Combined Evidence of Coverage and Disclosure Form

Custom POS Classic Option
California Association of Professional Employees Benefit Trust
Group Number: W0052320-M0031699
Effective Date: January 1, 2023
Provider Network: Added Advantage POS℠

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Summary of Benefits

CAPE
Effective January 1, 2023
POS Plan

California Association of Professional Employees Custom POS Classic Option

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: POS Added Advantage Network

This Plan uses a specific network of Health Care Providers, called the POS Added Advantage provider network. This Plan provides benefits at three different levels:

- **Level I (HMO Participating Providers):** Services must be provided or prior authorized by your primary care Physician or medical group/IPA, with some exceptions. Please review your EOC for details about how to access care under this level.
- **Level II (PPO Participating Providers):** Services are provided by Participating Providers. Any Copayment or Coinsurance is calculated from the Allowable Amount.
- **Level III (Non-Participating Providers):** Services are provided by Non-Participating Providers.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. You pay less for Covered Services when you use a Level I or Level II provider than when you use a Level III provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		Level I[3]	Level II[3]	Level III[4]
Calendar Year medical Deductible	*Individual coverage*	$0	$300	
	Family coverage	$0: individual $0: Family	$300: individual $600: Family	

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	Level I[3]	Level II[3]	Level III[4]
Individual coverage	$1,500	$4,000	$6,000
Family coverage	$1,500: individual $3,000: Family	$4,000: individual $8,000: Family	$6,000: individual $12,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Preventive Health Services[7]						
Preventive Health Services	$0		$0		$0	
California Prenatal Screening Program	$0		$0		$0	
Physician services						
Primary care office visit	$10/visit		$20/visit		30%	✔
Specialist care office visit	$10/visit		$20/visit		30%	✔
Office visit for allergy serum injection	$10/visit		$20/visit		30%	✔
Physician home visit	$25/visit		10%	✔	30%	✔
Physician or surgeon services in an Outpatient Facility	$0		10%	✔	30%	✔
Physician or surgeon services in an inpatient facility	$0		10%	✔	30%	✔
Other professional services						
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$10/visit		$20/visit		30%	✔
Teladoc consultation	$0		$0		Not covered	
Family planning						
• Counseling, consulting, and education	$0		$20/visit		30%	✔
• Injectable contraceptive, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		$20/visit		30%	✔
• Diaphragm fitting procedure	$0		$0		$0	
• Tubal ligation	$0		50%	✔	50%	✔
• Vasectomy	$75/surgery		50%	✔	50%	✔
Podiatric services	$10/visit		$20/visit		30%	✔
Medical nutrition therapy, not related to diabetes	$0		10%	✔	30%	✔
Pregnancy and maternity care						
Physician office visits: prenatal and postnatal	$0		$20/visit		30%	✔
Abortion and abortion-related services	$0		$0		$0	

Benefits[6]	Your payment					
	Level I[3]	**CYD[2] applies**	**Level II[3]**	**CYD[2] applies**	**Level III[4]**	**CYD[2] applies**
Emergency Services						
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Level I member payment under Inpatient facility services/ Hospital services and stay.*	$50/visit		$50/visit		$50/visit	
Emergency room Physician services	$0		$0		$0	
Urgent care center services	$10/visit		$20/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	$50/transport		10%	✔	10%	✔
Outpatient Facility services						
Ambulatory Surgery Center	$50/surgery		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Outpatient Department of a Hospital: surgery	$50/surgery		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Inpatient facility services						
Hospital services and stay	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*						
• Special transplant facility inpatient services	$0		Not covered		Not covered	
• Physician inpatient services	$0		Not covered		Not covered	

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Bariatric surgery services, designated California counties						
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.						
Inpatient facility services	$0		10%	✔	Not covered	
Outpatient Facility services	$50/surgery		10%	✔	Not covered	
Physician services	$0		10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services						
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.						
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*						
• Laboratory center	$0		10%	✔	30%	✔
• Outpatient Department of a Hospital	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
X-ray and imaging services *Includes diagnostic mammography.*						
• Outpatient radiology center	$0		10%	✔	30%	✔
• Outpatient Department of a Hospital	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment					
	Level I[3]	CYD[2] applies	Level II[3]	CYD[2] applies	Level III[4]	CYD[2] applies
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*						
• Office location	$0		10%	✔	30%	✔
• Outpatient Department of a Hospital	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Radiological and nuclear imaging services						
• Outpatient radiology center	$0		10%	✔	30%	✔
• Outpatient Department of a Hospital	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*						
Office location	$10/visit		10%	✔	30%	✔
Outpatient Department of a Hospital	$10/visit		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Durable medical equipment (DME)						
DME	$0		$0		$0	
Breast pump	$0		$0		$0	
Orthotic equipment and devices	$0		$0		$0	
Prosthetic equipment and devices	$0		$0		$0	

Benefits[6]	Your payment					
	Level I[3]	**CYD[2] applies**	**Level II[3]**	**CYD[2] applies**	**Level III[4]**	**CYD[2] applies**
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$10/visit		10%	✔	Not covered	
Home infusion and home injectable therapy services						
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0		10%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		10%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*						
Freestanding SNF	$0		10%	✔	10%	✔
Hospital-based SNF	$0		10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0		Not covered		Not covered	
Other services and supplies						
Diabetes care services • Devices, equipment, and supplies	$0		$0		$0	
• Self-management training	$10/visit		$20/visit		30%	✔

Benefits[6]	Your payment					
	Level I[3]	**CYD[2] applies**	**Level II[3]**	**CYD[2] applies**	**Level III[4]**	**CYD[2] applies**
• Medical nutrition therapy	$10/visit		$20/visit		30%	✔
Dialysis services	$0		10%	✔	30% Subject to a Benefit maximum of $300/day	✔
PKU product formulas and special food products	$0		10%	✔	10%	✔
Allergy serum billed separately from an office visit	50%		50%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment					
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**Level I[3]** Care authorized by the MHSA or provided by MHSA participating providers	**CYD[2] applies**	**Level II[3]** There are no separate benefit payments under Level II	**CYD[2] applies**	**Level III[4]** When using MHSA Non-Participating Providers	**CYD[2] applies**
Outpatient services						
Office visit, including Physician office visit	$10/visit				30%	✔
Teladoc mental health	$0				Not covered	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0				30%	✔
Partial Hospitalization Program	$0				30% Subject to a Benefit maximum of $600/day	✔
Psychological Testing	$0				30%	✔
Inpatient services						
Physician inpatient services	$0				30%	✔

Mental Health and Substance Use Disorder Benefits

Your payment

Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**Level I**[3] Care authorized by the MHSA or provided by MHSA participating providers	**CYD**[2] **applies**	**Level II**[3] There are no separate benefit payments under Level II	**CYD**[2] **applies**	**Level III**[4] When using MHSA Non-Participating Providers	**CYD**[2] **applies**
Hospital services	$0				30% Subject to a Benefit maximum of $600/day	✔
Residential Care	$0				30% Subject to a Benefit maximum of $600/day	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Notes

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Once the individual Deductible or Family Deductible is reached, cost sharing applies until the Out-of-Pocket Maximum is reached.

3 Using Level I and Level II Participating Providers:

Level I and Level II Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Level I or Level II Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Level III Non-Participating Providers:

Level III Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Level III Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Plans may be modified to ensure compliance with State and Federal requirements.
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Introduction

Welcome! We are happy to have you as a Member of our Blue Shield of California (Blue Shield) health plan.

At Blue Shield, our mission is to ensure all Californians have access to high-quality health care at an affordable price. To achieve this mission, we pledge to:

- Provide personal service to you that is worthy of our family and friends; and

Build deep, trusting relationships with providers to improve the quality of health care and lower the cost.

A Blue Shield health plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on your plan.

About this Evidence of Coverage

The Combined Evidence of Coverage and Disclosure Form (Evidence of Coverage) describes the health care coverage that is provided under the Group Health Service Contract (Contract) between Blue Shield and your Employer. The Evidence of Coverage tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your plan;
- Which services are not covered under your plan;
- When and how you must get prior authorization for certain services; and
- Important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Evidence of Coverage includes a *Summary of Benefits* section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care.

Please read this Evidence of Coverage carefully. Some topics in this document are complex. For additional explanation on these topics, you may be directed to a section at the back of the Evidence of Coverage called *Other important information about your plan*. Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Evidence of Coverage in your files for future reference.

Tables and images

In this Evidence of Coverage, you will see the following tables and images to highlight key information:

This table provides easy access to information
Phone numbers and addresses
Answers to commonly-asked questions
Examples to help you better understand important concepts

This box tells you where to find additional information about a specific topic.

This box alerts you to information that may require you to take action.

"You" means the Member

In this Evidence of Coverage, "you" or "your" means any Member enrolled in the plan, including the Subscriber and all Dependents. "Your Employer" means the California Association of Professional Employees Benefit Trust.

Capitalized words have a special meaning

Some words and phrases in this Evidence of Coverage may be new to you. Key terms with a special meaning within this Evidence of Coverage are capitalized in this document and explained in the *Definitions* section.

About this plan

This is a Point of Service (POS) plan. A POS plan combines the predictable out-of-pocket costs of a Health Maintenance Organization (HMO) plan with the flexibility available with a Preferred Provider Organization (PPO) plan. You can choose to receive care from:

- Level I: An HMO Participating Provider;
- Level II: A PPO Participating Provider; or
- Level III: A PPO Non-Participating Provider.

Your out-of-pocket costs depend on the level of Benefits you choose. See the *How to access care* section for information about the three levels of benefits under a POS plan.

How to contact customer service

If you have questions at any time, we're here to help. Blue Shield's website and app are useful resources. Visit blueshieldca.com or use the Blue Shield mobile app to:

- Download forms;

- View or print a temporary ID card;
- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

Blue Shield contact information appears at the bottom of every page.

Contacting Customer Service

If you need information about	*You should contact*
Medical Benefits	Blue Shield Customer Service: 1-855-256-9404 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Mental Health and Substance Use Disorder services, including prior authorization	Mental Health Customer Service: (877) 263-9952 Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002

If you are hearing impaired, you may contact Customer Service through Blue Shield's toll-free TTY number: 711.

Your bill of rights

	As a Blue Shield Member, you have the right to:
1	Receive considerate and courteous care with respect for your right to personal privacy and dignity.
2	Receive information about all health services available to you, including a clear explanation of how to obtain them.
3	Receive information about your rights and responsibilities.
4	Receive information about your Blue Shield plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you.
5	Select a PCP and expect their team to provide or arrange for all the care you need.
6	Have reasonable access to appropriate medical and mental health services.
7	Participate actively with your Physician in decisions about your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8	A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your Physician, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
10	Receive Preventive Health Services.
11	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12	Have confidential health records, except when the law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your Physician.
13	Communicate with, and receive information from, Customer Service in a language you can understand.
14	Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
15	Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care.

	As a Blue Shield Member, you have the right to:
16	Voice complaints or grievances about your Blue Shield plan or the care provided to you.
17	Make recommendations on Blue Shield's Member rights and responsibilities policies.

Your responsibilities

	As a Blue Shield Member, you have the responsibility to:
1	Carefully read all Blue Shield plan materials immediately after you are enrolled so you understand how to: • Use your Benefits; • Minimize your out-of-pocket costs; and • Follow the provisions of your plan as explained in the Evidence of Coverage.
2	Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.
3	Provide, to the extent possible, information needed for you to receive appropriate care.
4	Understand your health problems and take an active role in developing treatment goals with your Physician, whenever possible.
5	Follow the treatment plans and instructions you and your Physician agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6	Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7	Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8	Communicate openly with your Physician so you can develop a strong partnership based on trust and cooperation.
9	Offer suggestions to improve the Blue Shield plan.
10	Help Blue Shield maintain accurate and current records by providing timely information regarding changes in your address, family status, and other plan coverage.
11	Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints or grievances.
12	Treat all Blue Shield personnel respectfully and courteously.
13	Pay your Premiums, Copayments, Coinsurance, and charges for non-Covered Services in full and on time.

How to access care

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

Health care professionals and facilities

This plan covers care at three levels:

- Level I: HMO Participating Providers including Primary Care Physicians (PCP), Mental Health Service Administrator (MHSA) Participating Providers, or Health Care Providers your PCP or MHSA Participating Providers refer you to,
- Level II: PPO Participating Providers, and
- Level III: PPO Non-Participating Providers.

For Covered Services under Level I, your PCP will manage referrals to other Level I Health Care Providers or other providers in your Medical Group, as well as any related prior authorization.

Some services from PPO Participating Providers under Level II and Non-Participating Providers under Level III require prior authorization. See the *Medical management* section for information about prior authorization.

Participating Providers

Level I Participating Providers practice within a Medical Group and participate in Blue Shield's HMO network. At Level I, services from providers outside of your Medical Group are not covered.

Level II Participating Providers participate in the Blue Shield PPO network and agree to accept Blue Shield's Allowable Amount as payment in full for Covered Services. As a result, your Cost Share is less when you receive Covered Services from a Level II Participating Provider than from a Level III Non-Participating Provider.

If a provider leaves your Medical Group, you will no longer have Level I coverage for services received from that provider. If the provider is also a Participating Provider in the PPO network, you can continue to receive services from that provider, but Level II coverage and Cost Share will apply.

When a provider leaves the HMO and the PPO networks, the status of the provider will change from Participating to Non-Participating. See the *Continuity of Care* section for more information on how you may be able to continue treatment with a Non-Participating Provider.

Visit ***blueshieldca.com*** or use the Blue Shield mobile app and click on ***Find a Doctor*** for a list of your plan's ***Participating Providers***.

Non-Participating Providers

Non-Participating Providers (Level III) do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges or Allowable Amount as payment in full for Covered Services. Except for Emergency Services and services received at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, you will pay more for Covered Services from a Non-Participating Provider.

Non-Participating Providers at a Participating Provider facility

When you receive care at any Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Level I Participating Provider under similar circumstances, and you will not be responsible for additional charges above the Allowed Charges or Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

Three levels of Benefits

Benefits are available at three network levels under this POS plan.

Level I (HMO Participating Providers)

Level I applies when you access Benefits through your Primary Care Physician. This level provides you with Benefits at the lowest out-of-pocket cost. You will be covered under Level I when you receive care from:

- Your PCP;
- Any provider your PCP authorizes;
- An MHSA Participating Provider;
- Any provider the MHSA authorizes; or
- Any provider of Emergency Services.

Covered Services may be subject to the prior authorization requirements explained in the *Medical management* section.

Level II (PPO Participating Providers)

Level II coverage is available when you choose to access Benefits through a Participating Provider in the PPO network. This level provides you with Benefits at the second lowest out-of-pocket cost. Benefits under Level II are provided when you receive care from a PPO Participating Provider. You do not need a referral or authorization from your PCP to see a specialist. However, Covered Services may be subject to the prior authorization requirements explained in the *Medical management* section.

Level III (PPO Non-Participating Providers)

Level III coverage is available when you choose to access Benefits through a Non-Participating Provider. This level of Benefits has the highest out-of-pocket cost.

Benefits under Level III are provided when you receive Covered Services from any Non-Participating Provider. You do not need a referral from your PCP to see a Level III provider, but Covered Services may be subject to the prior authorization requirements explained in the *Medical management* section.

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants
Physician Specialists, such as dermatologists and cardiologists
Physical, occupational, and speech therapists
Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers
Hospitals
Freestanding labs and radiology centers
Ambulatory Surgery Centers

Mental Health Service Administrator (Benefit Administrator)

Blue Shield contracts with the Mental Health Service Administrator (MHSA) to manage Mental Health and Substance Use Disorder services through their own network of providers. The MHSA authorizes services, processes claims, and addresses complaints and grievances for those Benefits on behalf of Blue Shield. If you receive a Covered Service from an MHSA Participating Provider, you should interact with the MHSA in the same way you would otherwise interact with your PCP.

MHSA provider networks are separate from Blue Shield's medical provider networks. Under Level I, care is provided by MHSA Participating Providers and authorized by the MHSA when required. There is no Level II for MHSA providers. Under Level III, care is provided by MHSA Non-Participating Providers and authorized by Blue Shield when required. Visit blueshieldca.com and click on Find a Doctor to access the MHSA network.

Your Primary Care Physician (Level I)

For Level I, you are required to have a Primary Care Physician (PCP). Your PCP is your first point of contact for any health concern and for Preventive Health Services. Your PCP will also manage other aspects of your care, including:

- Prior authorization requests;
- Health education;

- Specialist referrals;
- Hospital admissions; and
- Hospice program admissions.

Selecting a PCP

Blue Shield will initially choose a PCP for you, but you can change this selection. You do not need to choose the same PCP for each Member in your family. To change your PCP, visit blueshieldca.com.

PCPs may be:

- General practitioners;
- Family practitioners;
- Internists;
- Obstetrician/gynecologists; or
- Pediatricians.

Your PCP must be a Level I Participating Provider in the Added Advantage POS℠ HMO network. If your PCP leaves this plan's network, Blue Shield will choose a new PCP for you and notify you.

Your relationship with your PCP

The relationship you have with your PCP is an important element of a POS plan. Your PCP has a unique, holistic view of your medical care. He or she will know your health history, which may help identify problems before they become serious. Your PCP will work with you to ensure you receive Medically Necessary professional services and accommodate your preferences to the extent possible. This relationship also allows for more open communication between you and your PCP. If you are unable to establish a satisfactory relationship with your PCP, you can choose a new one.

Your Medical Group (Level I)

Some PCPs contract directly with Blue Shield, but most are part of a Medical Group. Medical Groups:

- Share administrative responsibilities with your PCP;
- Work with your PCP to authorize Covered Services;
- Ensure that a full panel of Specialists are available to you; and
- Have admission arrangements with Blue Shield's contracted Hospitals within the Medical Group Service Area.

Your PCP and Medical Group are listed on your ID card.

Changing your Medical Group

You can change your Medical Group at any time. If your PCP is not part of your new Medical Group, you will also have to select a new PCP. Visit blueshieldca.com to change your Medical Group or PCP.

Changes to your Medical Group are effective on the first day of the month after Blue Shield approves the change. At that time, authorizations for any services by your old

Medical Group are no longer valid. If you still need these services, they must be reauthorized by your new Medical Group.

Blue Shield does not recommend that you change Medical Groups while you are admitted to the Hospital or in the third trimester of pregnancy. A change in Medical Group during an ongoing course of treatment may interrupt your care. Any requested changes to your Medical Group in these situations will be effective on the first day of the month after the date when it is medically appropriate to transfer your care. Exceptions must be approved by a Blue Shield Medical Director. Call Customer Service for more information.

Visits for obstetrical/gynecological (OB/GYN) services

OB/GYN services are female reproductive and sexual health care services. OB/GYN services include Physician services related to:

- Family planning and contraception;
- Treatment during pregnancy;
- Diagnosis and treatment of disorders of the female reproductive system and genitalia;
- Treatment of disorders of the breast; and
- HIV testing.

Level I: You do not need a referral from your PCP for OB/GYN services as long as the obstetrician, gynecologist, or family practice Physician you see is in your Medical Group. Your Cost Share for OB/GYN services with that Physician will be the same as if you received those services from your PCP.

Level II and Level III: You do not need a referral from your PCP for OB/GYN services. You may see any PPO Participating Provider under Level II or any Non-Participating Provider under Level III for OB/GYN services.

Specialist visits

Level I: You will need a referral from your PCP to see most types of specialists. Your PCP will refer you to a specialist or other appropriate Participating Provider in your Medical Group, if possible.

Level II and Level III: You do not need a referral from your PCP to see specialists. However, Covered Services are subject to the prior authorization requirements explained in the *Medical management* section.

ID cards

Blue Shield will provide the Subscriber and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at blueshieldca.com or on the Blue Shield mobile app.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice.

Continuity of care

Continuity of care may be available if:

- Blue Shield, the Medical Group, or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

Continuity of care may also be available to you when your Employer terminates its contract with Blue Shield and contracts with a new health plan (insurer) that does not include your Blue Shield Participating Provider in its network.

If your Former Participating Provider is no longer available to you for one of the reasons noted above, Blue Shield, the Medical Group, or the MHSA will notify you of the option to continue treatment with your Former Participating Provider.

You can request to continue treatment with your Former Participating Provider in the situations described above if you are currently receiving the following care:

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.

To request continuity of care, visit blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and may review your request for Medical Necessity.

Under Federal law, the Former Participating Provider must accept Blue Shield's, the Medical Group's, or the MHSA's Allowed Charges (Level I) or Allowable Amount (Level II) as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Participating Provider at the applicable Level I or Level II Participating Provider Cost Share.

See the *Your payment information* section for more information about the Allowed Charges for Level I and Allowable Amount for Level II and Level III.

Second medical opinion

You can seek a second medical opinion in situations including but not limited to:

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;
- Your diagnosis is unclear;
- Your condition has not improved after completing the prescribed course of treatment;
- You need additional information before deciding on a treatment plan; or
- You have questions about your diagnosis or treatment plan.

Level I: Ask your PCP for a referral to another provider for a second medical opinion. Your Medical Group must authorize all requests for a second medical opinion.

Level II: You can consult any PPO Participating Provider for a second medical opinion. You do not need a referral or prior authorization from Blue Shield, your PCP, or your Medical Group.

Level III: You can consult any Non-Participating Provider for a second medical opinion. You do not need a referral or prior authorization from Blue Shield, your PCP, or your Medical Group. You may request a second opinion on care your received from a specialist from any Non-Participating Provider.

Care outside of California

If you need medical care while traveling outside of California, you're covered. Blue Shield has relationships with health plans in other states, Puerto Rico, and the U.S. Virgin Islands through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care from participating and non-participating providers in those geographic areas.

See the ***Out-of-area services*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Emergency Services

If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you

will be responsible for the Level II Participating or Level III Non-Participating Provider Cost Share for that non-emergency Covered Service.

For the lowest out-of-pocket expenses, you can go to a Participating Physician's office for emergency room follow-up services, such as suture removal and wound checks.

If you cannot find a Participating Provider

Your PCP will refer you to other providers in your Medical Group for the care you need. If these services cannot reasonably be obtained from a Participating Provider, you can ask your Medical Group for authorization to see a Non-Participating Provider. We will review your request for Medical Necessity, and if approved, your Medical Group will pay for Covered Services from the Non-Participating Provider. You will only be responsible for the Level I Cost Share. If the Medical Group cannot provide the necessary care, you can call Customer Service for help finding a Participating Provider who can provide the requested services.

Other ways to access care

For non-emergencies, it may be faster and easier to access care in one of the following ways. For more information, visit blueshieldca.com or use the Blue Shield mobile app.

Teladoc

Teladoc, a Third-Party Corporate Telehealth Provider, provides health consultations by phone or secure online video. Teladoc general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc mental health consultations are available for Members age 13 and older. Members under age 13 may obtain telebehavioral health services for Mental Health and Substance Use Disorders from MHSA Participating Providers. Teladoc is a supplemental service that is not intended to replace care from your Physician, care from your MHSA Participating Provider, or your relationship with your Physician.

How to access Teladoc		
Teladoc service	**Ways to access**	**Availability**
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladoc	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment
Mental health	Phone: 1-800-835-2362 Online: blueshieldca.com/teladoc	7 a.m. to 9 p.m., 7 days a week by scheduled appointment only Consultations must be scheduled online and cannot be requested by phone

Telebehavioral health services

Online telebehavioral health services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers and are a Covered Service regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. If you are currently receiving telebehavorial health services for Mental Health and Substance Use Disorders, you can continue to receive those services with the MHSA Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider. Visit blueshieldca.com and click on Find a Doctor to access the MHSA network.

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

Level I: If you are close to home, you should go to the urgent care center designated by your Medical Group. If you are away from home, you may visit any urgent care center near you.

Ambulatory Surgery Centers

Many of the more common, uncomplicated, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Timely access to care

Participating Providers agree to provide timely access to care. This means that when you call for an appointment, you will see your provider within a reasonable timeframe. Blue Shield's access standards are listed below.

When your appointment will occur	
Urgent appointments	***Appointment will occur***
Services that do not require prior authorization	Within 48 hours
Services that do require prior authorization	Within 96 hours
Non-urgent appointments	***Appointment will occur***
Primary Care Physician office visit	Within 10 business days
Specialist office visit	Within 15 business days
Mental or substance use disorder health provider (who is not a Physician) office visit	Within 10 business days
Other services to diagnose or treat a health condition	Within 15 business days
Phone inquiries	***Appointment will occur***
Access to a health care professional for phone screenings	24 hours a day, seven days a week

Contact ***Customer Service*** to schedule ***interpreter services*** for your appointment. For more information about interpreter services, see the ***Language access services*** notice.

Health advice and education

Blue Shield provides several ways for you to get health advice and access to health education and wellness services. These resources are available to you at no extra cost.

NurseHelp 24/7SM

You can contact a registered nurse 24 hours a day, seven days a week through the NurseHelp 24/7SM program. Nurses are available to help you select appropriate care and answer questions about:

- Symptoms you are experiencing;
- Minor illnesses and injuries;
- Medical tests and medications;
- Chronic conditions; and
- Preventive care.

Call (877) 304-0504 or log in to your account at blueshieldca.com and use the chat feature to connect with a nurse. This service is free and confidential.

NurseHelp 24/7 SM is not meant to replace the advice and care you receive from your Physician or other health care professional.

LifeReferrals 24/7SM

The LifeReferrals 24/7 SM program offers you access to support services 24 hours a day, seven days a week, including assessments and referrals for consultations for health and psychosocial issues. Professional counselors can provide confidential telephone or in-person support by approved appointment. You are limited to three consultations with a professional counselor every six months.

This bundle of services also includes referrals, resources, and support for additional topics such as:

- Legal services;
- Financial counseling;
- Mediation;
- Child and family care;
- Adult and elder care;
- Chronic conditions and illnesses;
- Income tax preparation; and
- Identity theft assistance.

Call (800) 985-2405 to obtain services or access online tools and resources by visiting lifereferrals.com and using the code: "BSC". These services are free and confidential.

Health and wellness resources

Your Blue Shield coverage gives you access to a variety of health education and wellness services, such as:

- Prenatal and other health education programs;
- Healthy lifestyle programs to help you get more active, quit smoking, lower stress, and much more; and
- A health update newsletter.

Visit blueshieldca.com to explore these resources.

Medical management

Medical management can help you coordinate your care and treatment. It includes utilization management and care management. Blue Shield uses utilization management to help you and your providers identify the most appropriate and cost-effective way to use the Benefits of this plan. Care management and palliative care can help you access the care you need to manage serious health conditions and complex treatment plans.

For written information about ***Blue Shield's Utilization Management Program***, visit blueshieldca.com.

Prior authorization and PCP referrals

Coverage for most Benefits requires pre-approval. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting.

Level I: Your provider must obtain prior authorization from your Medical Group or the MHSA when required. Your PCP will manage your prior authorization requests.

A referral from your PCP is usually required when you want to see a Specialist or other provider, but there are some exceptions. You do not need a referral for:

- Emergency Services;
- Urgent Services;
- Trio+ Specialist visits;
- OB/GYN services by an obstetrician, gynecologist, or family practice Physician within your Medical Group; and
- Office visits with your PCP or for outpatient Mental Health and Substance Use Disorder services with an MHSA Participating Provider.

Level II: If you see a Participating Provider, your provider must obtain prior authorization from Blue Shield when required. When prior authorization is required but not obtained, Blue Shield may deny payment to your provider. You are not responsible for Blue Shield's portion of the Allowable Amount if this occurs, only your Cost Share.

Level III: If you see a Non-Participating Provider, you or your provider must obtain prior authorization from Blue Shield when required. When prior authorization is required but not obtained, and the services provided are determined not to be a Benefit of the plan or not Medically Necessary, Blue Shield may deny payment and you will be responsible for all billed charges.

You do not need prior authorization for Emergency Services or emergency Hospital admissions at Participating or Non-Participating facilities. For non-emergency inpatient services, your provider should request prior authorization at least five business days before admission. If the Non-Participating Hospital is unable to determine the contact

information for Blue Shield in order to request prior authorization, the Non-Participating Hospital may bill the Member for such services.

For more details about medical and surgical services and select prescription Drugs that require prior authorization, log in to your account at blueshieldca.com and click on Benefits.

Frequently utilized services that require prior authorization (Level II and Level III)

Benefit	***Services that require prior authorization***
Medical	• Surgery • Non-emergency inpatient facility services, such as Hospitals and Skilled Nursing Facilities • Non-emergency ambulance services • Routine patient care received while enrolled in a clinical trial • Hospice program enrollment • PKU-related formulas and special food products
Radiological and nuclear imaging	• CT (Computerized Tomography) scan • MRI (Magnetic Resonance Imaging) • MRA (Magnetic Resonance Angiography) • PET (Positron Emission Tomography) scan • Diagnostic cardiac procedure utilizing nuclear medicine
Mental Health and Substance Use Disorder	• Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Behavioral Health Treatment • Partial Hospitalization Program • Intensive Outpatient Program • Transcranial magnetic stimulation

When a decision will be made about your prior authorization request

Prior authorization	*Time for decision*
Routine medical and Mental Health and Substance Use Disorder requests	Within five business days
Expedited medical and Mental Health and Substance Use Disorder requests	Within 72 hours

Expedited requests include urgent medical requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

While you are in the Hospital (inpatient utilization review)

When you are admitted to the Hospital, your stay will be monitored for continued Medical Necessity. If it is no longer Medically Necessary for you to receive an inpatient level of care, your Medical Group or Blue Shield will send a written notice to you, your provider, and the Hospital. If you choose to stay in the Hospital past the date indicated in this notice, you will be financially responsible for all inpatient charges after that date. Exceptions to inpatient utilization review include maternity and mastectomy care.

For maternity, the minimum length of an inpatient stay is 48 hours for a normal, vaginal delivery and 96 hours for a C-section. The provider and mother together may decide that a shorter length of stay is adequate.

For mastectomy, you and your provider determine the Medically Necessary length of stay after the surgery.

After you leave the Hospital (discharge planning)

You may still need care at home or in another facility after you are discharged from the Hospital. Your Medical Group will work with you, your provider, and the Hospital's discharge planners to determine the most appropriate and cost-effective way to provide this care.

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. A Blue Shield care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Customer Service. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and

- Identify community resources to lend support as you learn to manage a chronic health condition.

Alternative services may be offered when they are medically appropriate and only utilized when you, your provider, and Blue Shield mutually agree. The availability of these services is specific to you for a set period of time based on your health condition. Blue Shield does not give up the right to administer your Benefits according to the terms of this Evidence of Coverage or to discontinue any alternative services when they are no longer medically appropriate. Blue Shield is not obligated to cover the same or similar alternative services for any other Member in any other instance.

Managing a serious illness (palliative care services)

Blue Shield covers palliative care services if you have a serious illness. Palliative care provides relief from the symptoms, pain, and stress of a serious illness to help improve the quality of life for you and your family.

Palliative care services include access to Physicians and case managers who are specially trained to help you:

- Manage your pain and other symptoms;
- Maximize your comfort, safety, autonomy, and well-being;
- Navigate a course of care;
- Make informed decisions about therapy;
- Develop a survivorship plan; and
- Document your quality-of-life choices.

Your payment information

Paying for coverage

Your Employer is responsible for a monthly payment to Blue Shield for health care coverage for the Subscriber and any enrolled Dependents. This monthly payment is a Premium. Any amount the Subscriber must contribute to the Premium is set by your Employer.

The contract states the monthly Premiums for this plan for the Subscriber and any enrolled Dependents.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Blue Shield Allowed Charges (Level I) or Allowable Amount (Level II and Level III).

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services under Level I, Level II, and Level III.

Allowed Charges and capitation (Level I)

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Services provided or arranged by Blue Shield, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections.

Covered Services provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them.

If there is a payment dispute between Blue Shield and a Participating Provider over Covered Services you receive, the Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the Allowed Charges. You are only required to pay your Cost Share for those services.

When you see a Participating Provider, you are responsible for your Cost Share.

Allowable Amount (Level II and Level III)

The Allowable Amount is the maximum amount Blue Shield will pay for Covered Services, or the Level II or Level III provider's billed charge for those Covered Services,

whichever is less. Blue Shield's payment to the provider is the difference between the Allowable Amount and your Cost Share.

Level II Participating Providers agree to accept the Allowable Amount as payment in full for Covered Services, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections. When you see a Level II Participating Provider, you are responsible for your Cost Share.

Generally, Blue Shield will pay its portion of the Allowable Amount and you will pay your Cost Share. If there is a payment dispute between Blue Shield and a Level II Participating Provider over Covered Services you receive, the Level II Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the Allowable Amount. You are only required to pay your Cost Share for those services.

Non-Participating Providers do not agree to accept the Allowable Amount as payment in full for Covered Services. When you see a Non-Participating Provider, you are responsible for:

- Your Cost Share; and
- All charges over the Allowable Amount.

Calendar Year Deductible

Level I: There is no Calendar Year Deductible under Level I.

Level II and Level III: The Deductible is the amount you pay each Calendar Year for Covered Services before Blue Shield begins payment. Blue Shield will pay for some Covered Services before you meet your Deductible.

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

Copayment and Coinsurance

A Covered Service may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Service. A Coinsurance is a percentage of the Allowed Charges (Level I) or Allowable Amount (Level II and Level III) you pay for a Covered Service.

Your provider will ask you to pay your Copayment or Coinsurance at the time of service. For Covered Services that are subject to your plan's Deductible, you are also responsible for all costs up to the Allowed Charges (Level I) or Allowable Amount (Level II and Level III) until you reach your Deductible.

You will continue to pay the Copayment or Coinsurance for each Covered Service you receive until you reach your Out-of-Pocket Maximum.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges (Level I) or Allowable Amount (Level II and Level III) for Covered Services for the rest of the Calendar Year.

If you want information about your Out-of-Pocket Maximum, you can call Customer Service.

The following do not count toward your Out-of-Pocket Maximum:

- Any amounts you pay toward your Deductible;
- Charges for services that are not covered; and
- Charges over the Allowed Charges (Level I) or Allowable Amount (Level II and Level III).

You will continue to be responsible for these costs even after you reach your Out-of-Pocket Maximum.

See the *Summary of Benefits* section for details on how the Out-of-Pocket Maximum works for your plan.

Accrual balance

Blue Shield provides a summary of your accrual balances toward your Calendar Year Deductible, if any, and Out-of-Pocket Maximum for every month in which your Benefits were used until the full amount has been met. This summary will be mailed to you unless you opt to receive it electronically or have already opted out of paper mailings. You can opt back in to receive paper mailings at any time or elect to receive your balance summary electronically by logging into your member portal online and updating your communication preferences, or by calling Customer Service at the number on the back of your ID card. You can also check your accrual balances at any time by logging into your member portal online, which is updated daily, or calling Customer Service. Your accrual balance information is updated once a claim is received and processed.

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Services until you reach your Deductible. Once you reach your Deductible, Blue Shield will pay the Allowed Charges (Level I) or Allowable Amount (Level II and Level III) for Covered Services, minus your Copayment or Coinsurance amounts, until you reach your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges (Level I) or Allowable Amount (Level II and Level III) for Covered Services. Exceptions are described above.

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

Example: You visit the doctor for a sore throat. You have received Covered Services throughout the year and have already met your $500 Level II and Level III Deductible. However, you have not yet met your $1,000 Out-of-Pocket Maximum.

Level II and III Deductible: **$500**

Amount paid to date toward Deductible: **$500**

Level I, II, and III Out-of-Pocket Maximum: **$1,000**

Amount paid to date toward Out-of-Pocket Maximum: **$500**

Level I Participating Provider Copayment: **$20**

Level II Participating Provider Copayment: **$30**

Level III Non-Participating Provider Copayment: **$40**

Blue Shield Allowed Charges/Allowable Amount for the doctor's visit: **$100**

Non-Participating Provider billed charge for the doctor's visit: **$140**

	Level I Participating Provider	***Level II Participating Provider***	***Level III Non-Participating Provider***
You pay	**$20** ($20 Copayment)	**$30** ($30 Copayment)	**$80** ($40 Copayment plus $40 for charges over Allowable Amount)
Blue Shield pays	$80 (Allowed Charges minus your Cost Share)	$70 (Allowed Amount minus your Cost Share)	$60 (Allowable Amount minus your Cost Share)

Total payment to the doctor	$100 (Allowed Charges)	$100 (Allowable Amount)	$140 (Billed charge)

In this example, because you have already met your Deductible, you are only responsible for:

- **Level I:** The HMO Partcipating Provider Copyament;
- **Level II:** The PPO Participating Provider Copayment; or
- **Level III:** The Non-Participating Provider Copayment plus all charges over the Allowable Amount.

Claims

When you see any Participating Provider (Level I and Level II), your provider submits the claim to Blue Shield. When you see a Non-Participating Provider (Level III), you must submit the claim to Blue Shield or the Benefit Administrator.

If you receive Emergency or Urgent Services from a Non-Participating Provider, you may be required to pay the charges in full and submit a claim to Blue Shield to request reimbursement. Blue Shield may send the payment to the Subscriber or directly to the Non-Participating Provider.

Claim forms are available at blueshieldca.com or by contacting the Benefit Administrator. Please submit your claim form and medical records within one year of the service date.

See the *Out-of-area services* section in the *Other important information about your plan* section for more information on claims for Emergency or Urgent Services outside of California.

How to submit a claim (Level III)

Type of claim	*What to submit*	*Where to submit it*	*Due date*
Medical services	• Blue Shield claim form; and • The itemized bill from your provider	Blue Shield of California P.O. Box 272540 Chico, CA 95927	Within one year of the service date
Mental Health and Substance Use Disorder services	• Blue Shield claim form; and • The itemized bill from your provider	Blue Shield of California P.O. Box 272540 Chico, CA 95927	Within one year of the service date

Claim processing and payments

Blue Shield or the Benefit Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any

required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by Blue Shield or the Benefit Administrator to the provider.

When you receive Covered Services from a Non-Participating Provider, Blue Shield or the Benefit Administrator may send the payment to the Subscriber, or directly to the Non-Participating Provider.

The Subscriber must make sure ***the Non-Participating Provider*** receives the ***full billed amount*** for non-emergency services, whether or not Blue Shield makes payment to the Non-Participating Provider.

Your coverage

This section explains eligibility and enrollment for this plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this plan

To be eligible for coverage as a Subscriber, you must meet all of your Employer's eligibility requirements and complete any waiting period established by your Employer.

If you fail or refuse to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the plan, you will immediately lose eligibility to continue enrollment.

Dependent eligibility

To be eligible for coverage as a Dependent, you must:

- Be listed on the enrollment form completed by the Subscriber; and
- Be the Subscriber's spouse, Domestic Partner, or be under age 26 and the child of the Subscriber, spouse, or Domestic Partner.
  - For the Subscriber's spouse to be eligible for this plan, the Subscriber and spouse must not be legally separated.
  - For the Subscriber's Domestic Partner to be eligible for this plan, the Subscriber and Domestic Partner must have a registered domestic partnership (except as otherwise permitted by your Employer).
  - "Child" includes a stepchild, newborn, child placed for adoption, child placed in foster care, and child for whom the Subscriber, spouse, or Domestic Partner is the legal guardian. It does not include a grandchild unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
  - A child age 26 or older can remain enrolled as a Dependent if the child is disabled, incapable of self-support because of a mental or physical disability, and chiefly dependent on the Subscriber for economic support.
    - The Dependent child's disability must have begun before the period he or she would become ineligible for coverage due to age.
    - Blue Shield will send a notice of termination due to loss of eligibility 90 days before the date coverage will end.
    - The Subscriber must submit proof of continued eligibility for the Dependent at Blue Shield's request. Blue Shield may not request this information again for two years after the initial determination. Blue Shield may request this information no more than once a year after that. The Subscriber's failure to provide this information could result in termination of a Dependent's coverage.

Enrollment and effective dates of coverage

As the Subscriber, you can enroll in coverage for yourself and your Dependents during your initial enrollment period, your Employer's annual open enrollment period, or if you qualify for a special enrollment period.

You are eligible for coverage as a Subscriber on the day following the date you complete any applicable waiting period established by your Employer. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan are not available before the effective date of coverage. This Contract has a 12-month term that begins on your Employer's effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. You will have an annual open enrollment period set by your Employer. Your Employer will notify its Employees of the open enrollment period each year.

Special enrollment period

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Qualifying Event.

A special enrollment period gives you at least 30 days from a Qualifying Event to apply for or change coverage for yourself or your Dependents. See the *Special enrollment period* section for more information. You should notify your Employer as soon as possible if you experience a Qualifying Event that requires a change in your coverage.

Common Qualifying Events
Change in Dependents
Loss of coverage under another employer health plan or other health insurance
Loss of eligibility in a government program

For a complete list of Qualifying Events, see ***Special enrollment period*** on page 81 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Employee or Dependents qualify for a special enrollment period, coverage will begin no later than the 1st of the month

following the date Blue Shield receives the request for special enrollment from your Employer.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

- Newborn;
- Adopted child;
- Child placed for adoption;
- Child placed in foster care; or
- Child for whom the Subscriber, spouse, or Domestic Partner is the court-appointed legal guardian.

For coverage to continue beyond 31 days without lapse for a newborn, adopted child, or child placed for adoption, the Subscriber must ***notify the Employer within 90 days*** of birth, adoption, or placement for adoption and request that the child be added as a Dependent.

If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, both are eligible for Dependent Benefits. You may enroll a child as a Dependent of either or of both parents.

A child will be considered adopted for the purpose of Dependent eligibility when one of the following happens:

- The child is legally adopted;
- The child is placed for adoption and there is evidence of the Subscriber, spouse, or Domestic Partner's right to control the child's health care; or
- The Subscriber, spouse, or Domestic Partner is granted legal authority to control the child's health care.

The child's eligibility as a Dependent will continue while waiting for a legal decree of adoption unless the child is removed from the Subscriber, spouse, or Domestic Partner's home before the decree is issued.

Plan changes

Blue Shield has the right to change the Benefits and terms of this plan as the law permits. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Premiums; and
- Limitations and exclusions.

Blue Shield will give your Employer written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. Your Employer is responsible for letting you know of any changes.

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

Coordination of benefits

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits determines which plan will pay first when both plans have responsibility for paying the medical claim. For more information, see the *Coordination of benefits, continued* section.

When coverage ends

Your coverage will end if:

- Your Employer cancels or does not renew coverage;
- The Subscriber cancels coverage; or
- Blue Shield cancels or rescinds coverage.

There is no right to receive the Benefits of this plan after coverage ends, except as described in the *Extension of Benefits*, *Continuity of care,* and *Continuation of group coverage* sections.

If your Employer cancels coverage

Your Employer may cancel coverage at any time. To cancel coverage, your Employer must provide written notice to Blue Shield and its Employees.

If the Subscriber cancels coverage

If the Subscriber decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by your Employer. In addition, if your Employer does not notify Blue Shield within 90 days following the Dependent's effective date of coverage for a newborn or a child placed for adoption, Benefits under this plan will be terminated for those Dependents on the 31st day at 11:59 p.m. Pacific Time.

Reinstatement

If the Subscriber voluntarily cancels coverage, the Subscriber can contact the Employer for reinstatement options.

If Blue Shield cancels coverage

Blue Shield can cancel coverage if:

- You are no longer eligible for coverage in this plan;
- Your Employer fails to meet Blue Shield's Employer eligibility, participation, and contribution requirements;
- Blue Shield terminates this plan; or
- You or your Employer commit fraud or intentional misrepresentation of material fact.

Blue Shield will provide 30 days' advance written notice of cancellation of coverage to your Employer if your Employer fails to meet Blue Shield's Employer eligibility,

participation, and contribution requirements. It is your Employer's responsibility to provide a copy of the notice to its Employees.

Cancellation for Employer's nonpayment of Premiums

Blue Shield can cancel coverage if your Employer does not pay the required Premiums in full and on time. Your Employer is responsible for all Premiums during the term of coverage, including the 45-day grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five business days after the date coverage ends

Cancellation or rescission for fraud or intentional misrepresentation of material fact

Blue Shield may cancel or rescind your coverage if you, your Dependent, or your Employer commit fraud or intentional misrepresentation of material fact. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation, Rescission or Nonrenewal. Rescission voids the Contract as if it never existed. Cancellation is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.

Extension of Benefits

If you become Totally Disabled while covered under this plan and continue to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits directly related to the condition, illness, or injury causing your Total Disability until one of the following occurs:

- 12 months from the effective date of termination;
- The date you are no longer Totally Disabled; or
- The date on which a replacement carrier provides coverage for your Total Disability.

Your extension of Benefits will be subject to all the limitation and restrictions of this plan.

You will not receive an extension of Benefits unless a Physician provides Blue Shield with written certification of your Total Disability within 90 days of the effective date of termination. After that, the Physician must continue to provide written certification of your Total Disability at reasonable intervals Blue Shield determines.

Continuation of group coverage

Please examine your options carefully before declining this coverage.

You can continue coverage under this group plan when your Employer is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, or the California Continuation Benefits Replacement Act (Cal-COBRA).

Your benefits under the group continuation of coverage provisions will be identical to the Benefits you would have received as an active Employee if the qualifying event had not occurred. Any changes in the coverage available to active Employees will also apply to group continuation coverage.

COBRA

You may elect to continue group coverage under this plan if you would otherwise lose coverage because of a COBRA qualifying event. Please contact your Employer for detailed information about COBRA continuation coverage, including eligibility, election of coverage, and Premiums.

Cal-COBRA

If you enroll in COBRA and exhaust the time limit for COBRA group continuation coverage, you may be able to continue your group coverage under Cal-COBRA for a combined total (COBRA plus Cal-COBRA) of 36 months.

You will not be eligible for benefits under Cal-COBRA if, at the time of the Cal-COBRA qualifying event, you are entitled to benefits under Medicare or are covered under another group health plan. Medicare entitlement means that you are eligible for Medicare benefits and enrolled in Part A only.

Cal-COBRA qualifying event

A Cal-COBRA qualifying event is an event that, except for the election of continuation coverage, would result in a loss of coverage for the Subscriber or eligible Dependents:

- The death of the Subscriber;
- Termination of the Subscriber's employment (except termination for gross misconduct which is not a qualifying event);
- Reduction in hours of the Subscriber's employment;
- Divorce or legal separation of the Subscriber from the covered spouse;
- Termination of the Subscriber's domestic partnership with a covered Domestic Partner;
- Loss of Dependent status by a covered Dependent;
- The Subscriber's entitlement to Medicare (This only applies to a covered Dependent); and
- With respect to any of the above, such other qualifying event as may be added to Cal-COBRA.

A child born to or placed for adoption with a covered Subscriber or Domestic Partner during the Cal-COBRA group coverage continuation period may be immediately added as a Dependent provided the Employer is properly notified of the birth or placement for adoption, and the child is enrolled within 90 days of the birth or placement for adoption.

Notification of a qualifying event

You are responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a Dependent's loss of Dependent status under this plan. This notice must be given within 60 days of the date of the qualifying event. Failure to

provide such notice within 60 days will disqualify you from receiving continuation coverage under Cal-COBRA.

Your Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the qualifying event.

When Blue Shield is notified that a qualifying event has occurred, Blue Shield will, within 14 days, provide you with written notice of your right to continue group coverage under this plan. You must then give Blue Shield notice in writing of your election of continuation coverage within 60 days of the date of the notice of your right to continue group coverage, or the date coverage terminates due to the qualifying event, whichever is later. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If you do not notify Blue Shield within 60 days, your coverage will terminate on the date you would have lost coverage because of the qualifying event.

If this plan replaces a previous group plan that was in effect with your Employer, and you had elected Cal-COBRA continuation coverage under the previous plan, you may continue coverage under this plan for the balance of your Cal-COBRA eligibility period. To begin Cal-COBRA coverage with Blue Shield, you must notify us within 30 days of the date you were notified of the termination of your previous group plan.

Duration and extension of group continuation coverage

COBRA enrollees who reach the maximum coverage period available under COBRA may elect to continue coverage under Cal-COBRA for a combined maximum period of 36 months from the date continuation of coverage began under COBRA. You must notify Blue Shield of your Cal-COBRA election at least 30 days before COBRA termination. Your Cal-COBRA coverage will begin immediately after the COBRA coverage ends.

You must exhaust all available COBRA coverage before you can become eligible to continue coverage under Cal-COBRA.

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this plan for up to a maximum of 36 months, regardless of the type of qualifying event.

In no event will continuation of group coverage under COBRA, Cal-COBRA, or a combination of COBRA and Cal-COBRA be extended for more than 36 months from the date of the qualifying event that originally entitled you to continue your group coverage under this plan.

Payment of Premiums

Premiums for continuing coverage will be 110 percent of the applicable group Premium rate, except if you are eligible to continue Cal-COBRA coverage beyond 18 months because of a Social Security disability determination. In that

case, the Premiums for months 19 through 36 will be 102 percent of the applicable group Premium rate.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premiums must be paid within 45 days of the date you provided written notification to Blue Shield of your election to continue coverage and must be sent to Blue Shield by first-class mail or other reliable means. You must pay the entire amount due within the 45-day period or you will be disqualified from Cal-COBRA continuation coverage.

Effective date of the continuation of group coverage

If your initial group continuation coverage is Cal-COBRA rather than COBRA, your Cal-COBRA coverage will begin on the date your coverage under this plan would otherwise end due to a qualifying event. Your coverage will continue for up to 36 months unless terminated due to an event described in the *Termination of group continuation coverage* section.

Termination of group continuation coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

- Termination of the Contract (if your Employer continues to provide any group benefit plan for Employees, you may be able to continue coverage with another plan);
- Failure to pay Premiums in full and on time to Blue Shield. Coverage will end as of the end of the period for which Premiums were paid;
- You become covered under another group health plan;
- You become entitled to Medicare; or
- You commit fraud or deception in the use of the services of this Plan.

Continuation of group coverage while on leave

Employers are responsible to ensure compliance with state and federal laws regarding leaves of absence, including the California Family Rights Act, the Family and Medical Leave Act, the Uniformed Services Employment and Re-employment Rights Act, and Labor Code requirements for Medical Disability.

Family leave

The California Family Rights Act of 1991 and the federal Family & Medical Leave Act of 1993 allow you to continue your coverage under this plan while you are on family leave. Your Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Military leave

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) allows you to continue your coverage under this plan while you are on military leave. If you are planning to enter the Armed Forces, you should contact your Employer for information about your rights under the (USERRA).

Your Benefits

This section describes the Benefits your plan covers. They are listed in alphabetical order so they are easy to find.

Blue Shield provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the medical management section; and
- The terms, conditions, limitations, and exclusions of this Evidence of Coverage.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. Blue Shield's medical management helps your provider ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

See the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
- Preparation and provision of allergy serum; and
- Allergy serum injections.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

Benefits are available for ambulance services provided by a licensed ambulance or psychiatric transport van.

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and

- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

Air ambulance services are covered at the Participating Provider Cost Share, even if you receive services from a Non-Participating Provider.

Bariatric surgery Benefits

Benefits are available for bariatric surgery services. These Benefits include facility and Physician services for the surgical treatment of morbid obesity.

Services for residents of designated California counties

The following section does not apply if you are obtaining bariatric services:

- Under Level I; or
- Under Level II or Level III as a resident of a non-designated county.

Blue Shield has a network of Participating Providers for bariatric surgery services in certain designated counties within California. If you live in a designated county, services are only covered if you receive them from one of these Participating Providers.

Bariatric surgery services designated counties		
Imperial	Orange	San Diego
Kern	Riverside	Santa Barbara
Los Angeles	San Bernardino	Ventura

Travel expense reimbursement for residents of designated counties

You may be eligible for reimbursement of your travel expenses for bariatric surgery services if you meet the following conditions:

- Live in a designated county;
- Live at least 50 miles away from the nearest bariatric surgery services provider in the network;
- Receive prior authorization for travel expense reimbursement; and
- Submit receipts and any other documentation of your expenses to Blue Shield.

Reimbursable bariatric surgery travel expenses		
Expense type	***Maximum reimbursement***	***Limitations & exclusions***
Transportation to and from the facility	$130/roundtrip	• Maximum of 3 roundtrips (pre-surgery, surgery, follow-up)

Reimbursable bariatric surgery travel expenses		
Expense type	***Maximum reimbursement***	***Limitations & exclusions***
		• 1 companion is covered for a maximum of 2 roundtrips (surgery & surgery follow-up)
Hotel accommodations	$100/day	• Maximum of 2 trips, 2 days/trip (pre-surgery & post-surgery follow-up) for you and 1 companion • 1 companion alone may be reimbursed for a maximum of 4 days during your surgery admission • Hotel stays are limited to 1 double-occupancy room. Only the room is covered. All other hotel expenses are excluded
Related reasonable expenses	$25/day/Member	• Maximum of 4 days/trip • Expenses for tobacco, alcohol, drugs, phone, television, delivery, and recreation are excluded

Services for residents of non-designated counties

If you receive bariatric surgery services under Level I, or if you do not reside in a designated county, bariatric surgery services are covered like other surgery services from Participating or Non-Participating Providers. See the *Hospital services* and *Physician and other professional services* sections for more information.

Blue Shield does not reimburse travel expenses associated with bariatric surgery services for residents of non-designated counties.

Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

The clinical trial must have therapeutic intent and the treatment must meet one of the following requirements:

- Your Participating Provider determines that your participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by you; or
- You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate.

Coverage for routine patient care received while participating in a clinical trial requires prior authorization. Routine patient care is care that would otherwise be covered by the plan if those services were not provided in connection with an approved clinical trial. The *Summary of Benefits* section lists your Cost Share for Covered Services. These Cost Share amounts are the same whether or not you participate in a clinical trial. Routine patient care does not include:

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions, and the study or investigation meets one of the following requirements:

- It is a drug trial conducted under an investigational new drug application reviewed by the FDA;
- It is a drug trial exempt under federal regulations from a new drug application; or
- It is federally funded or approved by one or more of the following:
  - One of the National Institutes of Health;
  - The Centers for Disease Control and Prevention;
  - The Agency for Health Care Research and Quality;
  - The Centers for Medicare & Medicaid Services; or
  - A designated Agency affiliate or research entity as described in the Affordable Care Act, including the Departments of Veterans Affairs, Defense, or Energy if the study has been reviewed and approved according to Health and Human Services guidelines.

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. Services will be covered when provided by a Physician,

registered dietician, registered nurse, or other appropriately-licensed Health Care Provider who is certified as a diabetes educator.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including continuous blood glucose monitors and those designed to help the visually impaired;
- Insulin pens, syringes, pumps, and all related necessary supplies;
- Blood and urine testing strips and tablets;
- Lancets and lancet puncture devices;
- Podiatric footwear and devices to prevent or treat diabetes-related complications;
- Medically Necessary foot care; and
- Visual aids, excluding eyewear and video-assisted devices, designed to help the visually impaired with proper dosing of insulin.

Your plan also covers the replacement of a covered item after the expiration of its life expectancy.

Self-management training and medical nutrition therapy

Benefits are available for outpatient training, education, and medical nutrition therapy when directed or prescribed by your Physician. These services can help you manage your diabetes and properly use the devices, equipment, and supplies available to you. With self-management training, you can learn to monitor your condition and avoid frequent hospitalizations and complications.

Diagnostic X-ray, imaging, pathology, laboratory, and other testing services

Benefits are available for imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury.

Benefits include:

- Diagnostic and therapeutic imaging services, such as X-rays and ultrasounds;
- Radiological and nuclear imaging, including CT, PET, and MRI scans;
- COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing;
- Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month. See the *Claims* section for information about how to submit a claim for repayment for this Benefit;
- Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit. A Physician or other Health Care Provider's order must be provided for coverage;
- Clinical pathology services;
- Laboratory services;

- Other areas of diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services. During the federal COVID-19 Public Health Emergency, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing and related services from Non-Participating Providers.

Blue Shield encourages Members to seek services from Participating Providers to avoid paying extra fees. Some Non-Participating Providers may charge extra fees that are not covered by Blue Shield. Any fees not covered by Blue Shield will be the Member's responsibility. See the *How to access care* section for information about Participating and Non-Participating Providers

Dialysis Benefits

Benefits are available for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting, or in your home.

Benefits include:

- Renal dialysis;
- Hemodialysis;
- Peritoneal dialysis; and
- Self-management training for home dialysis.

Benefits do not include:

- Comfort, convenience, or luxury equipment; or
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

- Mobility devices, such as wheelchairs;
- Peak flow meter for the self-management of asthma;
- Glucose monitor including continuous blood glucose monitor for the self-management of diabetes;
- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;

- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price; and
- Breast pumps.

Benefits do not include:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers;
- Exercise equipment;
- Routine maintenance, repair, or replacement of DME due to loss or misuse, except when authorized;
- Self-help or educational devices;
- Speech or language assistance devices, except as specifically listed;
- Wigs;
- Adult eyewear;
- Video-assisted visual aids for diabetics;
- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefits Rider.

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes. Self-applied continuous blood glucose monitors are also covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

Orthotic equipment and devices

Benefits are available for orthotic equipment and devices you need to perform Activities of Daily Living. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities;
- Orthopedic shoes and other supportive devices for the feet, except as listed;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Prosthetic equipment and devices

Benefits are available for prosthetic appliances and devices used to replace a part of your body that is missing or does not function, and related supplies.

Benefits include:

- Tracheoesophageal voice prosthesis (e.g. Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- Supplies necessary for the operation of prostheses;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Speech or language assistance devices, except as listed;
- Dental implants;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Emergency Benefits

Benefits are available for Emergency Services received in the emergency room of a Hospital or other emergency room licensed under state law. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an unexpected Emergency Medical Condition at any Hospital, even if it is a Non-Participating Hospital.

If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

Benefits include:

- Physician services;

- Emergency room facility services; and
- Inpatient Hospital services to stabilize your Emergency Medical Condition.

After your condition stabilizes

Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

- Be released from the emergency room if you do not need further treatment;
- Receive additional inpatient treatment at the Participating Hospital; or
- Transfer to a Participating Hospital for additional inpatient treatment if you received treatment of your Emergency Medical Condition at a Non-Participating Hospital.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. 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 delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

If you are admitted to the Hospital for Emergency Services, you should notify your PCP within 24 hours, or as soon as possible after your condition has stabilized.

Family planning and Infertility Benefits

Family planning

Benefits are available for family planning services without illness or injury.

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Tubal ligation; and
- Vasectomy.

Family planning services may also be covered under the Preventive Health Services Benefit and the Prescription Drug Benefits Rider.

Infertility Benefits

Benefits are provided for the diagnosis and treatment of the cause of Infertility, including professional, Hospital, Ambulatory Surgery Center, and related services to diagnose and treat the cause of Infertility, with the exception of what is excluded in the *Exclusions and limitations* section.

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Services that may directly or indirectly cause iatrogenic Infertility.

Under these circumstances, standard fertility preservation services are a Covered Service and do not fall under the scope of Infertility Benefits described in the *Family Planning and Infertility Benefits* section.

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

Benefits are available from a Participating home health care agency for diagnostic and treatment services received in your home under a written treatment plan approved by your Physician.

Benefits include:

- Intermittent home care for skilled services from:
  - Registered nurses;
  - Licensed vocational nurses;
  - Physical therapists;
  - Occupational therapists;
  - Speech and language pathologists;
  - Licensed clinical social workers; and
  - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

- Fewer than seven days per week; or
- Daily, for fewer than eight hours per day, up to 21 days.

Benefits are limited to a visit maximum as shown in the *Summary of Benefits* section for home health agency visits. For this Benefit, coverage includes:

- Up to four visits per day, two hours maximum per visit, with a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or licensed clinical social worker. A visit of two hours or less is considered one visit. Nursing visits cannot be combined to provide Continuous Nursing Services.
- Up to four hours maximum per visit with a Home Health Aide. A visit of four hours or less is considered one visit.

Benefits do not include:

- Continuous Nursing Services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These services may also be described as "shift care" or "private duty nursing."

Home infusion and injectable medication services

Benefits are available through a Participating home infusion agency for home infusion, enteral, and injectable medication therapy.

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Parenteral nutrition services and associated supplies and solutions;
- Enteral nutrition services and associated supplies and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include:

- Insulin;
- Insulin syringes; and
- Services related to hemophilia, which are described below.

Hemophilia home infusion services

Benefits are available for hemophilia home infusion products and services for the treatment of hemophilia and other bleeding disorders. Benefits must be prior authorized and provided in the home or in an infusion suite managed by a Participating Hemophilia Home Infusion Provider.

Benefits include:

- 24-hour service;
- Home delivery of hemophilia infusion products;
- Blood factor product;
- Supplies for the administration of blood factor product; and
- Nursing visits for training or administration of blood factor products.

There is no Calendar Year visit maximum for hemophilia home infusion agency services.

Benefits do not include:

- In-home services to treat complications of hemophilia replacement therapy; or
- Self-infusion training programs, other than nursing visits to assist in administration of the product.

Most Participating home health care and home infusion agencies are not Participating Hemophilia Home Infusion Providers. A list of Participating Hemophilia Home Infusion Providers is available at blueshieldca.com.

Hospice program services

Benefits are available through a Participating Hospice Agency for specialized care if you have been diagnosed with a terminal illness with a life expectancy of one year or less. When you enroll in a Hospice program, you agree to receive all care for your terminal illness through the Hospice Agency. Hospice program enrollment is prior authorized for a specified period of care based on your Physician's certification of eligibility. The period of care begins the first day you receive Hospice services and ends

when the specified timeframe is over or you choose to receive care for your terminal illness outside of the Hospice program.

The authorized period of care is for two 90-day periods followed by unlimited 60-day periods, depending on your diagnosis. Your Hospice care continues through to the next period of care when your Physician recertifies that you have a terminal illness. The Hospice Agency works with your Physician to ensure that your Hospice enrollment continues without interruption. You can change your Participating Hospice Agency only once during each period of care.

A Hospice program provides interdisciplinary care designed to ease your physical, emotional, social, and spiritual discomfort during the last phases of life, and support your primary caregiver and your family. Hospice services are available 24 hours a day through the Hospice Agency.

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;
- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

- Services provided by a Non-Participating Hospice Agency, except in certain circumstances where there are no Participating Hospice Agencies in your area and services are prior authorized.

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
  - Semiprivate Hospital room, or private room if Medically Necessary;
  - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
  - General and specialized nursing care; and
  - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
  - Operating, recovery, labor and delivery, and other specialized treatment rooms;
  - Anesthesia, oxygen, medicines, and IV solutions;
  - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
  - Dialysis services and supplies;
  - Blood and blood products;
  - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
  - Radiation therapy, chemotherapy, and associated supplies;
  - Therapy services, including physical, occupational, respiratory, and speech therapy;
  - Acute detoxification;
  - Acute inpatient rehabilitative services; and
  - Emergency room services resulting in admission.

Medical treatment of the teeth, gums, jaw joints, and jaw bones

Benefits are available for outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues.

Benefits include:

- Treatment of gum tumors;
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;
- Surgical treatment of temporomandibular joint syndrome (TMJ);
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:
  - The Member is younger than seven years old; or
  - The Member is developmentally disabled; or
  - The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

- Adult routine dental or periodontal care;
- Adult orthodontia for any reason other than cleft palate repair;
- Dental implants for any reason other than cleft palate repair;
- Any procedure to prepare the mouth for dentures or for the more comfortable use of dentures;
- Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums, or periodontal structures, or to support natural or prosthetic teeth; or
- Fluoride treatments for any reason other than preparation of the oral cavity for radiation therapy.

Mental Health and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) administers Mental Health and Substance Use Disorder services from MHSA Participating Providers for Members in California (Level I). Blue Shield administers Mental Health and Substance Use Disorder services from MHSA Non-Participating Providers for Members in California (Level III). See the *Out-of-area services* section for an explanation of how Benefits are administered for out-of-state services. Mental health services provided through Teladoc are administered by Blue Shield, not the MHSA. See the *Teladoc* section for more information.

All non-emergency Hospital admissions for Mental Health and Substance Use Disorder services, and for certain outpatient Mental Health and Substance Use Disorder services must be prior authorized by the MHSA. See the *Medical management* section for more information about prior authorization.

The MHSA Participating Providers network is separate from Blue Shield's Participating Provider network. Visit blueshieldca.com and click on Find a Doctor to access the MHSA Participating Provider network.

Office visits

Benefits are available for professional office visits, including Physician office visits, for the diagnosis and treatment of Mental Health and Substance Use Disorders in an individual, Family, or group setting.

Benefits are also available for telebehavioral health online counseling services, psychotherapy, and medication management with a mental health or substance use disorder provider.

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health and Substance Use Disorders. You can receive these other outpatient services in a facility, office, home, or other non-institutional setting.

Other Outpatient Mental Health and Substance Use Disorder Services include, but are not limited to:

- Behavioral Health Treatment – professional services and treatment programs, including applied behavior analysis and evidence-based intervention

programs, prescribed by a Physician or licensed psychologist and provided under a treatment plan approved by the MHSA to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression;
- Intensive Outpatient Program – outpatient care for mental health or substance use disorders when your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services at least five hours per day, four days per week when you are admitted directly or transferred from acute inpatient care following stabilization;
- Psychological Testing – testing to diagnose a mental health condition; and
- Transcranial magnetic stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Benefits do not include:

- Treatment for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health and Substance Use Disorders in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when you do not require acute inpatient care.

Medically Necessary acute inpatient substance use disorder detoxification is covered under the Hospital services Benefit.

Physician and other professional services

Benefits are available for services performed by a Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition.

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;

- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person; and
- Teladoc general medical consultations.

See the *Mental Health and Substance Use Disorder Benefits* section for information on Mental Health and Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for conditions other than diabetes. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to receive medical nutrition therapy as long as your treatment is Medically Necessary. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

Benefits are available for formulas and special food products if you are diagnosed with phenylketonuria (PKU). The items must be prior authorized part of a diet prescribed and managed by a Physician or appropriately-licensed Health Care Provider.

Benefits include:

- Enteral formulas; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods used by the general population; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

Benefits are available for the diagnosis and treatment of conditions of the foot, ankle, and related structures. These services, including surgery, are generally provided by a licensed doctor of podiatric medicine.

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;

- Elective newborn circumcision within 90 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized; and
- Abortion and abortion-related services, including pre-abortion and follow-up services.

See the *Diagnostic X-ray, imaging, pathology, and laboratory services* and *Preventive Health Services* sections for information about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
  - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
  - Screening for HPV;
  - Screening for osteoporosis; and
  - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- Adverse Childhood Experiences screenings;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. See the *Family planning Benefits* section for more information.

If there is a new recommendation or guideline in any of the resources described above, Blue Shield will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the plan year that begins after that year. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

Visit ***blueshieldca.com/preventive*** for more information about ***Preventive Health Services***.

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to:
  - Improve function; or
  - Create a normal appearance to the extent possible;
- Dental and orthodontic surgery services directly related to cleft palate repair; and
- Surgery and surgically-implanted prosthetic devices in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance;
- Reconstructive Surgery when there is a more appropriate procedure that will be approved; or
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

In accordance with the WHCRA, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered for either breast to restore and achieve symmetry following a mastectomy, and for the treatment of the physical complications of a mastectomy, including lymphedemas. For coverage of prosthetic devices following a mastectomy, see the *Durable medical equipment* section. Medically Necessary services will be determined by your attending Physician in consultation with you.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

Rehabilitative and habilitative services

Benefits are available for outpatient rehabilitative and habilitative services. Rehabilitative services help to restore the skills and functional ability you need to perform Activities of Daily Living when you are disabled by injury or illness. Habilitative services are therapies that help you learn, keep, or improve the skills or functioning you need for Activities of Daily Living.

These services include physical therapy, occupational therapy, and speech therapy. Your Physician or Health Care Provider must prepare a treatment plan. Treatment must be provided by an appropriately-licensed or certified Health Care Provider. You can continue to receive rehabilitative or habilitative services as long as your treatment is Medically Necessary.

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

See the *Hospital services* section for information about inpatient rehabilitative Benefits.

See the *Home health services* and *Hospice program services* sections for information about coverage for rehabilitative and habilitative services provided in the home.

Physical therapy

Physical therapy uses physical agents and therapeutic treatment to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents and therapeutic treatments include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage as a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan.

Occupational therapy

Occupational therapy is treatment to develop, improve, and maintain the skills you need for Activities of Daily Living, such as dressing, eating, and drinking.

Speech therapy

Speech therapy is used to develop, improve, and maintain vocal or swallowing skills that have not developed according to established norms or have been impaired by a diagnosed illness or injury. Benefits are available for outpatient speech therapy for the treatment of:

- A communication impairment;
- A swallowing disorder;
- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the *Summary of Benefits* section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

Transplant services

Benefits are available for tissue and kidney transplants and special transplants.

Tissue and kidney transplants

Benefits are available for facility and professional services provided in connection with human tissue and kidney transplants when you are the transplant recipient.

Benefits include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special transplants

Benefits are available for special transplants only if:

- The procedure is performed at a special transplant facility contracting with Blue Shield, or if you access this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield; and
- You are the recipient of the transplant.

Special transplants are:

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

Donor services

Transplant Benefits include coverage for donation-related services for a living donor, including a potential donor, or a transplant organ bank. Donor services must be directly related to a covered transplant for a Member of this plan.

Donor services include:

- Donor evaluation;

- Harvesting of the organ, tissue, or bone marrow; and
- Treatment of medical complications for 90 days after the evaluation or harvest procedure.

Urgent care services

Level I Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health.

If you need to visit an urgent care center and you are close to home, you should go to the urgent care center designated by your Medical Group. If you are away from home and need urgent care, you may visit any urgent care center near you.

See the *Out-of-area services* section for information on urgent care services outside California.

Exclusions and limitations

This section describes the general exclusions and limitations that apply to all your plan Benefits.

	General exclusions and limitations
1	This plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary. This exclusion does not apply to services which Blue Shield is required by law to cover for Reconstructive Surgery.
2	Routine physical examinations solely for: • Immunizations and vaccinations, by any mode of administration, for the purpose of travel; or • Licensure, employment, insurance, court order, parole, or probation. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
3	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	Routine foot care items and services that are not Medically Necessary, including: • Callus treatment; • Corn paring or excision; • Toenail trimming; • Over-the-counter shoe inserts or arch supports; or • Any type of massage procedure on the foot. This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.
5	Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board. Domiciliary care is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
6	Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.

	General exclusions and limitations
7	Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the *Home infusion and injectable medication services* and *PKU formulas and special food products* sections, or as provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
8	Unless selected as an optional Benefit by your Employer, hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.
9	Eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
10	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section.
11	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections.
12	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.
13	Unless selected as an optional Benefit by your Employer, any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, 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, or services incident to reversal of surgical sterilization except for Medically Necessary treatment of medical complications of the reversal procedure.

	General exclusions and limitations
14	Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits, or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
15	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
16	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
17	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.
18	Select physical and occupational therapies, such as: • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
19	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.
20	Services or Drugs that are Experimental or Investigational in nature.

General exclusions and limitations

21	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that 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.
22	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
23	Member convenience items, such as internet, phones, televisions, guest trays, and personal hygiene items.
24	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.
25	Services incident to any injury or disease arising out of, or in the course of, 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, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.
26	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
27	Drugs dispensed by a Physician or Physician's office for outpatient use.

Grievance process

Blue Shield has a formal grievance process to address any complaints, disputes, requests for reconsideration of health care coverage decisions made by Blue Shield, or concerns with the quality of care you received from a provider. Blue Shield will receive, review, and resolve your grievance within the required timeframes.

Submitting a grievance

If you have a question about your Benefits or any action taken by Blue Shield (or a Benefit Administrator), your first step is to make an inquiry through Customer Service. If Customer Service is not able to fully address your concerns, you can then submit a grievance or ask the Customer Service representative to submit one for you. If Blue Shield denies authorization or coverage for health care services, you can appeal the denial and Blue Shield will reconsider your request.

You have 180 days after a denial or other incident to submit your grievance to Blue Shield. Your provider, or someone you choose to represent you, can also submit a grievance on your behalf.

The fastest way to submit a grievance is online at blueshieldca.com. You can also submit the form by mail or begin the grievance process by calling Customer Service.

Where to mail grievances

Type of grievance	*Address*
Medical Benefits, and prescription Drug Benefits	Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762
Mental Health and Substance Use Disorder services from an MHSA Participating Provider	Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171
Mental Health and Substance Use Disorder services from an MHSA Non-Participating Provider	Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762

Once Blue Shield or the MHSA receives your grievance, they will send a written acknowledgment within five calendar days.

Blue Shield will resolve your grievance and provide a written response within 30 calendar days. The response will explain what action you can take if you are not satisfied with how your grievance is resolved.

Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, or when you are experiencing severe pain.

Blue Shield will make a decision within three calendar days for expedited grievance requests related to medical Benefits and Mental Health and Substance Use Disorder services.

Once a decision is made, Blue Shield will notify you and your provider as soon as possible to accommodate your condition.

California 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 **1-855-256-9404** 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, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **(www.dmhc.ca.gov)** has complaint forms, IMR application forms, and instructions online.

If you feel Blue Shield improperly cancels, rescinds, or does not renew coverage for you or your Dependents, you can submit a request for review to Blue Shield or to the Director of the California Department of Managed Health Care. Any request for review submitted to Blue Shield will be treated as an expedited grievance request.

Independent medical review

You may be eligible for an independent medical review if your grievance involves a claim or service for which coverage was denied on the grounds that the service is:

- Not Medically Necessary; or
- Experimental or Investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996).

You can apply to the Department of Managed Health Care (DMHC) for an independent medical review of the denial. For a Medical Necessity denial, you must first submit a grievance to Blue Shield and wait for at least 30 days before requesting an

independent medical review. However, if the request qualifies for an expedited review as described above, or if it involves a determination that the requested service is Experimental or Investigational, you may request an independent medical review as soon as you receive a notice of denial from Blue Shield. The DMHC's application for independent medical review is included with your appeal outcome letter.

The DMHC will review your application. If the request qualifies for independent medical review, the DMHC will select an independent review organization to conduct a clinical review of your medical records. You can submit additional records for consideration as well. There is no cost to you for this independent medical review. You and your provider will receive copies of the independent medical review determination. The decision of the independent review organization is binding on Blue Shield. If the reviewer determines that the requested service is clinically appropriate, Blue Shield will arrange for the service to be provided or the disputed claim to be paid.

The independent medical review process is in addition to any other procedures or remedies available to you to resolve coverage disputes. It is completely voluntary. You are not required to participate in the independent medical review process, but if you do not, you may lose your statutory right to pursue legal action against Blue Shield regarding the disputed service.

ERISA review

If your Employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your Employer-sponsored plan may have other voluntary alternative dispute resolution options, such as mediation.

Other important information about your plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document and is part of the contractual agreement between the Subscriber and Blue Shield.

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 46 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when an eligible Subscriber or Dependent can enroll in, or change enrollment in, a health plan. The special enrollment period is 30 days following the date of a Qualifying Event except as otherwise specified below and will be required to furnish Blue Shield written evidence of loss of coverage. The following are examples of Qualifying Events. For complete details and a determination of eligibility for special enrollment, please consult your Employer.

- Loss of eligibility for coverage, including the following:
  - The eligible Employee or Dependent loses coverage under another employer health benefit plan or other health insurance and meets all of the following requirements:
    - The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time the Employee was initially offered enrollment under this Plan;
    - If required by the Employer, the Employee certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that the Employee was given notice that such certification was required and that failure to comply could result in later treatment as a Late Enrollee;
  - The Employee or Dependent was eligible for coverage under the Healthy Families Program or Medi-Cal and such coverage was terminated due to loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage;
  - The eligible Employee or Dependent loses coverage due to legal separation, divorce, loss of dependent status, death of the Employee, termination of employment, or reduction in the number of hours of employment;
  - In the case of coverage offered through an HMO, loss of coverage because the eligible Employee or Dependent no longer resides, lives,

or works in the service area (whether or not within the choice of the individual), and if the previous HMO coverage was group coverage, no other benefit package is available to the Employee or Dependent;
    - Termination of the employer health plan or contributions to Employee or Dependent coverage;
    - Exhaustion of COBRA group continuation coverage; or
- The Employee or Dependent is eligible for coverage under the Healthy Families Program or Medi-Cal premium assistance program, provided that enrollment is within 60 days of the notice of eligibility for these premium assistance programs;
- A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit plan. The health plan shall enroll a Dependent child effective the first day of the month following presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party or the Employer, as described in Sections 3751.5 and 3766 of the Family Code; or
- An eligible Employee acquires a Dependent through marriage, establishment of domestic partnership, birth, or placement for adoption. Applies to both the Employee and the Dependent.

Cancellation for Employer's nonpayment of Premiums

Premium grace period

After payment of the first Premium, your Employer has a 45-day grace period from the due date to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. Coverage will continue through the grace period. However, if your Employer does not pay all outstanding Premiums within the grace period, coverage will end the day following the 45-day grace period. Your Employer will be liable for all Premiums owed, even if coverage is canceled. This includes Premiums for coverage during the 45-day grace period. Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the day coverage ends.

Out-of-area services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Services outside of California, the claims for those services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue) and will be covered under Level I or Level II. Non-participating providers don't contract with the Host Blue and will be covered

under Level III. Blue Shield's payment practices for both kinds of providers are described below and in the *Health care professionals and facilities* section of this Evidence of Coverage.

See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Arrangements

BlueCard® Program (Level I)

Emergency Services. Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition, under Level I of your POS plan.

BlueCard® Program (Level II)

Under the BlueCard® Program, Level II benefits will be provided for Covered Services received from a participating provider outside of California, but within the BlueCard® Service Area, except for those Level II services described above. When you receive Covered Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Evidence of Coverage. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

Whenever you receive Level II Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard® Program, your Member share of cost for these services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Blue Shield.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the

price Blue Shield used for your claim because these adjustments will not be applied retroactively to claims already paid.

To find participating BlueCard® providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at bcbs.com and select "Find a Doctor."

Prior authorization may be required for non-emergency services. Please see the *Medical Management Programs* section for additional information on prior authorization and the *Emergency Benefits* section for information on emergency admission notification.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully-insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee as part of the claim charges passed on to you. Claims for covered Level I Emergency Services are paid based on the Allowed Charges as defined in this Evidence of Coverage.

BlueCard® Program (Level III)

When Level III Covered Services are provided outside of California and within the BlueCard® Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard® Program, you will have to pay the entire bill for your Level III medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Blue Shield of California for reimbursement. Blue Shield will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a Level III non-participating provider.

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services, as listed in the Summary of Benefits.

Blue Shield Global® Core (Level I)

Care for Covered Urgent and Emergency Services outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global® Core when accessing Level I Out-of-Area Covered Health Care Services. Blue Shield Global® Core is unlike the BlueCard® Program available within the BlueCard® Service Area in certain ways. For instance, although Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard® Service Area, you will typically have

to pay the providers and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Prior authorization is not required for Level I Emergency Services. In an emergency, go directly to the nearest hospital. Please see the *Medical Management Programs* section for additional information on emergency admission notification.

Submitting a Blue Shield Global® Core claim

When you pay directly for services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Shield Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Blue Shield Value-Based Programs

You may have access to Covered Services from providers that participate in a Blue Shield Value-Based Program. Blue Shield Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes, and Shared Savings arrangements.

If you receive covered services under a Blue Shield Value-Based Program, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement.

BlueCard® Program

If you receive Level II Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that

are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Limitation for duplicate coverage

Medicare

Blue Shield will provide Benefits before Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws); or
- You are eligible for Medicare solely due to end-stage renal disease during the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare.

Blue Shield will provide Benefits after Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

When Blue Shield provides Benefits after Medicare, your combined Benefits from Medicare and Blue Shield may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You do not have to pay any Blue Shield Deductibles, Copayments, or Coinsurance.

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, Blue Shield will pay the reasonable value or the Allowable Amount for Covered Services you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or the Allowable Amount for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and Blue Shield will equal but not be more than what Blue Shield would pay if you were not eligible for Benefits under that coverage. Blue Shield will provide Benefits based on the reasonable value or the Allowable Amount.

Exception for other coverage

A Participating Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this plan.

If you recover from a third party the reasonable value of Covered Services received from a Participating Provider, the Participating Provider is not required to accept the fees paid by Blue Shield as payment in full. You may be liable to the Participating Provider for the difference, if any, between the fees paid by Blue Shield and the reasonable value recovered for those services.

Reductions – third-party liability

If you are injured or become ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the plan and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for services provided to you on a fee-for-service basis from any recovery (defined below) obtained by or on your behalf, from or on behalf of the third party responsible for the injury or illness, and you must agree to the provisions below. In addition, if you are injured and no other person is responsible but you receive (or are entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, you must agree to the following provisions.

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance, or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for Benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay you or your representatives. For purposes of this provision, your representatives include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is Blue Shield's right of recovery.
- Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery you receive as a result of the injury or illness. This includes any amount awarded to you or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party or third-party insurer, related to the illness or injury (the "Recovery"), whether or not you have been "made whole" by the Recovery. The amount Blue Shield seeks as restitution, reimbursement, or other available remedy will be calculated in accordance with California Civil Code Section 3040.
- Blue Shield will not reduce its share of any Recovery unless, in the exercise of our discretion, Blue Shield agrees in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.

- You must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. You must not take any action that may prejudice Blue Shield's right of recovery.
- You must tell Blue Shield promptly if you have made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for. You must seek recovery of Blue Shield's payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of your claim in order to be reimbursed to the full amount of Benefits Blue Shield has paid or will pay.

Blue Shield may request that you sign a reimbursement agreement consistent with this provision. Your failure to comply with the above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

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

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

- Ensure that any recovery is kept separate from and not comingled with any other funds or your general assets;
- Agree in writing that the portion of any recovery required to satisfy the lien or other right of recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield; and
- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

Coordination of benefits, continued

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable expenses. The coordination of benefits rules also determine which group health plan is primary and prevent delays in benefit payments. Blue Shield follows the rules for coordination of benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group health plans:

- When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering you as an Employee will provide its benefits before the plan covering you as a Dependent.
- Coverage for Dependent children:

    - When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
    - When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:
        - The plan of the custodial parent;
        - The plan of the stepparent; then
        - The plan of the non-custodial parent.
- If the above rules do not apply, the plan which has covered you for the longer period of time is the primary plan. There may be exceptions for laid-off or retired Employees.
- When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.
- Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

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

General provisions

Independent contractors

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts, or omissions of any person providing services, including any Physician, Hospital, or other Health Care Provider or their employees.

Assignment

The Benefits of this plan may not be assigned without the written consent of Blue Shield. Level I and Level II Participating Providers are paid directly by your Medical Group or Blue Shield. When you receive Covered Services from a Level III Non-Participating Provider, Blue Shield, at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider. The Subscriber must make sure the Non-Participating Provider receives the full billed amount for non-emergency services, whether or not Blue Shield makes payment to the Non-Participating Provider.

Plan interpretation

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

Public policy participation procedure

Blue Shield allows Members to participate in establishing the public policy of Blue Shield. Such participation is not to be used as a substitute for the grievance process.

Recommendations, suggestions or comments should be submitted in writing to:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: (510) 607-2065

Please include your name, address, phone number, Subscriber number, and group number with each communication. Please state the public policy issue clearly. Submit all relevant information and reasons for the policy issue with your letter.

Public policy issues will be heard as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes.

At least one third of the Board of Directors is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from the Sr. Manager, Regulatory Filings as listed above.

Access to information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this plan and the Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in the Member's possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without the Member's consent, except as otherwise permitted or required by law.

Right of recovery

Whenever payment on a claim is made in error, Blue Shield has the right to recover such payment from the Subscriber or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, Blue

Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber's coverage, or payments made on fraudulent claims.

ERISA information

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

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

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

Summary plan description

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

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

Employer's name (plan sponsor) and address:

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

Employer's Identification Number (EIN):

95-6995453

Name of plan:

California Association of Professional Employees Benefit Trust

Plan number:

501

Plan description:

Group health service plan.

Contract year:

The plan year ends on December 31, 2023.

Type of administration:

The Plan is administered by contract.

Plan Administrator:

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

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

Name of Trustee:

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

Funding of plan:

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

Health care service plan issuer:

The medical benefits in this Evidence of Coverage are guaranteed under a contract issued by the issuer. The issuer provides various administrative services including claims administration. The issuer of the contract is Blue Shield of California, 601 12th Street, Oakland, California, 94607.

Eligibility:

Refer to the Eligibility for this plan section of this booklet.

Termination of benefits:

Refer to the When coverage ends section of this booklet.

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

Benefits:

Refer to the Your Benefits section of this booklet.

To claim benefits:

Refer to the Claims section of this booklet.

Statement of ERISA rights

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

- Receive information about your plan and Benefits
  - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the plan, including Group Health Service Contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including the Group Health Service Contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue group health plan coverage
  - Continue health care coverage for yourself, spouse or dependent if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
  - California law also limits the circumstances under which a group health plan may exclude coverage for medical conditions present before an individual enrolled. The California law applies only to insurance and HMO contracts issued, amended, delivered or renewed in California.
- Prudent actions by plan fiduciaries
  - In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- Enforce your rights
  - If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating

to this decision without charge, and to appeal any denial, all within certain time schedules.
    - Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
    - If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- Assistance with your questions
    - If you have any questions about your plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Definitions

Adverse Childhood Experiences	An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.
Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Allowed Charges	The amount a Participating Provider agrees to accept as payment from Blue Shield or the billed amount for Non-Participating Providers (except that Physicians rendering Emergency Services, Hospitals which are not Participating Providers rendering any services, and non-contracting dialysis centers rendering any services when authorized by Blue Shield will be paid based on the Reasonable and Customary Charge, as defined).

Allowable Amount	The maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Evidence of Coverage, the Allowable Amount is:
	• 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 rendered.
	• For a Non-Participating Provider who provides Emergency Services:
	  ○ Physicians and Hospitals: the amount is the Reasonable and Customary amount; or
	  ○ All other providers: (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under state and federal laws.
	• For a Non-Participating Provider in California, 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 but not exceeding any stated Benefit maximum;

	○ Non-Participating dialysis center: for services prior authorized by Blue Shield, the amount is the Reasonable and Customary amount. • For a provider outside of California but inside the BlueCard® Service Area, the lower of: ○ The provider's billed charge, or ○ The local Blue Plan's Participating Provider payment or the pricing arrangement required by applicable state law. • For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core. • For a Non-Participating Provider outside of California (within the BlueCard® Service Area) 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. Or, if applicable, the amount determined under federal law. • For Blue Shield's contracted Benefit Administrators (MHSA, DPA, VPA), the Allowable Amount is based on the administrator's contracted rate for its participating providers. Where required under federal law, the Allowable Amount used to determine your Cost Share may be based on the plan's "qualifying payment amount," which may differ from the amount Blue Shield pays the Non-Participating Provider or facility for Covered Services.
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
ASH Participating Provider	A Physician or Health Care Provider under contract with ASH Plans to provide Covered Services to Members.
Behavioral Health Treatment (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or

	autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Benefit Administrator	Administrator for specialized Benefits such as Mental Health and Substance Use Disorder Benefits.
Blue Shield of California	California Physicians' Service, d/b/a Blue Shield of California, is a California not-for-profit corporation, licensed as a health care service plan. It is referred to throughout this Evidence of Coverage as Blue Shield.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.

Deductible	The Calendar Year amount you must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Contract.
Dependent	An individual who is enrolled and maintains coverage under the Contract, and who meets one of the following eligibility requirements: • A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber. • A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Evidence of Coverage. • A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

Domestic Partner	An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements:
	• Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
	• The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
	• The partners are:
	  ○ not currently married to someone else or a member of another domestic partnership, and
	  ○ not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
	• Both partners are capable of consenting to the domestic partnership; and
	• The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the

	above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code). The domestic partnership is deemed created on the date when both partners meet the above requirements.
Emergency Medical Condition	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.
Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical

	Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.
Employee	An individual who meets the eligibility requirements set forth in the Contract between Blue Shield and the Employer.
Employer (Contractholder)	County of Los Angeles Chief Administrative Office 3333 Wilshire Blvd., 10th Floor Los Angeles, CA 90010
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services that require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies that themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.
Family	The Subscriber and all enrolled Dependents.
Former Participating Provider	A Former Participating Provider is a provider of services to the Member under any of the following conditions: • A provider who is no longer available to you as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a*

	Former Participating Provider table in the *Continuity of care* section. • A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section. • A provider who is a Participating Provider with Blue Shield or the MHSA but no longer available to you as a Participating Provider or an MHSA Participating Provider because: o The Employer has terminated its contract with Blue Shield; and o The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider or the MHSA Participating Provider in its network; and o At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
Generally Accepted Standards of Mental Health and Substance Use Disorder Care	Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include: • Peer-reviewed scientific studies and medical literature; • Clinical practice guidelines and recommendations of nonprofit health care provider professional associations; • Specialty societies and federal government agencies; and • Drug labeling approved by the United States Food and Drug Administration.
Group Health Service Contract (Contract)	The contract for health coverage between Blue Shield and the Employer (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.

Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Massage therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law; • Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • Registered respiratory therapist; • Speech and language pathologist.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

	A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria: • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.
Infertility	May be either of the following: • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.
Intensive Outpatient Program	An outpatient treatment program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.
Inter-Plan Arrangements	Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Late Enrollee	An eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the

	earlier of 12 months from the date that would have been considered the initial enrollment date or at the Employer's next open enrollment period.
Medical Group	An organization of Physicians who are generally located in the same facility and provide Benefits to Members, or an independent practice association (a group of Physicians in individual offices who form an organization to contract, manage, and share financial responsibilities for providing Benefits to Members).
Medical Group Service Area	The geographic area served by the Medical Group.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are: • Consistent with Blue Shield medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and

	• Inpatient rehabilitation that can be provided on an outpatient basis. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants. This definition does not apply to services which Blue Shield is required by law to cover for Reconstructive Surgery or to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.
Medically Necessary Treatment of a Mental Health or Substance Use Disorder	A Covered Service or product addressing the specific needs of a Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: • In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care; • Clinically appropriate in terms of type, frequency, extent, site, and duration; and • Not primarily for the economic benefit of the disability insurer and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.
Member	An individual who is enrolled and maintains coverage in the plan pursuant to the Contract as either a Subscriber or a Dependent. Use of "you" in this document refers to the Member.
Mental Health and Substance Use Disorder(s)	A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
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 administer Blue Shield's Mental Health and Substance Use Disorder 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 use disorder services.

MHSA Participating Provider	A provider who has an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.
Non-Participating (Non-Participating Provider)	Any provider who does not participate in this plan's network and does not contract with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services. Also referred to as an out-of-network provider.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorders, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area.
Out-of-Pocket Maximum	The highest Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowed Charges, Allowable Amount, or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.

Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.
Participating Hospice or Participating Hospice Agency	An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits.
Participating (Participating Provider)	A provider who participates in this plan's network and contracts with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan Service Area	A geographical area designated by the plan within which a plan shall provide health care services.
Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician. Your PCP will provide your primary care and refer, authorize, supervise, and coordinate the provision of your Benefits.
Provider Incentive	An additional amount of compensation paid to a Health Care Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
Reasonable and Customary	In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider. Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency

	Services as shown in the Summary of Benefits, or if applicable, the amount determined under state and federal law.
Reconstructive Surgery	Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: • Improve function; or • Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and • Other designated as appropriate.
Subacute Care	Skilled Nursing or skilled rehabilitation provided in a hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Subscriber	An eligible Employee who is enrolled and maintains coverage under the Contract.

Third-Party Corporate Telehealth Provider	A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.
Total Disability (Totally Disabled)	In the case of an Employee, or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity. In the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
Urgent Services	Those Covered Services rendered outside of the Medical Group Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Medical Group Service Area.

Notices about your plan

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

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

Notice about this group health plan: Blue Shield makes this health plan available to Employees through a contract with the Employer. The Contract includes the terms in this Evidence of Coverage, as well as other terms. A copy of the Contract is available upon request. A Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage. The Summary of Benefits sets forth your Cost Share for Covered Services under this plan.

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as specifically provided under the *Extension of Benefits* section and, when applicable, the *Continuity of care* and *Continuation of group coverage* sections. Blue Shield may change Benefits during the term of coverage as specifically stated in this Evidence of Coverage. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your plan 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 contact Customer Service to ensure that you can obtain the health care services you need.

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

Notice about telehealth: You have the right to access your medical records. The records of any services provided to you through a Third-Party Corporate Telehealth Provider will be shared with your PCP, unless you object.

You can receive Covered Services on an in-person basis or via telehealth, if available, from your PCP, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the Timely Access to Care section.

If your plan includes Covered Services from Non-Participating Providers, you can receive the Covered Service either on an in-person basis or via telehealth.

Please see the Health care professionals and facilities section for additional information.

Notice about Manifest MedEx participation: Blue Shield participates in the Manifest MedEx health information exchange (HIE). Blue Shield makes its Members' health information available to Manifest MedEx for access by their authorized Health Care Providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized Health Care Providers may securely access their patients' health information through the Manifest MedEx HIE to support the provision of care.

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

You have the right to direct Manifest MedEx not to share your health information with your Health Care Providers. Although opting out of Manifest MedEx may limit your Health Care Provider's ability to quickly access important health care information about you, your Blue Shield coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or Hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

If you do not wish to have your health care information displayed in Manifest MedEx, you should fill out the online form at manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142.

Notice about organ and tissue donation: Thousands of people in the United States need an organ or tissue transplant. Each person on the transplant waiting list faces death while waiting for an available organ or tissue.

Many Californians are eligible to become organ and tissue donors. To learn more about organ and tissue donation, or to register as a donor, visit Donor Network West (donornetworkwest.org) or Donate Life California (donatelifecalifornia.org). You may also call the nearest city's regional organ procurement agency for additional information.

Notice about confidentiality of personal and health information: Blue Shield protects the privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service or by visiting blueshieldca.com.

Members who are concerned that Blue Shield may have violated their privacy rights, or who disagree with a decision Blue Shield made about access to their individually-identifiable personal information, may contact Blue Shield at:

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

Notice about confidential communication requests: A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to

blueshieldca.com/privacy and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

Mail: Blue Shield of California Privacy Office, P.O. Box 272540, Chico CA, 95927-2540
Email: privacy@blueshieldca.com
Fax: 1-800-201-9020

blue of california

Outpatient Prescription Drug Rider

Group Rider
POS

California Association of Professional Employees
Custom POS Plans
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

	When using a Participating[2] Pharmacy	
Calendar Year Pharmacy Deductible	*Per Member* $0	
Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Diabetic Testing Supplies	$0	
Formulary Generic Drugs	$5/prescription	
Formulary Brand Drugs	$15/prescription	
Non-Formulary Brand Drugs	$30/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	

Prescription Drug Benefits[3,4]	Your payment	
	When using a Participating Pharmacy[2]	CYPD[1] applies
Diabetic Testing Supplies	$0	
Formulary Generic Drugs	$10/prescription	
Formulary Brand Drugs	$30/prescription	
Non-Formulary Brand Drugs	$60/prescription	
Network Specialty Pharmacy Drugs		
Per prescription, up to a 30-day supply.		
Specialty Drugs	20% up to $100/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay do not count towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

Notes

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the Formulary Generic Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Benefit designs may be modified to ensure compliance with State and Federal requirements.
MS072622_GF

Prescription Drug Benefits

Benefits are available for outpatient prescription Drugs as described in this supplement. This Prescription Drug Benefit is separate from the medical Plan coverage. The Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Rider. However, the Calendar Year Out-of-Pocket Maximum, general provisions and exclusions of the Group Health Service Contract apply.

Outpatient prescription Drugs are self-administered Drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies that are prescribed and are not provided for use on an inpatient basis. Drugs also include diabetic testing supplies and self-applied continuous blood glucose monitors. Glucose monitors are also covered under the Durable medical equipment section of your Evidence of Coverage.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from a Participating Pharmacy, except as noted below. Drugs, items, and services that are not covered under this Benefit are listed in the *Exclusions and limitations* section.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization to be covered. The prior authorization process is described in the *Prior authorization/exception request process/step therapy* section. You or your Physician may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of FDA-approved preferred Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs.

Blue Shield's Formulary is established and maintained by Blue Shield's Pharmacy and Therapeutics (P&T) Committee. This committee consists of Physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year.

Your Physician or Health Care Provider might prescribe a Drug even though it is not included in the Blue Shield Formulary.

The prescription drug benefit is tiered, as described in the chart below. Your Copayment or Coinsurance will vary based on the drug tier.

Formulary Drug tiers
Formulary Generic Drugs
Formulary Brand Drugs
Non-Formulary Brand Drugs
Specialty Drugs

Visit ***blueshieldca.com/pharmacy***, use the Blue Shield mobile app, or contact Customer Service for more information on the ***Drug Formulary*** or to request a printed copy of the Formulary.

Obtaining outpatient prescription Drugs at a Participating Pharmacy

You must present a Blue Shield ID Card at a Participating Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. See the *Obtaining Specialty Drugs from a Network Specialty Pharmacy* section for more information.

Visit ***blueshieldca.com/pharmacy*** or use the Blue Shield mobile app to locate a *retail Participating Pharmacy*.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

You are responsible for paying 100% of the cost of Drugs that are not on the Blue Shield Formulary and Drugs listed in Tier 3, unless you get Prior Authorization for the non-Formulary or Tier 3 Drug.

There is no Copayment or Coinsurance for generic, FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance only when Medically Necessary.

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you pay the difference in cost, plus the Generic Drug Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Generic Drug Copayment or Coinsurance. For

example, you select Brand Drug A when there is an equivalent Generic Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300 and the contracted rate for Generic Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the Generic Drug Copayment or Coinsurance. This difference in cost does not apply to your Deductible or your Out-of-Pocket Maximum responsibility.

If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you can request an exception to paying the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity.

See the *Prior authorization/exception request/step therapy process* section for more information on the prior authorization process and exception requests. If the request is approved, you pay only the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

Blue Shield created a Patient Review and Coordination (PRC) program to help reduce harmful prescription drug misuse and the potential for abuse. Examples of harmful misuse include obtaining an excessive number of prescription medications or obtaining very high doses of prescription opioids from multiple providers or pharmacies within a 90-day period. If Blue Shield determines a Member is using prescription drugs in a potentially harmful, abusive manner, Blue Shield may, subject to certain exemptions and upon 90 days' advance notice, restrict a Member to obtaining all non-emergent outpatient prescriptions drugs at a single pharmacy home. This restriction applies for a 12-month period and may be renewed. The pharmacy home, a single Participating Pharmacy, will be assigned by Blue Shield or a Member may request to select a pharmacy home. Blue Shield may also require prior authorization for all opioid medications if sufficient medical justification for their use has not been provided. Members that disagree with their enrollment in the PRC program can file an appeal or submit a grievance to Blue Shield as described in the *Grievance process* section of your Evidence of Coverage. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Customer Service at the number listed on their Identification Card.

Obtaining outpatient prescription Drugs from the mail service pharmacy

You have an option to receive prescription Drugs from the mail service pharmacy when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of the Drug, which may save you money. You may enroll in this program online, by phone, or by mail. Once enrolled, please allow up to 14 days to receive the Drug. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the mail service pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the mail service pharmacy.

You must pay the applicable mail service prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com or use the Blue Shield mobile app for additional information about how to get prescription Drugs from the mail service pharmacy.

Obtaining Specialty Drugs from a Network Specialty Pharmacy

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

Specialty Drugs are only available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, at your request, will transfer the Specialty Drug to an associated retail store for pickup.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA.

To be covered, most Specialty Drugs require prior authorization by Blue Shield, as described in the *Prior authorization/exception request/step therapy process* section.

Drug manufacturers or other third parties may offer Drug discounts or copayment assistance for certain Drugs. These types of programs can lower your out-of-pocket costs. If you receive any discounts at a Network Specialty Pharmacy, only the amount you pay will be applied to any applicable Deductible and Out-of-Pocket Maximum.

Visit blueshieldca.com for a complete list of Specialty Drugs or to select a Network Specialty Pharmacy.

Prior authorization/exception request/step therapy process

Some Drugs and Drug quantities require approval based on Medical Necessity before they are eligible for coverage under this Benefit. This process is prior authorization.

A non-Formulary Drug may be covered when approved by Blue Shield through the exception process.

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy; and
- Some brand contraceptives, in order to be covered without a Copayment or Coinsurance.

You pay the Formulary Brand Drug Copayment or Coinsurance for covered compounded medications.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

Prior authorization decisions are based on the following:

- The requested Drug, dose, and/or quantity is both safe and Medically Necessary for the specified use;
- You have tried and failed Formulary alternative(s), or they are inappropriate;
- You are stable on treatment, and changing to an alternative may cause immediate harm;
- You have tried and failed Drug(s) recommended as initial treatment, or they are inappropriate; and
- Relevant clinical information supports the use of the requested medication over Formulary Drug alternatives.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a Drug should be used, nationally recognized treatment guidelines, medical studies, information from the Drug manufacturer, and the relative cost of treatment for a condition. If your Physician or Health Care Provider believes that step therapy coverage requirements for a prescription need not be met and that the Drug is Medically Necessary, the step therapy exception process must be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

If Blue Shield denies a request for prior authorization or an exception request, you, your representative, your Physician, or your Health Care Provider can file a grievance with Blue Shield. See the *Grievance process* section of your Evidence of Coverage for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Limitation on quantity of Drugs that may be obtained per prescription or refill

Except as otherwise stated in this section, you may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

If you, your Physician, or your Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, your Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.

Blue Shield has a short cycle Specialty Drug program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for the initial prescription. This program allows you to receive a 15-day supply of the Specialty Drug to help determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save money if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You, your Physician, or your Health Care Provider may choose a full 30-day supply for the first fill.

If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug.

Visit ***blueshieldca.com/pharmacy*** for a list of *Specialty Drugs* in the *short cycle Specialty Drug program*.

You may receive up to a 90-day supply of Drugs from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable mail service Copayment or Coinsurance listed in the *Summary of Benefits* section. Refill authorizations cannot be combined to reach a 90-day supply.

Select over-the-counter 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.

You may receive up to a 12-month supply of contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

Exclusions and limitations

This section describes the exclusions and limitations that apply to this Outpatient prescription Drug Benefit. You may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Evidence of Coverage to determine if the plan covers Drugs under that Benefit.

	Outpatient prescription Drug exclusions and limitations
1	Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Evidence of Coverage.
2	Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital services* and *Skilled Nursing Facility (SNF) services* sections of your Evidence of Coverage.
3	Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician.
4	Drugs that are Experimental or Investigational in nature.
5	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 *Durable medical equipment* section of your Evidence of Coverage.
6	Blood or blood products. See the *Hospital services* section of your Evidence of Coverage.
7	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.
8	Medical food, dietary, or nutritional products. See the *Home health services, Home infusion and injectable medication services, PKU formulas and special food products* sections of your Evidence of Coverage.
9	Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home health services, Home infusion and injectable medication services, Hospice program services,* or *Family Planning* sections of your Evidence of Coverage.
10	All Drugs related to assisted reproductive technology.

Outpatient prescription Drug exclusions and limitations

11	Compounded medications unless all of the following requirements are met: • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially available, medically appropriate alternatives; and • The compounded medication is self-administered.
12	Replacement of lost, stolen or destroyed Drugs.
13	If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice program services* section of your Evidence of Coverage.
14	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.
15	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list.
16	Immunizations and vaccinations solely for the purpose of travel.
17	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
18	Prescription Drugs that are repackaged by an entity other than the original manufacturer.

Definitions

Anticancer Medications	Drugs used to kill or slow the growth of cancerous cells.
Brand Drugs	Drugs that are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer.
Calendar Year Pharmacy Deductible	The amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit.

Drugs	Drugs include the following:
	• FDA-approved medications that require a prescription either by California or Federal law;
	• Insulin;
	• Pen delivery systems for the administration of insulin, as Medically Necessary;
	• Self-applied continuous blood glucose monitors;
	• Diabetic testing supplies including the following:
	  ○ Lancets,
	  ○ Lancet puncture devices,
	  ○ Blood and urine testing strips, and
	  ○ Test tablets;
	• Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;
	• Contraceptive drugs and devices, including the following:
	  ○ Diaphragms,
	  ○ Cervical caps,
	  ○ Contraceptive rings,
	  ○ Contraceptive patches,
	  ○ Oral contraceptives,
	  ○ Emergency contraceptives, and
	  ○ Female OTC contraceptive products when ordered by a Physician or Health Care Provider;
	• Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers.

Formulary	A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.
Generic Drugs	Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency

	as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs.
Network Specialty Pharmacy	Select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.
Non-Participating Pharmacy	A pharmacy that does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.
Participating Pharmacy	A pharmacy that has contracted with Blue Shield to provide covered Drugs at certain rates. A Participating Pharmacy participates in the Blue Shield Pharmacy Network. Retail pharmacy participation may be at either Level A or Level B.
Schedule II Controlled Substance	Prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.
Specialty Drugs	Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available exclusively at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high-cost.

Please be sure to retain this document. It is not a Contract but is a part of your Evidence of Coverage.

blue of california

Acupuncture and Chiropractic Services Rider

Group Rider
Effective January 1, 2023
HMO/POS

CAPE Custom Chiro-Acu $10 Classic Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Unlimited visits per Member, per Calendar Year.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
Acupuncture Services		
Office visit	$10/visit	Not covered
Chiropractic Services		
Office visit	$10/visit	Not covered
Chiropractic Appliances	All charges above $50	Not covered

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your

Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Definitions	
American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Services to Members.

Musculoskeletal and Related Disorders	Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.
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blue of california

Hearing Aid Services Rider

Group Rider
Effective January 1, 2023
POS

California Association of Professional Employees Additional Coverage for POS plans
Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California hearing aid services Benefit.

Benefits	Your Payment
Up to a $1,000 maximum per Member in any 24-month period. Services are not subject to the Calendar Year Deductible.	**When using any provider**
Hearing Aid Services	
Hearing aid examinations for the appropriate type of hearing aid and/or for fittings, counseling and adjustments	All charges above $1,000
Hearing aid device checks	
Electroacoustic evaluations for hearing aids	
Hearing aid instrument, monaural or binaural, including ear mold(s) and the initial battery and cords	

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for hearing aid services, as described in this supplement. These hearing aid services Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply.

Because Blue Shield does not maintain a network of contracted providers for these services, the Benefits covered under this supplement can be received from any provider and you may submit a claim to Blue Shield for reimbursement.

Benefits

Benefits are available for hearing aid services as shown on the Summary of Benefits. Services are limited to a maximum payment per Member in any period, are not subject to the Calendar Year Deductible.

Blue Shield will reimburse you for Covered Services up to the maximum shown on the Summary of Benefits.

Submitting a Claim Form

Blue Shield will pay Members directly for services rendered. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to:

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

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's bill showing the services rendered, dates of treatment and the patient's name.

Blue Shield provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Exclusions

Benefits do not include:

- surgically implanted hearing devices;
- spare hearing aids;
- assisted listening devices or amplification devices;
- purchase of batteries or other equipment, except those covered under the terms of the initial hearing aid purchase;
- charges for a hearing aid that exceed specifications prescribed for correction of a hearing loss; or
- replacement parts for hearing aids, repair of hearing aids after the covered warranty period, and replacement of hearing aids more than once in any 24-month period.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.
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Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

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

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

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

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

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

Language access services

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

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

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

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

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

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

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

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

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

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

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