Disclosure

Shield Savings℠ Plus, Shield Spectrum PPO℠ Savings Plus or Full PPO Savings Disclosure Form

(Available to groups of 101 and above)
Blue Shield Disclosure Form:  
PPO HSA Plan

This Disclosure Form, including the separate benefit summary (uniform health plan benefits and coverage matrix) provided, is only a summary of the health plan. You have the right to review the Group Health Services Contract, which you can obtain from your employer upon request, to determine the terms and conditions governing your coverage.

The Evidence of Coverage (EOC) contains the terms and conditions of coverage of your Blue Shield health plan. It is your right to view the EOC prior to enrollment in the health plan. After you enroll, you will automatically receive an Evidence of Coverage (EOC) booklet. You should refer to the EOC for detailed information on your health plan.

Please read the Disclosure Form and the EOC carefully and completely so that you understand which services are covered, and the limitations and exclusions that apply to the health plan. If you or your dependents have special health care needs, you should read carefully those sections of the EOC that apply to those needs.

To obtain a copy of the EOC or if you have questions about the benefits of the plan, please contact Blue Shield’s Member Services at 1-800-424-6521. The hearing impaired may contact Member Services by calling the TTY number 1-800-241-1823.

PLEASE NOTE

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 Blue Shield's Customer Service Department at 1-800-200-3242 to ensure that you can obtain the health care services that you need.
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Important Information Regarding HSAs

The Shield Spectrum PPO Savings Plus, Shield Savings Plus and Full PPO HSA is not a "Health Savings Account" or an "HSA," but is designed as a "high Deductible health plan" that may allow the Member, if eligible, to take advantage of the income tax benefits available when he or she establishes an HSA and uses the money put into the HSA to pay for qualified medical expenses subject to the Deductibles under this Plan.

If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, the Member may not be eligible for the income tax benefits associated with an HSA. In this instance, the Member may have adverse income tax consequences with respect to his or her HSA for all years in which the Member was not eligible.

NOTICE: Blue Shield does not provide tax advice. If a Member intends to purchase this Plan to use with an HSA for tax purposes, the Member should consult with a tax advisor about whether he or she is eligible and whether the HSA meets all legal requirements.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

Members may locate a Participating Provider by accessing Blue Shield's Web site located at http://www.blueshieldca.com, and selecting "Find a Provider".

How the Plan Works

Choice of Physicians and Providers

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

The Blue Shield PPO Plan is specifically designed for Members to use Blue Shield Participating Providers. However, Members may choose to seek services from non-Participating Providers for most services. Covered Services obtained from non-participating Providers will usually result in higher share of cost for the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider. Please be aware that a provider’s status as a Participating Provider or MHSA Participating Provider may change. Participating Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and Other Providers.

Mental Health and Substance Abuse Services

Blue Shield has contracted with a Mental Health Service Administrator (MHSA) to underwrite and deliver covered mental health and substance abuse services through a unique network of MHSA Participating Providers.

MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services and Substance Abuse services to Members. A Blue Shield Participating Provider may not be an MHSA Participating Provider. It is the Member’s responsibility to ensure that the Provider selected for Mental Health Services and Substance Abuse Services is an MHSA Participating Provider.

Prior authorization is required for all non-emergency mental health and substance abuse hospital admissions and non-routine mental health and substance abuse services. Blue Shield or the MHSA will render a decision on all requests for prior authorization within 5 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 subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize
the life or health of a person or when the person is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the person's condition not to exceed 72 hours from receipt of the request.

**Liability of Subscriber or Enrollee for Payment**

Blue Shield Participating Providers agree to accept Blue Shield’s payment as payment-in-full for Covered Services, except for the deductibles, Copayment or Coinsurance amounts in excess of specified benefit maximums, or as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability sections described in the EOC. This is not true of Non-Participating Providers.

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

If Emergency care is needed in a Hospital that is not a Participating Provider, payment will be made at the Hospital's billed charge for Covered services less any applicable Deductible or Copayment.

**Reimbursement Provisions**

Providers are usually paid directly by Blue Shield. Members are not liable to these providers for any amounts payable by Blue Shield for Covered Services.

Members are paid directly by Blue Shield if services are rendered by a Non-Participating Provider.

Claims for payment or reimbursement must be submitted to Blue Shield within one year after the month services were provided. Special claim forms are not necessary, but each claim submission must contain the Member's name, home address, group Contract number, subscriber's number, and a copy of the provider's billing showing the services rendered, dates of treatment, and the patient's name. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

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.

**Facilities**

To locate a Blue Shield provider, Members may access Blue Shield’s Web site at http://www.blueshieldca.com or by calling 1-800-424-6521.

**Continuity of Care by a Terminated Provider**

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

**Services for Emergency Care**

Benefits will be provided for Emergency Services received anywhere in the world.

1. A Member who reasonably believes that he or she has an emergency medical condition or mental health condition that requires an emergency response is encouraged to appropriately use the “911” emergency response system (where available) or seek immediate care from the nearest Hospital.
2. A Member should notify Blue Shield (or the MHSA in the case of mental health Services) within 24 hours of receiving emergency Services 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 she or he had an emergency medical condition.

3. Medically Necessary emergency care is covered at the Participating Provider level. The member is 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.

4. If Blue Shield determines that the Member did not have a medical condition for which a reasonable person would have believed that he or she had an emergency, benefits will be determined based upon whether services were provided by a Participating or Non-Participating Provider.

For urgent care, a Member should call his or her regular doctor or the MHSA.

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 health plan.

Blue Shield has documentation of this process, as required under Section 1363.5 of the California Health and Safety Code.

The document describing Blue Shield’s Utilization Management Program is available online at www.blueshieldca.com or Members may call the Customer Service Department to request a copy.

Principal Benefits and Coverages

The Benefits of this health plan, including acute and subacute care, are provided only for services that are Medically Necessary, and only if a Member follows the requirements of Blue Shield’s Benefits Management Program as described in the EOC.

Please refer to the Benefit Summary and or EOC for more detailed information on the benefits and coverages included in the health plan.

Principal Exclusions and Limitations on Benefits

General Exclusions

Blue Shield does not provide benefits for the following:

1. 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;

2. Home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary care, except as provided under the Hospice Program Benefits section of the EOC;

3. Services performed in a hospital by house officers, residents, interns, and others in training;

4. Services performed by a close relative or by a person who ordinarily resides in the Member’s home;

5. Hearing aids;

6. Mammographies, Pap tests, or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, annual health appraisal exams by Non-Participating Providers;

7. Eye exams and refractions, lenses and frames for eyeglasses, contact lenses, except as specifically listed in the EOC, and video-assisted visual aids or video
magnification equipment for any purpose;

8. Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed in the EOC;

9. Routine physical examinations, except as specifically listed in the EOC, 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, or insurance; or on court order or required for parole or probation;

10. 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 the California Health and Safety Code Section 1367.21 have been met;

11. For or incident to vocational, educational, recreational, art, dance, music, or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided in the EOC. 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;

12. Sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

13. Treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications;

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

15. 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 under the Hospice Program Benefits section of the EOC; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;

16. Services which are experimental or investigational in nature, except for services for Members who have been accepted into an approved clinical trial for treatment of cancer or life-threatening condition as listed in the EOC;

17. Learning disabilities or behavioral problems or social skills/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;

18. Hospitalization primarily for X-ray, laboratory, or any other diagnostic studies or medical observation;

19. 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 listed in the EOC;

20. 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, 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 mentioned in the EOC;

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

22. 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 does not apply to the breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to restore symmetry;

23. Patient convenience items such as telephone, television, guest trays, and personal hygiene items;

24. Services for which the Member is not legally obligated to pay, or for services for which no charge is made;

25. 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 workers’ 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;

26. Services in connection with private duty nursing, except as provided under the Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, sections of the EOC and except as provided through a Participating Hospice Agency;

27. Prescription and non-prescription food and nutritional supplements, except as provided under the Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits and PKU Related Formulas and Special Food Products Benefits sections of the EOC, or as provided through a Participating Hospice Agency;

28. Home testing devices and monitoring equipment except as specifically provided in the EOC;

29. 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 listed in the EOC;

30. Services for or incident to bariatric surgery services, except as provided in the EOC;

31. Genetic testing except as described in the EOC;

32. For services provided by an individual or entity that is not appropriately licensed or certified, by the state to provide health care services, except for services received under the Behavioral Health Treatment benefit under Mental Health
and Substance Abuse Benefits as specifically stated in the EOC;

33. Massage therapy that is not Physical Therapy or a component of a multimodality rehabilitation treatment plan;

34. Surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

35. 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.

36. Drugs dispensed by a physician or physician’s office for outpatient use; and

37. Not specifically listed as a Benefit.

The Grievance Process portion of the EOC provides information on filing a grievance, a Member’s right to seek assistance from the Department of Managed Health Care, and the right to an independent medical review.

Medical Necessity Exclusion

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

Outpatient Prescription Drug Benefit

For Outpatient Prescription Drug Copayments and for Brand Drug Deductibles (when applicable), please refer to the Benefit Summary, which is included as part of this Disclosure Form.

Outpatient Prescription Drug Formulary

Blue Shield’s Pharmacy and Therapeutics 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: The Physician or Health Care Provider might not prescribe a Drug even though the Drug is included on the Formulary.

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

Prior Authorization/Exception Request Process for Outpatient Prescription Drug Benefit

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

The Member the Member’s Physician or Health Care Provider may request prior authorization or exception request 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 two business days.

**Limitation on Quantity of Drugs that may be obtained per Prescription or Refill**

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

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

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

3. The Member may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if the Member’s Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and the Member is responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.

4. Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.

5. The Member may refill covered prescriptions at a Medically Necessary frequency.

**Outpatient Prescription Drug Exclusions**

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

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

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

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

4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.

5. Drugs that are considered to be experimental or investigational.
6. 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 the EOC.

7. Blood or blood products. See the Hospital Benefits section of the EOC.

8. 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.

9. 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 the EOC.

10. 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 the EOC.

11. All Drugs for the treatment of infertility.

12. 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.

13. 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 the EOC.

14. 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
   - The compound Drug is being prescribed for an FDA-approved indication (or medical literature supports its use for the requested diagnosis).

15. Replacement of lost, stolen or destroyed Drugs.

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

17. 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.

18. 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.

19. Immunizations and vaccinations solely for the purpose of travel.

20. 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.

21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

The Grievance Process portion of the EOC provides information on filing a grievance, a Member's right to seek assistance from the Department of Managed Health Care, and right to an independent medical review.

**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. Premiums may be changed to reflect new or changed terms of the contract, such as Benefit levels. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

**Other Charges**

**Deductibles, Benefit Levels and Maximums**

Certain benefits of this health plan require the application of calendar year Deductibles, Copayments, Coinsurance and charges in excess of benefit maximums and/or may be subject to maximum payments. Please refer to the Benefit Summary, which is a part of this Disclosure Form, to find information regarding the various Deductibles, benefit levels, or maximums that are applicable to the health plan.

**Renewal Provisions**

Blue Shield will offer to renew the Group Health Services Contract except in the following instances:

1. Non-payment of Premiums (see the “Termination of Benefits” section of the EOC);
2. Fraud or intentional misrepresentation of a 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;
6. Employer is an association and association membership ceases.

All groups will renew subject to the above.

**Plan Changes**

The Benefits of this health plan, including but not limited to Covered Services, Deductibles, Copayments, 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 to the Member's Employer.

**Termination of Benefits**

**Group Termination**

The Renewal Provisions section explains the reasons an Employer's Group Health Services Contract (Contract) may be terminated. Blue Shield may cancel the Contract for non-payment of Premiums.

If the employer fails to pay the required Premiums when due, coverage will terminate upon the expiration of a 30-day grace period following notice of termination for nonpayment of premium. The Employer
will be liable for all Premiums accrued while this coverage continues during the grace period. If the Contract is terminated, a Member enrolled through the Contract will no longer receive benefits – including COBRA (groups with 20 or more employees) or Cal-COBRA (groups with 2-19 employees). Exceptions due to a disability are specifically outlined in the Extension of Benefits provision in the EOC.

Note: If a Member is hospitalized or undergoing treatment for an ongoing condition and the Employer’s Contract is cancelled for any reason, including non-payment of Premiums, the Member will no longer receive Benefits unless the Member receives an extension of benefits.

**Individual Termination**

In addition to termination of the Group Health Services Contract with Blue Shield, a Member will no longer be eligible for coverage under the health plan if:

1. The Member no longer meets the eligibility requirements in the Employer’s Contract;
2. The Member engages in fraud or deception in the use of health plan benefits.

Please refer to the EOC or the Group Health Services Contract for additional information.

**Continuation of Benefits: COBRA**

If the Member’s employment with his/her current employer ends, the Member and covered family members may qualify for continued group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The section in the EOC entitled Group Continuation Coverage has information on COBRA continuation coverage.

**Grievance Process**

Blue Shield has established a grievance procedure for receiving, resolving, and tracking Member grievances with Blue Shield. For more information on this process, see the Grievance Process section in the EOC.

**External Independent Medical Review**

State law requires Blue Shield to disclose to Members the availability of an external independent review process when the grievance involves a claim 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. 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. For further information about this review process, see the External Independent Medical Review section in the EOC.

**Department of Managed Health Care Review**

The California Department of Managed Health Care is responsible for regulating health care service plans. If the Member has a grievance against the health plan, the Member should first telephone the health plan at the Customer Service number in the EOC and use the health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member. If the Member needs help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by the health plan, or a grievance that has remained unresolved for more than 30 days, the Member may call the Department for assistance. The Member may also be eligible for an Independent Medical Review (IMR). If the Member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments...
that are experimental or investigational in nature, and payment disputes for Emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department’s Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for the Member or his/her dependents and the Member feels that such action was due to reasons of health or utilization of benefits, the Member or his/her dependents may request a review by the Department of Managed Health Care Director.

Confidentiality of Personal and Health Information

Blue Shield is committed to protecting the personal and health information our Members in each of the settings in which such information is received or exchanged.

When a Member completes an application for coverage, his or her signature authorizes Blue Shield to collect personal and health information that includes both the Member’s medical information and individually identifiable information about the Member such as the Member’s address, telephone number, or other individual information. If a Member becomes enrolled in a Blue Shield health plan, this general consent allows Blue Shield to communicate with the Member’s physicians and other providers regarding treatment and payment decisions.

Blue Shield also participates in quality measurement activities that may require us to access a Member’s personal and health information. We have policies to protect this information from inappropriate disclosure and we release this information only if aggregated or encoded. We will not disclose, sell, or otherwise use a Member’s personal and health information unless permitted by law and to the extent necessary to administer the health plan. We will obtain written authorization from the Member to use his or her personal and health information for any other purpose. For any of our prospective or current Members unable to give consent, we have a policy in place to protect that Member’s rights and that permits the Member’s legally authorized representative to give consent on his or her behalf. Blue Shield also will not release the Member’s personal and health information to the employer without his or her specific authorization, unless such release is permitted by law.

Through its contracts with providers, Blue Shield has policies in place to allow a Member to inspect his or her medical records maintained by his or her provider and, when needed, to include a written statement from the Member. The Member also has the right to review personal and health information that may be maintained by Blue Shield.

If you are a prospective, current, or former Member and need more detailed information about Blue Shield’s Corporate Confidentiality policy, it is available on Blue Shield’s Web site at http://www.blueshieldca.com or by calling Customer Service.

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.

Definitions

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

1. For a Participating Provider, the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.
2. For a Non-Participating provider who provides Emergency Services anywhere within or outside of the United States –
   a. Physicians and Hospitals— the amount is the Reasonable & Customary Charge; or
   b. All other providers — the amount is the provider’s billed charge for Covered Services, unless the provider and the local Blue Cross Blue Shield Plan have agreed upon some other amount.

3. For a Non-Participating provider in California (including an Other Provider) who provides services (other than Emergency Services) - the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
   a. Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable & Customary Charge.

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

5. For a Non-participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield Plan, who provides services (other than Emergency Services) - the amount that the local Blue Cross and/or Blue Shield Plan would have allowed for a non-participating provider performing the same services. Or, if the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

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 pays for Covered Services after meeting any applicable Deductible.

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

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 Services Contract.

Emergency Services – services provided for an unexpected medical condition, including a psychiatric Emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency Services means the following with respect to an emergency medical condition:

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

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

Post-Stabilization Care Services means Medically Necessary Services related to a Member’s Emergency Services that received after the treating physician determines that this condition is stabilized.

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

Medical Necessity – Benefits are provided only for services that are Medically Necessary.

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

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 that are Medically Necessary include only those Services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and that could not have been provided in the physician’s office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered. Inpatient services not Medically Necessary include hospitalization:
   a. for diagnostic studies that could have been provided on an outpatient basis;
   b. for medical observation or evaluation;
   c. for personal comfort;
   d. in a pain management center to treat or cure chronic pain; and
   e. for inpatient rehabilitation or rehabilitative care that can be provided on an outpatient basis.

Blue Shield reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of physician consultants, peer review committees of professional societies or hospitals, and other consultants.

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 the Blue Shield’s Mental Health and Substance Abuse Services through a separate network of MHSA Participating Providers.

MHSA Non-Participating Providers – a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health or Substance Abuse Services. NOTE: an MHSA Non-Participating Provider can be a Blue Shield Participating Provider.
MHSA Participating Providers – a provider who has an agreement in effect with the MHSA for the provision of Mental Health or Substance Abuse Services.

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

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

Plan — the Blue Shield PPO HSA Plan.

Reasonable & Customary Charge —

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

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