Blue Shield Disclosure Form: PPO for 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 Customer Service Department at 1-800-424-6521. The hearing impaired may contact Customer 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 Full PPO for 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.

To learn more about Health Savings Accounts, eligibility, and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

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.

Blue Shield PPO plans are designed for Members to receive the highest level of benefits when they obtain covered services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members have the choice to seek services from non-Participating Providers for most covered 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. They are listed in the PPO Provider directory.

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 and Reductions- Third Party Liability sections 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

Participating Providers are usually paid directly by Blue Shield. Members are not liable to these provid-
ers 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.

Ratio of Healthcare Services

For Blue Shield small group health plans in 2012, the ratio of the value of health services provided to the amount Blue Shield collected in premiums was 78.1% which means that for every dollar of premiums it collected, Blue Shield paid $0.781 for healthcare services. The ratio was calculated after provider discounts were applied.

Facilities

The directory of Blue Shield's Participating Providers for the PPO plan in which the Member is enrolled will be provided after enrollment. Members may also find this information on Blue Shield's Web site http://www.blueshieldca.com or by calling the Customer Service Department.

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 only responsible for the applicable Deductible, Co-payment 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.

To request a copy of the document describing this Utilization Management process, call the Customer Service Department.

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 your health plan.
Principal Exclusions and Limitations on Benefits

General Exclusions

The PPO plans do not provide Benefits for the following:

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

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

3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot (e.g., weak or fallen arches); flat or pronated foot; pain or cramp of the foot; special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;

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

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

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

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

8) hearing aids;

9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;

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

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

12) 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) Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages. Without limiting the foregoing, no Benefits will be provided for the following surgeries or procedures:

a) Surgery to excise, enlarge, reduce, or change normal structures of any part of the body to improve appearance;

b) Surgery to reform or reshape skin or bone to improve appearance;

c) Lower eyelid blepharoplasty;

d) Upper eyelid blepharoplasty without documentation of significant visual impairment or symptomology;

e) To correct spider veins;

f) Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);

g) Items and services for the promotion, prevention, or other treatment of hair loss, hair growth or hair removal, including hair transplantation;

h) Reimplantation of breast implants originally provided for cosmetic augmentation;

i) Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;

j) Voice modification surgery.

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

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

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

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

19) services incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits;
20) home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

21) genetic testing except as described in the Outpatient X-ray, Imaging, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;

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

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

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

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

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

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

29) services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;

30) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

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

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

33) disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and di-
apers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home Health Care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

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

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

36) drugs dispensed by a physician or physician’s office for outpatient use; and

37) Services not specifically listed as a Benefit.

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

Drug coverage is based on the use of Blue Shield’s Prescription Drug Formulary. Formularies are lists of preferred, covered medications recommended to prescribing physicians. The inclusion of a drug in the Blue Shield Formulary does not guarantee that a Member’s physician will prescribe it for a particular medical condition.

Medications are selected for inclusion in Blue Shield’s Outpatient Prescription Drug Formulary based on safety, efficacy, FDA bioequivalency data, and then cost. New Drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by the Blue Shield Pharmacy and Therapeutics Committee during scheduled meetings four times a year.

Members may access the Formulary through the Blue Shield website at http://www.blueshieldca.com. Members may also contact Blue Shield Customer Service at the number listed on their Blue Shield Identification Card to inquire if a specific drug is included in the Formulary.

Select Drugs and Drug dosages and most Specialty Drugs require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy, or the efficacy of lower cost alternatives.

Benefits may be provided for non-Formulary (non-preferred) drugs subject to higher Copayments.

Prior Authorization Process for Outpatient Prescription Drug Benefit

Select Preferred, Non-Preferred, Compound and most Specialty Drugs require prior authorization for Medical Necessity and to determine if first-line therapy has been tried. Select Brand contraceptives may require prior authorization in order to be covered without a Copayment or Coinsurance. Compound drugs are covered only if the requirements listed under the Outpatient Prescription Drug Benefit Exclusions and Limitation section are met.

A Member or Member’s Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within two business days.
Limitation on Quantity of Drugs that may be Obtained per Prescription or Refill

1. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply, except as stated below.

Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by the Blue Shield Pharmacy and Therapeutics Committee.

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

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

3. Mail service prescription drugs are limited to a quantity not to exceed a 90-day supply.

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

Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Outpatient Prescription Drug Exclusions

No Benefits are provided under the Outpatient Prescription Drug benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of the EOC. Refer to the applicable section of the EOC to determine if Drugs are covered under that benefit):

1. Any drug provided or administered while the Member is an inpatient, or in a Physician's office, Skilled Nursing Facility or Outpatient Facility;

2. Take home drugs received from a hospital, Skilled Nursing Facility, or similar facilities;

3. Drugs (except as specifically listed as covered under the Outpatient Prescription Drugs benefit of the EOC) which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;

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 specifically listed as covered in the EOC. This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;

7. Blood or blood products;

8. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;

9. Dietary or nutritional products;

10. Any drugs which are not self-administered;

11. All Drugs for the treatment of infertility;

12. Appetite suppressants or drugs for body weight reduction except when Medically
Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;

13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) require a Physician’s prescription, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered;

14. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and (4) it is being prescribed for an FDA-approved indication;

15. Replacement of lost or stolen prescription Drugs;

16. Pharmaceuticals that are reasonable and necessary for the palliation and management of terminal illness and related conditions if they are provided to a person enrolled in a Hospice Program through a Participating Hospice Agency;

17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

18. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy, or included on a government exclusion list, except for a covered emergency;

19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) 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.

**Pediatric Vision Benefits for Children to Age 19**

For Pediatric Vision Plan Copayments, please refer to the Benefit Summary, which is included as part of this Disclosure Form. You may also refer to the EOC, which you will receive after you enroll. These materials offer more detailed information on the benefits and coverages included in the pediatric vision plan.

Blue Shield’s vision plans are administered by the contracted Vision Plan Administrator (VPA). The contracted VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this Vision Plan through a network of Participating Providers. The contracted VPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

Covered Services are limited to the following:

1. One comprehensive eye examination in a Calendar Year. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

2. One of the following in a Calendar Year:
   a. One pair of eyeglasses, including a pair of spectacle lenses and frame; or
   b. One pair of Elective Contact Lenses up to the benefit allowance (for cosmetic reasons or for convenience); or
c. One pair of Non-Elective (Medically Necessary) contact lenses, which are lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia; or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters), once each Calendar Year.

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

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

4. One diabetes management referral per calendar year to a Blue Shield disease management program. The contracted VPA will notify Blue Shield disease management program, subsequent to the annual comprehensive eye exam, when you are known to have or at risk for diabetes.

Pediatric Vision Plan Exclusions
The Pediatric Vision Plan does not provide benefits for:

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

b. Replacement or repair of lost or broken lenses or frames, except as provided in the EOC;

c. Any eye examination required by the employer as a condition of employment;

d. Medical or surgical treatment of the eyes;

e. Services performed by a Close Relative or by an individual who ordinarily resides in the Subscriber or Dependent’s home;

f. Services performed 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 shall be entitled to establish a lien upon such other Benefits up to the amount paid by Blue Shield for the treatment of the injury or disease;

g. Contact lenses, except as specifically provided in your plan’s Summary of Benefits;

h. Services required by any government agency or program, Federal, state or subdivision thereof;

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

j. Services not specifically listed as a Benefit;

k. Services, procedures, or supplies which are not reasonably necessary for the Member’s condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;

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

Prepayment Fees
The monthly dues (premiums) for a Subscriber and any enrolled dependents are indicated in the Group Health Services Contract. Members should check with their employer regarding the share they may be required to pay. The initial dues are payable on the effective date of this health plan, and subsequent dues are payable on the same date of each succeeding month.
All dues required for coverage for the Subscriber and Dependents will be handled through the Employer and must be paid to Blue Shield. Employers purchasing coverage through the Small Business Health Options Program (SHOP) will pay premiums directly to the SHOP and the SHOP will forward the premiums to Blue Shield.

The dues payable under this health plan are subject to change following at least 60 days' written notice by Blue Shield to the employer. The Employer will then notify the Subscriber immediately. Notice will not be provided to a Subscriber who is enrolled under a contract where monthly Dues increase, following an age change that moves the Subscriber into the next higher age category.

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 any Member share-of-costs 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 dues (see the “Termination of Benefits” section of the EOC);
2. Fraud, misrepresentations, or omissions;
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; or
7. Employer purchases coverage through the SHOP and the Employer is no longer eligible to purchase coverage through the SHOP.

All group contracts 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 your 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 dues.

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 non-payment 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 dues, 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.
Individual Continuation of Benefits

Each Member should refer to the EOC and examine their options carefully before declining this coverage.

Continuation of Benefits: Cal-COBRA (Small Employer Coverage)

State law provides that Members enrolled in group coverage and who later lose eligibility may be entitled to continuation of group coverage under certain conditions. Please refer to the EOC for information regarding eligibility for Cal-COBRA continuation coverage.

Continuation of Benefits: COBRA

Certain qualifying events may cause group coverage to terminate for a Subscriber and/or Dependents covered under the health plan. In such instances, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 provides for the continuation of group coverage for a period of time. 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's 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 you have a grievance against your health plan, you should first telephone your health plan at 1-800-200-3242 and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for Emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-319-5999) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site (http://www.dmhc.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.

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 your medical information and individually identifiable information about you such as your 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 per-
sonal 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 Evidence of Coverage, is:

1. For a Participating Provider, the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.
2. For a Non-Participating provider who provides Emergency Services anywhere within or outside of the United States -
   a. Physicians and Hospitals— the amount is the Reasonable & 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
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 have 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 is required to pay 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 Service 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 Service 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 Service 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; and
   d. Furnished at the most appropriate level that 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 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 Provider – a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health or Substance Abuse Services.

MHSA Participating Provider – a provider who has an agreement in effect with the MHSA for the provision of Mental Health 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.

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.

SHOP – the Small Business Health Option Program (“SHOP”) operated by Covered California through which an Eligible Employer can provide its employees and their Dependents with access to one or more health plans.