose

Screenings/counseling/services	
Alcohol misuse	Behavioral counseling
Blood pressure, height, weight, BMI, vision and hearing	At annual exam
Cervical cancer	Recommended for women who have been sexually active
Chlamydia	Recommended for all sexually active women under age 25 and for women at increased risk for infection[11]
Contraception	FDA-approved contraceptive methods for females, education and counseling[33]
Depression	For all adolescents
Gonorrhea	Recommended for all sexually active women who are at increased risk for infection[11]
Healthy diet and physical activity	Behavioral counseling[28]
Hepatitis B	Screening for HBV infection in persons at high risk of infection[30]
Hepatitis C	Screening for HBV infection in persons at high risk of infection[31]
HIV	For all adolescents at increased risk for HIV infection[24]
Obesity	Screening, counseling and behavioral interventions
Sexually transmitted infections	Behavioral counseling as needed[27]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for adolescents at high risk
Syphilis	For individuals at increased risk for infection[12]
Tuberculosis	Risk assessment and testing if risk identified

Promoting your pre-teen's and adolescent's social and emotional development

Parents need to offer open, positive communication while providing clear and fair rules and consistent guidance. Let your child find his or her own path while staying within the boundaries you have set.

- Be a good role model for how to handle disagreements, such as by talking calmly.
- Praise him or her for successfully avoiding a confrontation, such as by saying, "I'm proud of you for staying calm."
- Supervise the websites and computer games that your child uses.
- Set limits on use of computers, telephones, texting and TV after a set evening hour to help your child get regular sleep.
- Talk to your child about healthy relationships. Dating abuse does occur among preteens and teens.
- Be a role model for healthy eating and regular physical exercise.

For women ages 20 to 49

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day) can reduce the risks of coronary heart disease, osteoporosis, obesity and diabetes.
- Over 40: Consult physician before starting new vigorous physical activity.

Nutrition

- Know your body mass index (BMI), blood pressure and cholesterol level. Modify your diet accordingly.
- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
- Optimal calcium intake for women between ages 25 and 50 is estimated to be 1,000 mg/day.
- Vitamin D is important for bone and muscle development, function, and preservation.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention,[16] practice safer sex (use condoms) or abstinence.
- Avoid unintended pregnancy; use contraception.

Substance abuse

- Stop smoking. Limit alcohol consumption. Avoid alcohol or drug use while driving.

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.

If you are pregnant, please refer to the "For pregnant women" page for pregnancy-related recommendations.

Immunizations	
Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors; for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors; for individuals seeking protection[4]
HPV (human papillomavirus)	For all women age 26 and younger if not previously immunized
Meningococcal	College-bound students living in a dorm if not previously immunized[8]
MMR (measles, mumps, rubella)	Once, without proof of immunity or if no previous second dose[5]
Pneumococcal (pneumonia)	For individuals with risk factors[7]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[15]
Varicella (chicken pox)	Recommended for adults without evidence of immunity; should receive 2 shots[10]

Screenings/counseling/services	
Alcohol misuse	Behavioral counseling
Blood pressure, depression, height, weight and BMI	At well visit, annually
Breast cancer	Recommend mammogram every 1–2 years beginning at age 40; BRCA/BART testing is covered if medically necessary[21]
Breast cancer chemoprevention	Recommended for women at high risk for breast cancer and low risk for adverse effects from chemoprevention
Cervical cancer	Recommend for women who have been sexually active and have a cervix
Chlamydia	Recommended for all sexually active women under age 25 and for women at increased risk for infection[11]
Contraception	FDA-approved female contraceptive methods, education, and counseling[33]
Depression	For all adults
Diabetes	Recommend type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg[23]
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Gonorrhea	Recommend for all sexually active women who are at increased risk for infection[11]
Healthy diet and physical activity	Behavioral counseling[28]
Hepatitis B	Screening for HBV infection in persons at high risk of infection[30]
Hepatitis C	Screening for HBV infection in persons at high risk of infection[31]
HIV	For all adults at increased risk[24]
HPV	Recommended for all sexually active women age 30 and older in conjunction with cervical cancer screening (Pap smear)
Lipid disorder	Recommended for individuals at increased risk[9]
Obesity	Screening, counseling and behavioral interventions
Sexually transmitted infections	Behavioral counseling as needed[27]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for young adults to age 24 at high risk
Syphilis	Routine screening for pregnant women and individuals at increased risk for infection[12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

For men ages 20 to 49

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day) can reduce the risks of coronary heart disease, osteoporosis, obesity and diabetes.
- Men over 40: Consult physician before starting new vigorous physical activity.

Nutrition

- Know your body mass index (BMI), blood pressure and cholesterol level. Modify your diet accordingly.
- Vitamin D is important for bone and muscle development, function and preservation.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention,[16] practice safer sex (use condoms) or abstinence.

Substance abuse

- Stop smoking. Limit alcohol consumption.
- Avoid alcohol or drug use while driving.

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.

"Know your numbers." We encourage you to learn your "numbers" at your doctor visit and work toward the optimal goals through exercise and a healthy diet.

Immunizations	
Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors; for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors; for individuals seeking protection[4]
HPV (human papillomavirus)	For all men age 26 and younger if not previously immunized
Meningococcal	College-bound students living in a dorm if not previously immunized[8]
MMR (measles, mumps, rubella)	Once, without proof of immunity or if no previous second dose[5]
Pneumococcal (pneumonia)	For individuals with risk factors[7]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[15]
Varicella (chicken pox)	Recommended for adults without evidence of immunity; should receive two shots[10]

Screenings/counseling/services	
Alcohol misuse	Behavioral counseling
Aspirin[14]	Visit to discuss potential benefit of use[19]
Blood pressure, depression, height, weight and BMI	At annual exam
Depression	For all adults
Diabetes	Recommend type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg[23]
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Healthy diet and physical activity	Behavioral counseling[28]
Hepatitis B	Screening for HBV infection in persons at high risk of infection[30]
Hepatitis C	Screening for HBV infection in persons at high risk of infection[31]
HIV	For all adults at increased risk[24]
Lipid disorder	Screening periodically, starting at age 35; age 20 if at increased risk[9]
Obesity	Screening, counseling and behavioral interventions
Prostate cancer	Beginning at age 40 if at increased risk[26]
Sexually transmitted infections	Behavioral counseling as needed[27]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for young adults to age 24 at high risk
Syphilis, chlamydia and gonorrhea	Routine screening for individuals at increased risk for infection[11,12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

Heart health factors	Optimal goals
• **Total cholesterol**	**Less than 200 mg/dL**
• **LDL "bad" cholesterol**	**Less than 100 mg/dL**
• **HDL "good" cholesterol**	**50 mg/dL or higher**
• **Triglycerides**	**Less than 150 mg/dL**
• **Blood pressure**	**Less than 120/80 mmHg**
• **Fasting glucose**	**Less than 100 mg/dL**
• **Body mass index (BMI)**	**Less than 25 kg/m2**
• **Exercise**	**Minimum of 30 minutes most days of the week**

For men and women age 50 and older

Topics you may want to discuss with your doctor

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
- Optimal calcium intake is estimated to be 1,500 mg/day for postmenopausal women not on estrogen therapy.
- Vitamin D is important for bone and muscle development, function and preservation.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention;[6] practice safer sex (use condoms) or abstinence.

Substance abuse

- Stop smoking. Limit alcohol consumption. Avoid alcohol or drug use while driving.

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.

Other topics for discussion

- Fall prevention.
- Possible risks and benefits of hormone replacement therapy (HRT) for post-menopausal women.
- Risks for and possible benefits of prostate cancer screening in men to determine what is best for you.
- The dangers of drug interactions.
- Physical activity.
- Glaucoma eye exam by an eye care professional (i.e., an ophthalmologist, optometrist) for those age 65 and older.

For heart health, adults should exercise regularly (at least 30 minutes a day on most days), which can help reduce the risks of coronary heart disease, osteoporosis, obesity and diabetes. Consult your physician before starting a new vigorous physical activity.

Immunizations	
Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors; for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors; for individuals seeking protection[4]
Pneumococcal (pneumonia)	Recommended for individuals age 65 and older; and individuals under age 65 with risk factors[7]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[15]
Varicella (chicken pox)	Recommended for adults without evidence of immunity; should receive two shots[10]
Zoster (shingles)	Recommended for all adults age 60 and older

Screenings/counseling/services	
AAA (abdominal aortic aneurysm)	For ages 65–75 who have ever smoked, one-time screening for AAA by ultrasonography
Alcohol misuse	Behavioral counseling
Aspirin[14]	Visit to discuss potential benefit of use[19, 20]
Blood pressure, depression, height, weight, BMI, vision and hearing	At annual exam
Breast cancer	Recommend mammogram every 1–2 years for ages 50–74; BRCA/BART testing is covered if medically necessary[21]
Breast cancer chemoprevention	Covered for individuals at high risk for breast cancer and low risk for adverse effects from chemoprevention
Cervical cancer	At least every 3 years if cervix present; after age 65, Pap tests can be discontinued if previous tests have been normal
Colorectal cancer	Recommended for adults ages 50–75[22]
Depression	For all adults
Diabetes	Recommend type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg[23]
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Fall prevention	Age 65 or older[29]
Gonorrhea and chlamydia	Recommended for individuals who are at increased risk for infection[11]
Healthy diet and physical activity	Behavioral counseling[28]
HIV	For all adults at increased risk for HIV infection[24]
HPV	Recommended for all sexually active individuals age 65 and younger
Lipid disorder	Screening periodically
Lung cancer	Screening for lung cancer in persons with smoking history[32]
Obesity	Screening, counseling and behavioral interventions
Osteoporosis	Recommend routine screening for women age 65 and older; routine screening for men age 70 and older – beginning age can be reduced for individuals at increased risk[13]
Prostate cancer	Prostate-specific antigen (PSA) test and digital rectal exam. May or may not be appropriate. Discuss with your doctor to see if it is more beneficial than harmful in your case
Sexually transmitted infections	Behavioral counseling as needed[27]
Syphilis	Recommended for individuals at increased risk for infection[12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

For pregnant women

Screenings/counseling/services	
Alcohol misuse	Behavioral counseling
Asymptomatic bacteriuria	12–16 weeks gestation or first prenatal visit if after 16 weeks gestation
Breast-feeding counseling	Promote breast-feeding to pregnant or postpartum women. Provide comprehensive lactation support and breast-feeding equipment.
Chlamydia	During first prenatal visit and second screening during the third trimester for those at increased risk[11]
Depression	For all adults
Folic acid	Discuss use of 0.4 to 0.8 mg daily
Gestational diabetes	Women between 24- to 28-week gestations and the first prenatal visit for pregnancy. Women identified to be at increased risk for diabetes.
Gonorrhea	First prenatal visit and second screening during the third trimester if at increased risk[11]
Hepatitis B	First prenatal visit
HIV	First prenatal visit[24]
Iron deficiency anemia	Once during each pregnancy
Rh (D) incompatibility	First prenatal visit and repeat testing at 24- to 28-week gestation unless the biological father is known to be Rh (D) negative for unsensitized Rh (D) negative pregnant women
Syphilis	First prenatal visit, second screening during the third trimester, and at delivery for those at increased risk[12]
Tobacco use and cessation	Screening for tobacco use and tobacco-cessation intervention

Having a baby? Be aware that while almost all women get the "baby blues" after childbirth, as many as 10% will get postpartum depression. For more information visit our website, **blueshieldca.com**, and search "postpartum depression" or see your healthcare provider.

Recommendations for a healthy pregnancy

Prenatal care
Begin within 14 days of confirming pregnancy.

Dietary supplements
Women of childbearing age should take 0.4 to 0.8 mg of folic acid daily to decrease the risk of fetal birth defects of the brain or spine; recommended calcium intake for pregnant or nursing women: 1,000 milligrams daily.

Screenings and diagnostics
Blood pressure and weight check at all visits: urine test, obstetrical history and physical, screenings for asymptomatic bacteriuria, chlamydia, gestational diabetes, Group B streptococcal bacteria, Hepatitis B, syphilis, gonorrhea, hematocrit, rubella, varicella, Rh (D) incompatibility; HIV counseling and screening, ultrasonography, screening for alpha fetoprotein, chorionic villus screening (CVS) or amniocentesis (for women age 35 and older), blood test for certain birth defects, prior vaccinations (including flu shots), fundal height, fetal heart tones, discuss preterm labor risk, history of genital herpes, nutrition, smoking cessation, domestic abuse and other medication and drug use.

Discussion topics at prenatal care visits
Prior vaccinations (including flu shots), history of genital herpes, nutrition, smoking cessation, other medication and drug use.

Postpartum care
To be performed within three to seven weeks following delivery. Postpartum exam to include weight, blood pressure, breast and abdomen exam, or pelvic exam.

Endnotes

1. Blood test for newborns may include congenital hypothyroidism, phenylketonuria and sickle cell disease.
2. Annual vaccination against influenza is recommended for all persons age 6 months and older, including all adults. Healthy, nonpregnant adults under age 50 without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine, or inactivated vaccine. Other persons should receive the inactivated vaccine. Adults age 65 and older can receive the standard influenza vaccine or the high-dose influenza vaccine.
3. Risk factors for hepatitis A should be discussed with your provider.
4. Risk factors for hepatitis B should be discussed with your provider.
5. Measles component: Adults born before 1957 can be considered immune to measles. Adults born on or after 1957 should receive one or more doses of MMR , depending upon their immune status. Also, a second dose of MMR may be necessary if exposed, traveling internationally, and other factors. Rubella component: Women with unreliable vaccination history should check with their provider. Check with your doctor for details regarding pregnancy.
6. Administer pneumococcal vaccine to children with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.
7. One dose for adults at risk, including those with chronic lung diseases (including asthma and COPD); cardiovascular diseases, diabetes mellitus, chronic liver disease, chronic renal failure, sickle cell disease, and immunocompromising conditions. Vaccination is also recommended in adults who smoke cigarettes and residents of nursing homes and long-term care facilities. Vaccination is not recommended in Alaskan Native or Native American persons unless they have another risk factor present. A second pneumococcal dose may be necessary for people age 65 and older who received the vaccine more than 5 years previously and were younger than 65 at the time of the primary vaccination. A one-time revaccination is recommended after 5 years for people with certain medical conditions, including immunosuppressive conditions and people who have undergone chemotherapy.
8. Individuals at risk for meningococcal disease include international travelers, college-bound students or anyone with a damaged or removed spleen or with terminal complement component deficiency. These individuals should discuss the risks and benefits of vaccination with their doctor.
9. Lipid disorders risk factors for men ages 20–35 or women age 20 and older include diabetes, previous personal history of congestive heart disease or non-coronary atherosclerosis, family history of cardiovascular disease before age 50 in male relatives and age 60 in female relatives, tobacco use, and obesity (BMI ≥ 30).
10. Individuals at risk for varicella infection include those who have close contact with persons at high risk for severe disease (healthcare workers and family contacts of immunocompromised persons) or are at high risk for exposure or transmission (e.g., teachers of young children; childcare employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
11. Risk factors for chlamydia and gonorrhea infection include history of chlamydial or other sexually transmitted infections, new or multiple sexual partners, inconsistent condom use, commercial sex work, and drug use.
12. Risk factors for syphilis infection include all adolescents and adults who receive health care in a high-prevalence or high-risk clinical setting, men who have had sex with men, commercial sex workers, and those in adult correctional facilities. Individuals being treated for sexually transmitted diseases may be more likely than others to engage in high-risk behavior.
13. Increased risks for osteoporosis include women ages 60 to 64 with all of the following risks for osteoporotic fractures: lower body weight (weight < 70 kg) and no current use of estrogen therapy.
14. People with increased risk for coronary heart disease who may benefit from aspirin therapy are men over age 40, postmenopausal women, and younger people with hypertension, diabetes or who smoke.
15. People in contact with infants under 12 months of age and healthcare personnel can be given the Td vaccine as soon as feasible. It is recommended that Tdap should replace a single dose of Td for adults under age 65 if they have not previously received a dose of Tdap.
16. Sexually transmitted infections, also known as sexually transmitted diseases, include chlamydia, gonorrhea, herpes, HIV, HPV, syphilis, and others. See infection-specific notes for information on risk factors for sexually transmitted infections.
17. The Tdap (tetanus, diphtheria, acellular pertussis) booster is recommended in children ages 11 to 12 who have completed the childhood DTaP immunization series and have not yet received a tetanus and diphtheria (Td) booster dose.
18. Children through age 9 getting flu vaccine for the first time – or who received flu vaccine – should get two doses, at least four weeks apart.
19. Potential benefit of aspirin use in men ages 45 to 79 due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
20. Potential benefit of aspirin use in women ages 55 to 79 due to a reduction in ischemic strokes outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
21. For breast cancer screening, BRCA mutation referral for genetic risk assessment and evaluation for breast and ovarian susceptibility is recommended for women with family history associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. BRCA/BART testing, if medically necessary. Please see Blue Shield of California medical policy on Genetic Testing for Hereditary Breast and/or Ovarian Cancer.
22. Colorectal cancer screenings include fecal occult blood annually, sigmoidoscopy every five years, and colonoscopy every 10 years. Beginning age and screening interval can be reduced for patients at increased risk.
23. Diabetes screening should be performed for adults ages 40 to 70 who are overweight and obese. Intensive behavioral counseling interventions to promote a healthful diet and physical activity for patients with abnormal blood glucose.
24. Individuals at risk for HIV infection include all adolescents and adults who receive health care in high-prevalence or high-risk clinical setting; men who have had sex with men after 1975; individuals having unprotected sex with multiple partners; past or present injecting drug users; commercial sex workers; individuals whose past or present sex partners were HIV infected, bisexual, or injection drug users; individuals being treated for sexually transmitted diseases; individuals with a history of blood transfusion between 1978 and 1985; and individuals who requested an HIV test despite reporting no individual risk factors.
25. Fluoride oral supplement should be discussed at preventive care visit if primary water source is deficient in fluoride.
26. Increased risk factors for prostate cancer include African-American men and men with family history of prostate cancer.
27. Behavioral counseling to prevent sexually transmitted infections is for sexually active adolescents and adults who meet the following criteria: current sexually transmitted infections, sexually transmitted infections within the past year, multiple current sexual partners, and in non-monogamous relationships if they reside in a community with a high rate of sexually transmitted infections.
28. Intensive behavioral counseling to promote healthy diet and physical activity is recommended for all adults who have hyperlipidemia or have any known risk factors for cardiovascular and diet-related chronic disease.
29. Falls prevention counseling for older adults to exercise or physical therapy to prevent falls in community-dwelling adults age 65 and older who are at increased risk for falls.
30. Hepatitis B screening for non-pregnant adolescents and adults for hepatitis B virus infection at high risk for infection; pregnant women at their first prenatal visit.
31. Hepatitis C screening for adults for hepatitis C virus infection at high risk for infection
32. Lung cancer screening for adults ages 55 to 80 who have a smoking history.
33. For self-administered hormonal contraceptives, you may receive up to a 12-month supply.

These are Blue Shield of California's Preventive Health Guidelines, which are based on nationally recognized guidelines. Members must refer to their *Evidence of Coverage* or *Certificate of Insurance* or Policy for plan/policy coverage of preventive health benefits.

Planning ahead

Here is some information you should consider.

Organ donation

It's estimated that more than 100,000 Americans – including 21,000 people in California – are waiting for a donor organ that could save their lives. About 400 new candidates are added to the waiting list each month.

One donor can save or help as many as 50 people through organ and tissue transplantation. You can make the difference between life and death by becoming an organ donor. Here's how:

- Sign up for organ donation at www.donatelifecalifornia.org. This information-rich website is connected with all major organ procurement organizations.
- Fill out a donor card. You can get a free donor card from the California Transplant Donor Network at www.ctdn.org. Be sure to sign it and keep it with your driver's license.

After you decide to become an organ donor, be sure to tell your doctor and your family members. Unless you have registered with the state-sponsored organ donor registries, family members must consent to organ donation even if you have signed a donor card.

The following organizations are also good resources for information about organ and tissue donation:

Organ and tissue donation contacts

Donate Life California	(866) 797-2366 www.donatelifecalifornia.org
Caring Connections	(800) 658-8898 www.caringinfo.org
Sierra Donor Services	(877) 401-2546 www.sierradonor.org
OneLegacy Los Angeles	(213) 229-5600 www.onelegacy.org
Lifesharing Community Organ and Tissue Donation	(619) 521-1983 www.lifesharing.org
OneLegacy Orange County	(562) 608-4100 www.onelegacy.org
OneLegacy Riverside/Inland Empire	(909) 801-3701 www.onelegacy.org

Advance directives

It's important to have legal documents in place should you become too sick to make healthcare decisions for yourself.

An advance healthcare directive is a legally binding document in California that allows you to name a person or "agent" to make decisions about your health care when you are unable to do so yourself. You can choose any adult except your doctor or an employee of a healthcare facility where you are receiving care, unless that person is related to you, or is a co-worker.

- Choose as your agent a person whom you trust will respect your wishes and remain calm in a time of crisis. It's also wise to name a second person in case the first is not available.
- Consult your doctor, family, and friends when you create your advance directive.
- Put your wishes in writing and be as specific as possible.
- Give a copy to all your doctors to put in your file, and distribute copies to family members and friends, so they all know what types of care you do and do not desire in such a situation.

legal information

Find all the details related to your Blue Shield health plan in this section.

Blue Shield of California
Endorsement to your HMO Plan

This Endorsement should be attached to, and is made part of, your Blue Shield of California Evidence of Coverage (EOC). Please retain it for your records.

There are revisions effective **January 1, 2017** and **July 1, 2017**. Revisions effective **January 1, 2017** are described in **PART I. January 1, 2017.** and revision effective **July 1, 2017** are described in **PART II. July 1, 2017**.

PART I. January 1, 2017

Effective January 1, 2017, the Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. In the ***Principal Limitations, Exceptions, Exclusions and Reductions*** section of the **Evidence of Coverage**, the following exclusion under ***General Exclusions and Limitations*** has been revised as shown below (Please note that because the exclusion numbers vary by plan, "##" is used as a placeholder for the exclusion number.):

   ~~##~~ for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits or Preventive Health Services. 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;

PART II. July 1, 2017

Effective July 1, 2017, the Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. In the ***How to Use This Plan*** section of the **Evidence of Coverage**, the following section has been added immediately following the ***Health Education and Health Promotion Services*** section:

Timely Access to Care

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

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

Note: For availability of interpreter services at the time of the Member's appointment, consult the list of Blue Shield Access+ HMO Providers available at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this EOC.

2. In the ***How to Use This Plan*** section of the **Evidence of Coverage**, under ***Cost Sharing,*** the second paragraph in the ***Calendar Year Medical Deductible*** section is updated as follows:

The Summary of Benefits indicates whether or not the Calendar Year Medical Deductible applies to a particular Covered Service. Covered Services received at a Plan Provider facility will accrue to the Calendar Year Medical Deductible whether rendered by a Plan Provider or non-Plan Provider.

3. In the ***How to Use This Plan*** section of the **Evidence of Coverage**, under ***Cost Sharing,*** the first paragraph in the ***Calendar Year Out-of-Pocket Maximum*** section is updated as follows:

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

4. In the ***How to Use This Plan*** section of the **Evidence of Coverage**, the first paragraph in the ***Limitation of Liability*** section is updated as follows:

Members shall not be responsible to Plan Providers or non-Plan Providers rendering Services at a Plan Provider facility, for payment of services if they are a Benefit of the Plan. When Covered Services are rendered by a Plan Provider, or rendered by a non-Plan Provider at a Plan Provider facility, the Member is responsible only for the applicable Deductible,

Copayment or Coinsurance, except as set forth in the Third Party Liability section. Members are responsible for the full charges for any non-Covered Services they obtain.

Access+ HMO® Zero Admit 20

Evidence of Coverage

Group

Blue Shield of California

Evidence of Coverage

Access+ HMO® Zero Admit 20

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

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

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

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

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 EOC is available for review prior to enrollment in the plan.

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

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

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

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

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

number provided on the back page of this EOC to ensure that you can obtain the health care services that you need.

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

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

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

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

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

Blue Shield of California

Member Bill of Rights

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

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

Blue Shield of California

Member Responsibilities

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

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

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HMO Summary of Benefits

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

Summary of Benefits

Access+HMO® Zero Admit 20

Calendar Year Medical Deductible [1]	Member Deductible Responsibility [1, 2]
Calendar Year Medical Deductible There is no calendar year Deductible under this Plan.	None

Calendar Year Out-of-Pocket Maximum [3]	Member Maximum Calendar Year Out-of-Pocket Amount [2, 3]
Calendar Year Out-of-Pocket Maximum	$1,000 per Member/ $2,000 per Family

Maximum Lifetime Benefits	Maximum Blue Shield Payment
Lifetime Benefit Maximum	No maximum

Benefit	Member Copayment [2]
Access+ Specialist Benefits The Access+ Specialist benefit allows a Member to arrange an office visit within their Personal Physician's Medical Group/IPA without a referral from their Personal Physician. See the Access+ Specialist and Access+ Satisfaction sections of the EOC for details. Your Personal Physician's Medical Group/IPA must be an Access+ Provider for you to use this Benefit. Refer to the HMO Physician and Hospital Directory or call Blue Shield to determine whether your Personal Physician's Medical Group/IPA is an Access+ Provider.	
Laboratory services	You pay nothing
Conventional x-rays	You pay nothing
Office visit	$35 per visit
Allergy Testing and Treatment Benefits	
Allergy serum purchased separately for treatment	50%
Office visits (includes visits for allergy serum injections)	$20 per visit
Ambulance Benefits	
Emergency or authorized transport	$100
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery services may also be obtained from a Hospital or an Ambulatory Surgery Center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.	
Ambulatory Surgery Center outpatient surgery facility services	You pay nothing
Ambulatory Surgery Center outpatient surgery Physician services	You pay nothing
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits	
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Covered Services for Members who have been accepted into an approved clinical trial when prior authorized by Blue Shield. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.	You pay nothing
Diabetes Care Benefits	
Devices, equipment and supplies	20%
Diabetes self-management training – office location	$20 per visit
Durable Medical Equipment Benefits	
Breast pump	You pay nothing
Other Durable Medical Equipment	50%

Benefit	Member Copayment [2]
Emergency Room Benefits	
Emergency Room Physician services Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and not covered.	You pay nothing
Emergency Room services not resulting in admission Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and not covered.	$100 per visit
Emergency Room services resulting in admission (billed as part of inpatient Hospital services)	You pay nothing
Family Planning Benefits Note: Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc), the facility Copayment listed under the applicable facility benefit in the Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), an intrauterine device (IUD), and tubal ligation.	
Counseling, consulting, and education (Including Physician office visit for diaphragm fitting, injectable contraceptives or implantable contraceptives.)	You pay nothing
Diaphragm fitting procedure	You pay nothing
Implantable contraceptives	You pay nothing
Infertility services	50%
Injectable contraceptives	You pay nothing
Insertion and/or removal of intrauterine device (IUD)	You pay nothing
Intrauterine device (IUD)	You pay nothing
Tubal ligation	You pay nothing
Vasectomy	You pay nothing
Home Health Care Benefits	
Home health care agency services (Including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist or occupational therapist) Up to a maximum of 100 visits per Member, per Calendar Year, by home health care agency providers. If your benefit Plan has a Calendar Year Medical Deductible, the number of visits starts counting toward the maximum when services are first provided even if the Calendar Year Medical Deductible has not been met.	$20 per visit
Medical supplies	You pay nothing

Benefit	Member Copayment [2]
Home Infusion/Home Injectable Therapy Benefits	
Hemophilia home infusion services Services provided by hemophilia infusion providers and prior authorized by Blue Shield. Includes blood factor product.	You pay nothing
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit if selected as an optional Benefit by your Employer, and are described in a Supplement included with this booklet.	You pay nothing
Home visits by an infusion nurse Hemophilia home infusion nursing visits are not subject to the Home Health Care and Home Infusion/Home Injectable Therapy Benefits Calendar Year visit limitation.	$20 per visit
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program The Hospice Program Benefit must be prior authorized by Blue Shield and must be received from a Participating Hospice Agency.	
24-hour continuous home care	You pay nothing
Short term inpatient care for pain and symptom management	You pay nothing
Inpatient respite care	You pay nothing
Pre-hospice consultation	You pay nothing
Routine home care	You pay nothing
Hospital Benefits (Facility Services)	
Inpatient Facility services Semi-private room and board, services and supplies, including Subacute Care.	You pay nothing
Inpatient skilled nursing services, including Subacute Care Up to a maximum of 100 days per Member, per Calendar Year, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your benefit Plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	You pay nothing
Inpatient services to treat acute medical complications of detoxification	You pay nothing
Outpatient dialysis services	You pay nothing
Outpatient Facility services	You pay nothing
Outpatient services for treatment of illness or injury, radiation therapy, chemotherapy, and supplies	You pay nothing
Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated, and orthognathic surgery for skeletal deformity.	
Ambulatory Surgery Center outpatient surgery facility services	You pay nothing
Inpatient Hospital services	You pay nothing
Office location	$20 per visit
Outpatient department of a Hospital	You pay nothing

Benefit	Member Copayment [2]
Mental Health and Substance Use Disorder Benefits [4] All services provided through Blue Shield's Mental Health Service Administrator (MHSA).	
Inpatient Mental Health and Substance Use Disorder Services	
Inpatient Hospital services	You pay nothing
Inpatient Professional (Physician) services	You pay nothing
Residential care for Mental Health Condition	You pay nothing
Residential care for Substance Use Disorder Condition	You pay nothing
Non-Routine Outpatient Mental Health and Substance Use Disorder Services	
Behavioral Health Treatment in home or other non-institutional setting	You pay nothing
Behavioral Health Treatment in an office-setting	You pay nothing
Electroconvulsive Therapy (ECT) [5]	You pay nothing
Intensive Outpatient Program [5]	You pay nothing
Office-based opioid treatment: outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment	You pay nothing
Partial Hospitalization Program [6]	You pay nothing
Psychological testing to determine mental health diagnosis	You pay nothing
Transcranial magnetic stimulation	You pay nothing
Routine Outpatient Mental Health and Substance Use Disorder Services	
Professional (Physician) office visits	$20 per visit

Benefit	Member Copayment [2]
Orthotics Benefits	
Office visits	$20 per visit
Orthotic equipment and devices	You pay nothing
Outpatient Prescription Drug Benefits Outpatient Prescription Drug coverage if selected as an optional Benefit by your Employer, is described in a Supplement included with this booklet.	
Outpatient X-Ray, Pathology and Laboratory Benefits, Diagnostic Benefits	
Mammography and Papanicolaou test	You pay nothing
Outpatient Diagnostic X-ray, Pathology, Diagnostic Examination and Clinical Laboratory services	You pay nothing
PKU Related Formulas and Special Food Products Benefits	
Formulas and Special Food Products	You pay nothing
Podiatric Benefits	
Podiatric services – office location	$20 per visit
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Covered Services section of the EOC. Services will be covered as any other surgery and paid as noted in this Summary of Benefits.	
Inpatient Hospital services for normal delivery, Cesarean section, and complications of pregnancy	You pay nothing
Prenatal and preconception Physician office visit: initial visit	You pay nothing
Prenatal Physician office visit: subsequent visits (See Outpatient X-Ray, Pathology and Laboratory Benefits for prenatal genetic testing)	You pay nothing
Postnatal Physician office visits	You pay nothing
Abortion services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility coinsurance may apply.	You pay nothing
Preventive Health Benefits	
Preventive Health Services See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the EOC, for more information.	You pay nothing

Benefit	Member Copayment [2]
Professional (Physician) Benefits	
Inpatient Physician services	You pay nothing
Outpatient Physician services, other than an office setting	You pay nothing
Physician home visits	$50 per visit
Physician office visits A woman may self-refer to an OB-Gyn or family practice Physician in the Personal Physician's Medical Group/IPA.	$20 per visit
Specialist office visits See also the section "Access+ Specialist Benefits" of this Summary of Benefits.	$20 per visit
Teladoc consultation Teladoc consultation for primary care services provide confidential consultations using a network of board certified Physicians when your Physician's office is closed and you need quick access to a Physician. Teladoc Physicians are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. over secure video, 7 days a week. See the Principal Benefits and Coverages (Covered Services) section, Professional (Physician) Benefits for detailed information.	$5 per consultation
Prosthetic Appliance Benefits	
Office visits	$20 per visit
Prosthetic equipment and devices	You pay nothing
Reconstructive Surgery Benefits For Physician services for these Benefits, see the "Professional (Physician) Benefits" section of this Summary of Benefits.	
Ambulatory Surgery Center outpatient surgery facility services	You pay nothing
Inpatient Hospital services	You pay nothing
Outpatient department of a Hospital	You pay nothing
Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.	
Office location	$20 per visit
Outpatient department of a Hospital	$20 per visit
Skilled Nursing Facility (SNF) Benefits	
Skilled nursing services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Member, per Calendar Year, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing SNF. If your benefit Plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	You pay nothing

Benefit	Member Copayment [2]
Speech Therapy Benefits Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.	
Office location	$20 per visit
Outpatient department of a Hospital	$20 per visit
Transplant Benefits – Tissue and Kidney Organ Transplant Benefits for transplant of tissue or kidney.	
Hospital services	You pay nothing
Professional (Physician) services	You pay nothing
Transplant Benefits – Special Blue Shield requires prior authorization for all Special Transplant Services, and all services must be provided at a Special Transplant Facility designated by Blue Shield. See the Transplant Benefits – Special Transplants section of the Principal Benefits (Covered Services) section in the EOC for important information on this Benefit.	
Facility services in a Special Transplant Facility	You pay nothing
Professional (Physician) services	You pay nothing
Urgent Services Benefits	
Urgent Services Inside the Personal Physician's Service Area and not rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	Not covered
Urgent Services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	$20 per visit
Urgent Services Outside the Personal Physician's Service Area within California	$20 per visit

Summary of Benefits
Endnotes

[1] If applicable, the Calendar Year Medical Deductible must be satisfied once during the Calendar Year at the Member or Family level, before the Plan provides payments for Covered Services subject to the Deductible. The Calendar Year Medical Deductible accrues to the Calendar Year Out-of-Pocket Maximum.

[2] Coinsurance is calculated based on the Allowed Charge unless otherwise specified.

[3] Copayments or Coinsurance for Covered Services accrue to the Calendar Year Out-of-Pocket Maximum, except for Copayments or Coinsurance for:

Charges in excess of specified benefit maximums
any optional Infertility Benefits
any optional Vision Benefits;
any optional Dental Benefits;
any optional Hearing Aid Benefits;

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

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

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

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

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

The Blue Shield Access+ HMO Health Plan

Introduction to the Blue Shield Access+ HMO Health Plan

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

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

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

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

How to Use This Health Plan

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

Selecting a Personal Physician

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

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

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

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

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

Personal Physician Relationship

The Physician-patient relationship is an important element of an HMO Plan. The Member's Personal Physician will make every effort to ensure that all Medically Necessary and appropriate professional services are provided in a manner compatible with the Member's wishes. If the Member and Personal Physician fail to establish a satisfactory relationship or disagree on a recommended course of treatment, the Member may contact Customer Service at the number provided on the back page of this EOC for assistance in selecting a new Personal Physician.

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

Role of the Personal Physician

The Personal Physician chosen by the Member at the time of enrollment will coordinate all Covered Services including primary care, preventive services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological Physician services, Access+ Specialist, and Mental Health and Substance Use Disorder Services), Hospice admission through a Participating Hospice Agency, Emergency Services, Urgent Services and Hospital admission. The Personal Physician will also manage prior authorization when needed.

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

Obstetrical/Gynecological (OB/GYN) Physician Services

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

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

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

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

Referral to Specialty Services

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

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

In the event no Plan Provider is available to perform the needed services, the Personal Physician will refer the Member to a non-Plan Provider after obtaining authorization. Specialty services are subject to all benefit and eligibility provisions, exclusions and limitations described in this EOC.

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

Mental Health and Substance Use Disorder Services.

Role of the Medical Group or IPA

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

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

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

Changing Personal Physicians or Designated Medical Group or IPA

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

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

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

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

Additionally, changes in Personal Physician or Medical Group/IPA during an on-going course of treatment may interrupt care. For this reason, the effective date of a Personal Physician or Medical Group/IPA change, when requested during an ongoing course of treatment, will be the first of the month following the date it is medically appropriate to transfer the Member's care to a new Personal Physician or Medical Group/IPA, as determined by Blue Shield.

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

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

Access+ Specialist

The Member may arrange an office visit with an Access+ Specialist within their Personal Physician's Medical Group/IPA without a referral from the Personal Physician. The Member is responsi-

ble for the Copayment or Coinsurance listed in the Summary of Benefits for each Access+ Specialist visit including the initial visit and follow up care not referred through the Member's Personal Physician.

An Access+ Specialist visit includes an examination or other consultation including diagnosis and treatment provided by a Medical Group or IPA Plan Specialist without a Personal Physician referral.

An Access+ Specialist visit does not include:

1) Services which are not otherwise covered;
2) Services provided by a non-Access+ Provider (such as Podiatry and Physical Therapy);
3) Allergy testing;
4) Endoscopic procedures;
5) Diagnostic and nuclear imaging including CT, MRI, or bone density measurement;
6) Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics;
7) Infertility services;
8) Emergency Services;
9) Urgent Services;
10) Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services;
11) Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician;
12) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician.

Access+ Satisfaction

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

Mental Health and Substance Use Disorder Services

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

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

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

Prior Authorization

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

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

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

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

Continuity of Care by a Terminated Provider

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

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who (1) are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; (2) are children from birth to 36 months of age; or (3) have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with the non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

Second Medical Opinion

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

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

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

Urgent Services

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

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

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

(Urgent Care) While in your Personal Physician Service Area

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

Outside of California

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

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

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Customer Service at the number provided on the back page of this booklet for assistance in receiving Urgent Services through a Blue Shield of California Provider. You may also locate a Blue Shield Provider by visiting our web site at www.blueshieldca.com. However, you are not required to use a Blue Shield of California Provider to receive Urgent Services; you may use any provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Follow-up care is also covered through a Blue Shield of California Provider and may also be received from any provider. However, when outside your Personal Physician Service Area authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

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

When you receive covered Urgent Services outside your Personal Physician Service Area within California, the amount you pay, if not subject to a flat dollar Copayment, is calculated based on Blue Shield's Allowed Charges.

Emergency Services

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

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

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

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

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

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

If a Member receives non-authorized services under circumstances that were not a situation in which a reasonable person would believe that an emergency condition existed, the Member will be responsible for the cost of those services.

NurseHelp 24/7 sm

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

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

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

In the case of a medical emergency, call 911.

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

Life Referrals 24/7

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

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

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

Blue Shield Online

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

Health Education and Health Promotion Services

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

Cost Sharing

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

Calendar Year Medical Deductible

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 EOC. 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. The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

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

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

Calendar Year Out-of-Pocket Maximum

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

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

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

Liability of Subscriber or Member for Payment

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

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

1) Emergency Services
2) Urgent Services
3) Access+ Specialist visits
4) Hospice program services provided by a Participating Hospice Agency after the Member has been referred and accepted into the Hospice Program

5) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the Personal Physician's Medical Group/IPA; and

6) Routine Outpatient Mental Health and Substance Use Disorder Services by an MHSA Participating Provider.

In general, the Member is responsible for payment for:

1) Any services that are not Covered Services; and

2) Any Covered Services (except Emergency Services or Urgent Services) that are rendered by a non-Plan Provider, unless the Member has been referred to such services by their Personal Physician or the MHSA and the services are prior authorized by the Personal Physician or the MHSA. Prior authorization will not be granted and payment will not be made for services (other than Emergency Services or Urgent Services) that are rendered by a non-Plan Provider unless there is no Plan Provider available to render such services.

Limitation of Liability

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

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

Inter-Plan Programs

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

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

BlueCard Program

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

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

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

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or 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 covered Emergency Services are paid based on the Allowed Charges as defined in this EOC.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Negotiated (non–BlueCard Program) Arrangements

If Blue Shield has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on your behalf, Blue Shield will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Claims for Emergency and Out-of-Area Urgent Services

Emergency

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

Out-of-Area Urgent Services

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

been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

Utilization Management

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

Principal Benefits and Coverages (Covered Services)

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

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

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

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

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

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

Allergy Testing and Treatment Benefits

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

Ambulance Benefits

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

Ambulatory Surgery Center Benefits

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

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

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

1) the clinical trial has a therapeutic intent and the Personal Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and

2) the Hospital and/or Physician conducting the clinical trial is a Plan Provider, unless the protocol for the trial is not available through a Plan Provider.

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

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

1) the investigational item, device, or service, itself;

2) drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

3) services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

4) any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;

5) services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

6) services customarily provided by the research sponsor free of charge for any enrollee in the trial;

7) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

   a. one of the National Institutes of Health;

   b. the Centers for Disease Control and Prevention;

   c. the Agency for Health Care Research and Quality;

   d. the Centers for Medicare & Medicaid Services;

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

   f. qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

   g. the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

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

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

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices and equipment, including replacement after the ex-

pected 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 Supplement* if selected as an optional Benefit by your Employer.

Diabetic Outpatient Self-Management Training

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

Dialysis Benefits

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

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

Durable Medical Equipment Benefits

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

No DME Benefits are provided for the following:

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

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

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

Emergency Room Benefits

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

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

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

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

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

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

Family Planning and Infertility Benefits

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

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

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

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

Home Health Care Benefits

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

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

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled services are covered up to four visits per day, two hours per visit up to the Calendar Year visit maxi-

mum. The visit maximum includes all home health visits by any of the following professional providers:

1) registered nurse;
2) licensed vocational nurse;
3) physical therapist, occupational therapist, or speech therapist; or
4) medical social worker.

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

For the purpose of this Benefit, each two-hour increment of a visit from a nurse, physical therapist, occupational therapist, speech therapist, or medical social worker counts as a separate visit. Visits of two hours 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 Supplemental Benefit for Outpatient Prescription Drugs if selected as an optional Benefit by your Employer.

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

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

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

Home Infusion and Home Injectable Therapy Benefits

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

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

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

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

Hemophilia Home Infusion Products and Services

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

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

Following evaluation by the Member's Personal Physician, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once authorized by Blue Shield, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non- emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the *Emergency Room Benefits* section.)

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

No Benefits are provided for:

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

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

Hospice Program Benefits

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

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

disciplinary Hospice team and to the Member's Personal Physician with regard to pain and symptom management and as a liaison to community physicians;

i. physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;

j. respiratory therapy;

k. volunteer services.

3) Drugs, DME, and supplies.

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

a. Eight to 24 hours per day of continuous Skilled Nursing care (eight-hour minimum);

b. homemaker or Home Health Aide services up to 24 hours per day to supplement skilled nursing care.

5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.

6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

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

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

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

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

2) General nursing care and special duty nursing.

3) Meals and special diets.

4) Intensive care services and units.

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

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

7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield.

8) Drugs and oxygen.

9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.

10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.

11) Dialysis, radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

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

13) Subacute Care.

14) Medical social services and discharge planning.

15) Inpatient services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is

compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

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

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

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

No Benefits are provided for:

1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;
2) dental implants (endosteal, subperiosteal or transosteal);
3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support

natural or prosthetic teeth; and

5) fluoride treatments except when used with radiation therapy to the oral cavity.

Mental Health and Substance Use Disorder Benefits

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

Routine Outpatient Mental Health and Substance Use Disorder Services

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

Non-Routine Outpatient Mental Health and Substance Use Disorder Services

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

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

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

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

2) Electroconvulsive Therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.

3) Intensive Outpatient Program – an outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

4) Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment

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

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

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

Inpatient Services

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

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

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

Orthotics Benefits

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

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

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

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

Outpatient X-Ray, Pathology and Laboratory

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

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

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

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

PKU Related Formulas and Special Food Products Benefits

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

Podiatric Benefits

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

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

1) prenatal care;
2) outpatient maternity services;
3) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);
4) inpatient Hospital maternity care including labor, delivery and post-delivery care;
5) abortion services; and

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

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

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

Preventive Health Benefits

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

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

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

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

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

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

Professional (Physician) Benefits

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

1) Physician office visits for examination, diagnosis, and treatment of a medical condition, disease or injury.
2) Specialist office visits for second medical opinion or other consultation and treatment;
3) Mammography and Papanicolaou's tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
4) Preoperative treatment;
5) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;

6) Outpatient surgical procedures.

7) Outpatient routine newborn circumcision within 18 months of birth;

8) Office administered Injectable medications approved by the Food and Drug Administration (FDA) as prescribed or authorized by the Personal Physician

9) Outpatient radiation therapy and chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10) Diagnostic audiometry examination.

11) Physician visits to the home.

12) Inpatient medical and surgical Physician services when Hospital or Skilled Nursing Facility services are also covered.

13) Routine newborn care in the Hospital including physical examination of the infant and counseling with the mother concerning the infant during the Hospital stay;

14) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Personal Physician's office is closed and you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

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

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

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

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

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

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

Prosthetic Appliances Benefits

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

1) Tracheoesophageal voice prosthesis (e.g. Blom-Singer device), artificial larynx, or other prosthetic device for speech following laryngectomy (covered as a surgical professional benefit);

2) artificial limbs and eyes;

3) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, os-

seointegrated hearing devices and hip joints if surgery to implant the device is covered;

4) Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;

5) supplies necessary for the operation of Prostheses;

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

7) repairs, except for loss or misuse.

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

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

Reconstructive Surgery Benefits

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

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

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

Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy)

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

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

Benefits for Speech Therapy are described in the *Speech Therapy Benefits* section.

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

Skilled Nursing Facility Benefits

Benefits are provided for Skilled Nursing services in a Skilled Nursing Unit of a Hospital or a free-standing Skilled Nursing Facility, up to the Benefit maximum 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 the Member's Personal Physician and provided by a licensed speech therapist/pathologist or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

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

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

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

Transplant Benefits

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

Tissue and Kidney Transplant

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

Special Transplant

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield to provide the procedure, (2) prior authorization is obtained, in writing from Blue Shield and (3) the recipient of the transplant is a Subscriber or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

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

The following procedures are eligible for coverage under this Benefit:

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

Urgent Services Benefits

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

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

Inside California

For Urgent Services within California but outside the Member's Personal Physician Service Area, the Member should, if possible, contact Blue Shield Member Services at the number provided on the back page of this booklet in accordance with the *How to Use This Health Plan* section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Provider. Mem-

bers may also locate a Blue Shield Provider by visiting Blue Shield's internet site at www.blueshieldca.com. You are not required to use a Blue Shield of California Provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Outside California or the United States

When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. When a BlueCard Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. If you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. See *Claims for Emergency and Out-of-Area Urgent Services* in the How to Use This Health Plan section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, 7 days a week. For inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a Physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the How to *Use This Health Plan* section. See *BlueCard Program* in the *How to Use This Health Plan* section for additional information.

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

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

1) routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;

2) for hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;

3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;

4) inpatient treatment in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice

Agency or through a palliative care program offered by Blue Shield;

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

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

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

8) hearing aids, unless your Employer has purchased hearing aids coverage as an optional Benefit, in which case an accompanying supplement provides the Benefit description;

9) eye exams and refractions, lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;

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

11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;

12) for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

13) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

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

15) for Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

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

17) any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, services incident to reversal of surgical sterilization, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;

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

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

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

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

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

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

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

25) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

26) 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;

27) 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;

28) 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;

29) for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

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

31) for disposable supplies for home use , such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home HealthCare, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits Supplement if selected as an optional Benefit by your Employer.

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

33) services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease; and

34) for or incident to acupuncture, except as specifically provided;

35) for spinal manipulation and adjustment, except as specifically provided under *Professional (Physician) Benefits (other than for Mental Health and Substance Use Disorder Benefits)* in the Plan Benefits section;

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

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

38) for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician, Emergency Services or Urgent Services as provided under *Emergency Room Benefits* and *Urgent Services Benefits* in the Plan Benefits section.

39) for inpatient and Non-Routine Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA; and

40) services not specifically listed as a Benefit.

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

Medical Necessity Exclusion

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

Limitations for Duplicate Coverage

Medicare Eligible Members

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

gible to receive benefits for end-stage renal disease from Medicare.

d. When the Member is retired and age 65 years or older.

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

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

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

Members Covered by Another Government Agency

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

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

Exception for Other Coverage

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

Claims Review

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

Reductions - Third Party Liability

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

1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.

2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (a) because the Member does not receive the full amount of damages that the Member claimed or (b) because the Member had to pay attorneys' fees.

4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

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

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

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

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

1) Ensure that any recovery is kept separate from and not comingled with any other funds or the Member's general assets and agree in writing that the portion of any recovery required to satisfy the lien or other right of Recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield;

2) Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to the plan of the monies owed it.

Coordination of Benefits

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

1) When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering the Member as an employee will provide its benefits before the plan covering the Member as a Dependent.

2) Coverage for dependent children:

   a. When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

   b. When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.

   c. When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.

d. When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:

   i. The plan of the custodial parent

   ii. The plan of the stepparent

   iii. The plan of the non-custodial parent.

3) If the above rules do not apply, the plan which has covered the Member for the longer period of time is the primary plan. There may be exceptions for laid-off or retired employees.

4) When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.

5) Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

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

Conditions of Coverage

Eligibility and Enrollment

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

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

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

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

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group health plan. If the Employer fails to meet these requirements, this coverage will terminate. See the *Termination of Benefits* section of this EOC for further information. Employees will re-

ceive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

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

Effective Date of Coverage

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

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

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

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

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

Premiums (Dues)

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

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

Grace Period

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

Plan Changes

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

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

Renewal of Group Health Service Contract

This Contract has a 12-month term beginning with the eligible Employer's effective date of coverage. So long as the Employer continues to qualify for this health plan and continues to offer this plan to its Employees, Employees and Dependents will have an an-

nual Open Enrollment period of 30 days before the end of the term to make any changes to their coverage. The Employer will give notice of the annual Open Enrollment period.

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

1) non-payment of Premiums;
2) fraud or intentional misrepresentation of material fact;
3) failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4) termination of plan type by Blue Shield;
5) Employer relocates outside of California; or
6) Employer is an association and association membership ceases.

Cancellation and Rescission for Termination for Fraud and Intentional Misrepresentations of Material Fact

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

Cancellation at Member Request

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

Cancellation of Member's Enrollment by Blue Shield

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

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

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

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

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

See the Cancellation and Rescission for Termination for Fraud or Intentional Misrepresentations of Material Fact section.

Cancellation by the Employer

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

Cancellation for Employer's Non-Payment of Premium

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

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

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

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

Date Coverage Ends

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

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

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

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

Reinstatement

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

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under this health plan and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on which a replacement carrier provides coverage to the Member.

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

Group Continuation Coverage

Please examine your options carefully before declining this coverage.

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

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

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

Qualifying Event

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

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

   Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their

own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

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

4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1) With respect to COBRA enrollees:

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

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

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

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

2) With respect to Cal-COBRA enrollees:

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

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

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

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

   If this plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Group Continuation Coverage

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

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

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

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

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

Notification Requirements

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

Payment of Premiums (Dues)

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

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

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

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

Effective Date of the Continuation of Coverage

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

Termination of Group Continuation Coverage

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

1) discontinuance of this Group Health Service Contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);

2) failure to timely and fully pay the amount of required Premiums to the COBRA administrator or the Employer or to Blue Shield as applicable. Coverage will end as of the end of the period for which Premiums were paid;

3) the Member becomes covered under another group health plan;

4) the Member becomes entitled to Medicare;

5) the Member commits fraud or deception in the use of the services of this plan.

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

Continuation of Group Coverage for Members on Military Leave

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

General Provisions

Plan Service Area

The geographic area served by this Plan is defined as the Plan Service Area. Subscribers and Dependents must live or work within the prescribed Plan Service Area to enroll in this Plan and to maintain eligibility in this Plan. For specific information on the boundaries of the Plan Service Area members may call Customer Service at the number provided on the back page of this EOC. (Special arrangements may be available for Dependents who are full-time students or do not live in the Subscriber's home. Please contact the Member Services Department to request an Away From Home Care Program Brochure which explains these arrangements).

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

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

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

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

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

No Lifetime Benefit Maximum

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

No Annual Dollar Limits on Essential Health Benefits

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

Payment of Providers

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

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

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

Facilities

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

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

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

Independent Contractors

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

Non-Assignability

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield. Possession of a Blue Shield ID card confers no right to services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber who has been accepted by the Employer and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

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

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

Plan Interpretation

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

Public Policy Participation Procedure

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

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

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

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

Please follow the following procedure:

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

Confidentiality of Personal and Health Information

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

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this EOC, or by accessing Blue Shield's internet site at www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Access to Information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Contract. By enrolling in this health plan, each Member agrees that

any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in their possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

Grievance Process

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

Medical Services

The Member, a designated representative, or a provider on behalf of the Member, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact Blue Shield at the telephone number as noted on the back page of this EOC. If the telephone inquiry to Customer Service does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

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

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

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

For grievances due to denial of coverage for a Non-Formulary Drug: If your Employer selected the optional *Outpatient Prescription Drug Benefits* Supplement as a Benefit and Blue Shield denies an exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

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

Mental Health and Substance Use Disorder Services

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

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Depart-

ment. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms must be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting www.blueshieldca.com.

1-877-263-9952

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

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

If the grievance involves an MHSA Non-Participating Provider, the Member should contact the Blue Shield Customer Service Department as shown on the back page of this EOC.

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

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

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-256-1915** 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, **(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.

Customer Service

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

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

1-877-263-9952

Blue Shield of California

Mental Health Service Administrator

P.O. Box 719002
San Diego, CA 92171-9002

Definitions

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

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

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

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

Allowed Charges —

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

Ambulatory Surgery Center — an Outpatient surgery facility which:

1) is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,

2) provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital.

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

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

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

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

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

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

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

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

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

Creditable Coverage —

1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2) The Medicare Program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as 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) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.
8) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
9) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).
10) Any other Creditable Coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care

or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a Physician) or care furnished to a Member who is mentally or physically disabled, and

1) Who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or

2) when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

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

Dependent – the spouse or Domestic Partner, or child, of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber.

1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.

2) A Dependent Domestic Partner is an individual is meets the definition of Domestic Partner as defined in this Agreement.

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

4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

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

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

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

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

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

Domestic Partner — an individual who is personally related to the Subscriber by a 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.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the individual's home is not available or is unsuitable.

Emergency Services — services provided for an emergency medical condition, including a psychi-

atric emergency medical condition or active labor, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Services means the following with respect to an emergency medical condition:

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

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

Post-Stabilization Care means Medically Necessary services received after the treating Physician determines the emergency medical condition is stabilized.

Employee — an individual who meets the eligibility requirements set forth in the Group Health Service Contract between Blue Shield and the Employer.

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

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

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

Family — the Subscriber and all enrolled Dependents.

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

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

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

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

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

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

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

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

Hospital — an entity which is:

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

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

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

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

1) the presence of a demonstrated condition recognized by a licensed Physician as a cause of not being able to conceive; or
2) for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3) for women over age 35, failure to achieve a successful pregnancy (live birth) after six months or more of regular unprotected intercourse; or
4) failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (The initial six cycles are not a benefit of this Plan); or
5) three or more pregnancy losses.

Intensive Outpatient Program — an outpatient Mental Health or Substance 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.

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

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

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

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

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

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

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

Mental Health Service Administrator (MHSA) —The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver Blue Shield's Mental Health 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 or Substance Use Disorder Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Personal Physician — a general practitioner, board-certified or eligible family practitioner, in-

ternist, obstetrician/gynecologist, or pediatrician who has contracted with one of the contracted Independent Practice Associations, Medical Groups, or Blue Shield as a Personal Physician to provide primary care to Members and to refer, authorize, supervise, and coordinate the provision of all Benefits to Members in accordance with the contract.

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

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

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

Plan — the Blue Shield Access+ HMO Health Plan.

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

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

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

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

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

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

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

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

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

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

Reasonable and Customary Charge —

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

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by

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

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

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

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

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

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

1) has one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms; and

2) meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

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

   b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

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

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

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

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

1) The eligible Employee or Dependent meets all of the following requirements:

   a. The Employee or Dependent was covered under another employer health benefit plan at the time he was offered enrollment under this plan;

b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health plan was the reason for declining enrollment provided that, if he was covered under another employer health plan, he was given the opportunity to make the certification required as was notified that failure to do so could result in later treatment as a Late Enrollee;

c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership.

d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or

2) A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll such a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

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

4) For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or

5) For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or

6) For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

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

1) Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;

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

Speech Therapy — treatment under the direction of a Physician and provided by a licensed speech

pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by diagnosed illness or injury.

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

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

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

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

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

Total Disability (or Totally Disabled) —

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

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

This EOC should be retained for your future reference as a Member of the Blue Shield Access+ HMO Plan.

Should you have any questions, please call the Blue Shield of California Customer Service Department at the number provided on the back page of this EOC.

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

Notice of the Availability of Language Assistance Services

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

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

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

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

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

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

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

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

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

خدمات لغوية مجانية. يمكنك الحصول على مترجم شفهي واستخدام مستندات مترجمة إلى اللغة العربية. اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

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

Cov Kev 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

Handy Numbers

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

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Important Numbers:

Hospital _____

Pharmacy _____

Police Department _____

Ambulance _____

Poison Control Center _____

Fire Department _____

General Emergency _____*911*_____

HMO Customer Service Department (See back page of this EOC) _____

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

Contacting Blue Shield of California

For information contact your appropriate Blue Shield of California location.

Members may call Customer Service toll free at 1-888-256-1915

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

Please direct correspondence to:

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

blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW. Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում է՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի հետևի մասում, կամ (866) 346-7198 հեռախոսահամարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866). (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

blue of california

Outpatient Prescription Drug Benefits

Supplement to Your HMO/POS Evidence of Coverage

Summary of Benefits

Member Calendar Year Pharmacy Deductible	Deductible Responsibility	
	Participating Pharmacy	**Non-Participating Pharmacy**
Per Member There is no Pharmacy deductible.	None	Not covered

Benefit	Member Copayment	
	Participating Pharmacy[1]	**Non-Participating Pharmacy**
Retail Pharmacy (30-day supply)		
Contraceptive Drugs and Devices[2]	$0	Not covered
Tier 1 Drugs	$10	Not covered
Tier 2 Drugs	$25	Not covered
Tier 3 Drugs	$40	Not covered
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $200 coinsurance maximum per prescription	Not covered
Mail Service Pharmacy (90-day supply)		
Contraceptive Drugs and Devices[2]	$0	Not covered
Tier 1 Drugs	$20	Not covered
Tier 2 Drugs	$50	Not covered
Tier 3 Drugs	$80	Not covered
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $400 coinsurance maximum per prescription	Not covered
Network Specialty Pharmacies		
Tier 4 Specialty Drugs[3]	20% up to $200 maximum per prescription[4]	Not covered

[1.] Coinsurance is calculated based on the contracted rate. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

[2.] Contraceptive Drugs and Devices covered under the Outpatient Prescription Drug Benefits do not require a copayment and are not subject to the Member Calendar Year Pharmacy Deductible when obtained from a Participating Pharmacy. If a brand contraceptive is selected when a generic equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic equivalent. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

[3.] Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the EOC. In such circumstances, the applicable Tier 4 Drug Copayment or Coinsurance will be pro-rated.

[4.] Includes oral Anticancer Medications, which are not subject to the Member Calendar Year Pharmacy Deductible.

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more any time after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Outpatient Prescription Drug Benefit

Your plan provides coverage for Outpatient Prescription Drugs as described in this supplement. This Prescription Drug Benefit is separate from the medical Plan coverage. The Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Supplement. However, the Calendar Year Out-of-Pocket Maximum, general provisions and exclusions of the Group Health Service Contract apply.

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

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.

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

Outpatient Drug Formulary

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

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

The Formulary is categorized into drug tiers as described in the chart below. Your 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

You can find the Drug Formulary at https://www.blueshieldca.com/bsca/pharmacy/home.sp. You can also contact Customer Service at the number provided on the back page of your EOC to ask if a specific Drug is included in the Formulary, or to request a printed copy.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

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

Blue Shield negotiates contracted rates with Participating Pharmacies for covered Drugs. If your plan has a Pharmacy Deductible, you are responsible for paying the full contracted rate for Drugs until you meet the Member Calendar Year Pharmacy Deductible. Drugs in Tier 1 are not subject to, and will not accrue to the Calendar Year Pharmacy Deductible.

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

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not

be substituted, you pay your applicable tier Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you must pay the difference in cost, plus your 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 Generic Drug Copayment or Coinsurance. For example, you select Brand Drug "A" when there is an equivalent Generic Drug "A" available. The Participating Pharmacy's contracted rate for Brand Drug "A" is $300, and the contracted rate for Generic Drug "A" is $100. You would be responsible for paying the $200 difference in cost, plus your Tier 1 Copayment or Coinsurance. This difference in cost does not apply to the Member Calendar Year Pharmacy Deductible or the Calendar Year Out-of-Pocket Maximum.

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

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

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

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

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

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

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

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

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

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

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

Obtaining Specialty Drugs through the Specialty Drug Program

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

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

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

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

Prior Authorization/Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

- Some Formulary, compound Drugs, and most Specialty Drugs require prior authorization.
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.

- Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance.

Blue Shield covers compounded medication(s) when:

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

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

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

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

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

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

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

1. Except as otherwise stated below, you may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, you 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 your 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 you to receive a 15-day supply of your Specialty Drug and determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save out of pocket expenses if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You or your Physician may choose a full 30-day supply for the first fill.

   If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug. You 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. You 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. You may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your EOC to determine if the Plan covers Drugs under that Benefit.

1. Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained for a covered emergency. Nor does it apply to Drugs obtained for an urgently needed service for which a Participating Pharmacy was not reasonably accessible.
2. Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional (Physician) Benefits* and *Hospital Benefits (Facility Services)* sections of your EOC.

3. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of your EOC.
4. 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.
5. Drugs for which you are 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 your EOC.
8. Blood or blood products. See the *Hospital Benefits* section of your EOC.
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 your EOC.
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 your EOC.
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 your EOC.
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 medication is self-administered, and
    - Medical literature supports its use for the diagnosis.
16. Replacement of lost, stolen or destroyed Drugs.
17. If you are 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 your EOC.
18. Drugs prescribed for the 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 components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
22. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Definitions

When the following terms are capitalized in this Outpatient Prescription Drug Supplement, they will have the meaning set forth below:

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

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

Drugs — for coverage under the Outpatient Prescription Drug Benefit, 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.

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 FDA or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug.

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

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

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

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.

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

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

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

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Chiropractic Services

Supplement to Your Blue Shield
Access+ HMO EOC

Summary of Benefits

Benefit	Member Copayment
Covered Services as described in this Supplement and authorized by American Specialty Health Plans of California, Inc. (ASH Plans)	
Chiropractic Services	
Office Visit	$10 up to a maximum of 30 visits per Calendar Year[1]
Benefit	**Maximum Blue Shield Payment**
Chiropractic Appliances	$50 per Calendar Year[2]

[1] The 30 visits maximum is a per Member per Calendar Year maximum for all chiropractic Services.
[2] Member is responsible for all charges above the maximum payment indicated.

Introduction

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

Benefits

Benefits are provided for Medically Necessary chiropractic Services up to the maximum visits per Calendar Year as shown on the Summary of Benefits for routine chiropractic care when received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. This Benefit includes an initial examination and subsequent office visits, adjustments, and conjunctive therapy as authorized by ASH Plans up to the Benefit maximum specified above. Benefits are also provided for X-rays.

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

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

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

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

Services provided by Non-Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no Participating Providers. A Non-Participating Provider is a chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to Members.

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

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

Member Services

For all chiropractic Services, Blue Shield of California (BSC) has contracted with ASH Plans to act as the Plan's chiropractic Services administrator. ASH Plans should be contacted for questions about chiropractic Services, ASH Plans Participating Providers, or chiropractic Benefits. You may contact ASH Plans at the telephone number or address which appear below:

1-800-678-9133

American Specialty Health Plans of California, Inc.

P.O. Box 509002

San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Grievance Process

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

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

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

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

NOTE: If your employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans) - ASH Plans is a licensed, specialized health care Service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of chiropractic Services.

Neuromusculo-skeletal Disorders – conditions with associated signs and symptoms related to the nervous, muscular, and / or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and / or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments / capsules, discs, and synovial structures) and related to neurological manifestations or conditions.

Participating Provider – a Participating Chiropractor or other licensed health care provider under contract with ASH Plans to provide Covered Services to Members.

Please be sure to retain this document. It is not a contract but is a part of your *Blue Shield Access+ HMO EOC.*

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Domestic Partner Supplement

Supplement to your Blue Shield Evidence of Coverage

Your employer has elected to establish Domestic Partner eligibility requirements as described in this Supplement. The following changes have been made to your EOC:

Under the Definitions section of your EOC, the definition of Domestic Partner is changed to read as follows:

> Domestic Partner — an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:
>
> 1. Both partners are (a) 18 years of age or older and (b) of the same or different sex;
> 2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same common residence;
> 3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
> 4. Both partners were mentally competent to consent to a contract when their domestic partnership began.
>
> The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

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Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอคงามช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

This Notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.

Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this Notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

How we use and disclose your PHI

Uses of PHI without your authorization. We may disclose your PHI without your written authorization if necessary while

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providing health benefits and services to you. We may disclose your PHI for the following purposes:

- **Treatment:**
  - To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
  - To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
  - To coordinate your health care and related services with a healthcare facility or professional.
- **Payment:**
  - To obtain payment of premiums for your coverage.
  - To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
  - To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
  - To obtain payment from a third party that may be responsible for payment, such as a family member.
  - To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.
- **Healthcare operations:**
  - To provide customer service.
  - To support and/or improve the programs or services we offer you.
  - To assist you in managing your health – for example, to provide you with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.
  - To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
  - For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**
  - If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
  - If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do

disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

  - We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.
- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

    Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.
- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
  - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
  - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.

- **Health oversight activities.** We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.
  - Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses of PHI that require your authorization. Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

Uses and disclosure of certain PHI deemed "highly confidential." For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

Authorization cancellation. At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

Your individual rights

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this Notice. We are not required to agree

to your restriction requests, but we will consider them carefully.

If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a "designated record set." This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request.
  - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
  - Certain other disclosures that we are allowed by law to exclude from the accounting.

  If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI,

to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.

- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the "Notice Availability and Duration" section of this Notice.

Actions you may take

Contact Blue Shield. If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

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

Phone: (888) 266-8080 (toll-free)

Fax: (800) 201-9020 (toll-free)

Email: privacy@blueshieldca.com

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/bsca/about-blue-shield/privacy/home.sp**.

Contact a government agency. You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at **www.hhs.gov/ocr/privacy/hipaa/complaints**.

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

Region IX Regional Manager
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th St., Suite 4-100
San Francisco, CA 94103

Phone: (800) 368-1019

Fax: (415) 437-8329

TTY: (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

Notice availability and duration

Notice availability. A copy of this Notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp**.

Right to change terms of this Notice. We are required to abide by the terms of this Notice as long as it remains in effect. We may change the terms of this Notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new Notice when and as required by law.

Effective date. This Notice is effective as of August 16, 2013.