

Disclosure

PPO for Small Business Plans Disclosure Form

**Blue Shield Disclosure Form:
PPO for Small Business Plans**

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

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

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

To obtain a copy of the EOC or if you have questions about the benefits of the plan, please contact Blue Shield's Customer Service Department at 1-888-319-5999. The hearing impaired may contact Customer Services by calling the TTY number 711.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan Contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Blue Shield's Customer Service Department at 1-888-319-5999 to ensure that you can obtain the health care services that you need.

TABLE OF CONTENTS

How the Plan Works 1
Choice of Physicians and Providers 1
Mental Health, Behavioral Health, and Substance Use Disorder Services 1
Liability of Subscriber or Enrollee for Payment 1
Reimbursement Provisions 2
Ratio of Health Care Services 2
Facilities 2
Continuity of Care 2
Services for Emergency Care 2
Utilization Management..... 3
Principal Benefits and Coverages 3
Principal Exclusions and Limitations on Benefits 3
Medical Necessity Exclusion 6
Outpatient Prescription Drug Benefits 6
Pediatric Dental Benefits..... 12
Pediatric Vision Benefits 15
Prepayment Fees 17
Other Charges 17
Renewal Provisions 18
Plan Changes 18
Termination of Benefits 18
Grievance Process 19
Confidentiality of Personal and Health Information 19
Definitions..... 20

Pending Regulatory Approval

How the Plan Works

Choice of Physicians and Providers

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

Blue Shield PPO plans are designed for Members to receive the highest level of benefits when they obtain covered services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members have the choice to seek services from non-Participating Providers for most covered services. Covered Services obtained from non-Participating Providers will usually result in higher share of cost for the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider. Please be aware that a provider's status as a Participating Provider or MHSA Participating Provider may change. Participating Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and Other Providers. They are listed in the PPO Provider directory available on Blue Shield's website at <http://www.blueshieldca.com/FAP>.

Mental Health, Behavioral Health, and Substance Use Disorder Services

Blue Shield has contracted with a Mental Health Service Administrator (MHSA) to underwrite and deliver covered Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a unique network of MHSA Participating Providers.

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

Services is an MHSA Participating Provider. The MHSA Participating Provider directory is available on Blue Shield's website at <http://www.blueshieldca.com/FAP>.

If Members receive services at a facility that is an MHSA Participating Provider, MHSA's payment for Mental Health and Substance Use Disorder Services provided by a health professional at the MHSA Participating Provider facility will be paid at the MHSA Participating Provider level of Benefits, whether the health professional is an MHSA Participating Provider or MHSA Non-Participating Provider.

Prior authorization is required for all non-emergency Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder hospital admissions and Other Outpatient Mental Health Services and Behavioral Health Treatment and Substance Use Disorder Services except for electroconvulsive therapy and psychological testing. Blue Shield or the MHSA will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a person or when the person is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the person's condition not to exceed 72 hours from receipt of the request.

Liability of Subscriber or Enrollee for Payment

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

If a Member seeks services from a Non-Participating Provider, Blue Shield's payment

for a service by that Non-Participating Provider may be substantially less than the amount billed. The Member is responsible for the difference between the amount Blue Shield pays and the amount billed by Non-Participating Providers.

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

Reimbursement Provisions

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

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

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

Blue Shield contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the Contract.

Ratio of Health Care Services

For Blue Shield small group health plans in 2014, the ratio of the value of health services provided to the amount Blue Shield collected in premiums was 76.8% which means that for every dollar of premiums it collected, Blue Shield paid \$0.768 for health care services. The ratio was calculated after provider discounts were applied.

Facilities

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

Continuity of Care

Continuity of care with a Non-Participating Provider is available for the following Members: for Members who are currently seeing a provider who is no longer in the Blue Shield network; or for newly-covered Members whose previous health plan was withdrawn from the market.

Members who meet the eligibility requirements listed above may request continuity of care if they are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness. Continuity of care may also be requested for children who are up to 36 months old, or for Members who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment.

To request continuity of care, visit www.blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will review the request. The Non-Participating Provider must agree to accept Blue Shield's Allowable Amount as payment in full for ongoing care. When authorized, the Member may continue to see the Non-Participating Provider for up to 12 months at the Participating Provider rate.

Services for Emergency Care

Benefits will be provided anywhere in the world for the treatment of an Emergency Medical Condition. Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Arrangements. Covered Services received outside of California may be processed through an Inter-Plan Arrangement such as the BlueCard® or Blue Shield Global Core program.

For information on these programs, see the Inter-Plan Arrangements section of the EOC.

1. A Member who reasonably believes that he or she has an Emergency Medical Condition or mental health condition that requires an emergency response is encouraged to appropriately use the “911” emergency response system (where available) or seek immediate care from the nearest Hospital.
2. Medically Necessary emergency care is covered at the Participating Provider level. The member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowable Amount Blue Shield is obligated to pay.
3. A Member should notify Blue Shield (or the MHSA in the case of mental health Services) within 24 hours of receiving emergency Services or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition.
4. If the Member reasonably should have known that an Emergency Medical Condition did not exist, the services will be covered at the applicable Participating or Non- Participating Provider level of Benefits.

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

Utilization Management

State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services under the health plan.

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

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

Principal Benefits and Coverages

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

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

Principal Exclusions and Limitations on Benefits

General Exclusions

The PPO plans do not provide Benefits for the following:

1. routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
2. hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
3. routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot (e.g., weak or fallen arches); flat or pronated foot; pain or cramp of the foot; special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;

4. services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
5. home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or domiciliary Care, except as provided under Hospice Program Benefits;
6. services in connection with private duty nursing, except as provided under Home Health Care Benefits, home infusion/home injectable therapy Benefits, and except as provided through a Participating Hospice Agency;
7. prescription and non-prescription food and nutritional supplements, except as provided under home infusion/home injectable therapy Benefits, PKU-Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;
8. hearing aids;
9. eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;
10. surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);
11. any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
12. for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
13. for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Pediatric Dental Benefits and Hospital Benefits (Facility Services);
14. for Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages);
15. Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;
16. sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
17. for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

18. any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
19. services incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits;
20. home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;
21. genetic testing except as described in the Outpatient X-ray, Imaging, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;
22. mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Participating Providers;
23. services performed in a Hospital by house officers, residents, interns, and other professionals in training without the supervision of an attending physician in association with an accredited clinical education program;
24. services performed by a Close Relative or by a person who ordinarily resides in the Member's home;
25. services (except for services received under the Behavioral Health Treatment benefit under Mental Health, Behavioral Health, and Substance Use Disorder Benefits) 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 the laboratory testing services;
26. massage therapy that is not Physical Therapy or a component of a multiple-modality Rehabilitative Services treatment plan;
27. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits or Preventive Health Services. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
28. learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
29. services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;
30. drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

31. non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, home infusion/home injectable therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
32. patient convenience items such as telephone, television, guest trays, and personal hygiene items;
33. disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home Health Care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits;
34. services for which the Member is not legally obligated to pay, or for services for which no charge is made;
35. services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;
36. drugs dispensed by a physician or physician's office for outpatient use;
37. transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van); and

38. services not specifically listed as a Benefit. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.

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

Medical Necessity Exclusion

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

Outpatient Prescription Drug Benefits

This plan provides benefits for Outpatient Prescription Drugs as specified in this section.

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

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

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs. Drugs not listed on the Formulary may be covered the exception request submitted by the Member or the Member's Physician or Health Care Provider is approved by Blue Shield.

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

The Formulary drug list is categorized into drug tiers as described in the chart below. The Member's Copayment or Coinsurance will vary based on the drug tier. Drug tiering is based on recommendations made by the Pharmacy and Therapeutics Committee.

Drug Tier	Description
Tier 1	Most Generic Drugs and low-cost Preferred Brand Drugs.
Tier 2	<ol style="list-style-type: none"> 1. Non-preferred Generic Drugs; 2. Preferred Brand Name Drugs ; and 3. Any other Drugs recommended by the plan's Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost.

Tier 3	<ol style="list-style-type: none"> 1. Non-preferred Brand Name Drugs; 2. Drugs that are recommended by the P&T Committee based on drug safety, efficacy and cost; or 3. Generally, have a preferred and often less costly therapeutic alternative at a lower tier.
Tier 4	<ol style="list-style-type: none"> 1. Drugs that are biologics, and Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; 2. Drugs that require the Member to have special training or clinical monitoring; or 3. Drugs that cost the health plan (net of rebates) more than \$600 for a one-month supply.

Members can find the Drug Formulary at www.blueshieldca.com/bzca/pharmacy/home.sp

. Members can also contact Customer Service at the number provided on the back page of the Evidence of Coverage to ask if a specific Drug is included in the Formulary, or to request a printed copy of the Formulary.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Pharmacy by visiting www.blueshieldca.com/bzca/pharmacy/home.sp or by calling Customer Service at the number listed on the Identification Card. If the Member obtains Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny the claim, unless it is for a covered emergency.

Blue Shield negotiates contracted rates with Participating Pharmacies for covered Drugs. **Plans with Separate Rx/Medical Deductible:** If the Member's Plan has a Calendar Year Pharmacy Deductible, the Member is responsible for paying the contracted rate for Drugs until the Calendar Year Pharmacy Deductible is met.

The Member must pay the applicable Copayment or Coinsurance for each prescription when the Member obtains it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate. There is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See the *Prior Authorization/Exception Request Process/Step Therapy* section.

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

If the Member, his/her Physician or Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, the Member pays the difference in cost, plus the Tier 1 Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Tier 1 Copayment or Coinsurance. For example, the Member selects Brand Drug A when there is an equivalent Generic Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is \$300, and

the contracted rate for Generic Drug A is \$100. The Member would be responsible for paying the \$200 difference in cost, plus the Tier 1 Copayment or Coinsurance. This difference in cost does not accrue to the Member's Calendar Year Pharmacy Deductible or Out-of-Pocket Maximum responsibility.

If the Member or his/her Physician or Health Care Provider believes the Brand Drug is Medically Necessary, they can request an exception to the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity. If the request is approved, the Member pays the applicable tier Copayment or Coinsurance for the Brand Drug.

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

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

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

- The Member must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim Form to
Blue Shield of California
P.O. Box 419019,
Dept. 191
Kansas City, MO 64141
- Blue Shield will reimburse the Member based on the price the Member paid for the Drugs, minus any applicable Deductible, Copayment or Coinsurance.

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

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

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

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

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

Obtaining Specialty Drugs through the Specialty Drug Program

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

Specialty Drugs are available exclusively from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, upon the Member's request, will transfer the Specialty Drug to an associated retail store for pickup. See *Emergency Exception for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*.

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

To select a Network Specialty Pharmacy, you may go to <http://www.blueshieldca.com> or call Customer Service.

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

Prior Authorization /Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

1. Some Formulary, preferred, non-preferred, compound Drugs, and most Specialty Drugs;
2. Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;
3. Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance;
4. When the Brand Drug is Medically Necessary, prior authorization is required if the Member, Physician or Health Care Provider is requesting an exception to the difference in cost between the Brand Drug and the Generic Drug equivalent;

Blue Shield covers compound Drugs when:

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

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

The Member, his/her Physician or Health Care Provider may request prior authorization or an exception request for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

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

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If step therapy coverage requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, the Member, his/her Physician or Health Care Provider can file a grievance with Blue Shield, as described in the *Grievance Process* section in the EOC.

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

1. Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.
2. If the Member or Health Care Provider requests a partial fill of a Schedule II Controlled Substance prescription, the 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.
3. Blue Shield has a Short Cycle Specialty Drug Program. With the Member's agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows the Member to receive a 15-day supply of the Specialty Drug and determine whether the Member will tolerate it before he or she obtains the full 30-day supply. This program can help the Member save out of pocket expenses if the Member cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the program, which the Member can elect at that time. The Member or his/her Physician may choose a full 30-day supply for the first fill.

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

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

pharmacy will dispense that amount and you are responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.

5. Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
6. The Member may receive up to a 12-month supply of contraceptive Drugs.
7. The Member may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

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

1. Any Drug the Member receives while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional Benefits and Hospital Benefits (Facility Services)* sections of this Evidence of Coverage.
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits and Skilled Nursing Facility Benefits* sections of this Evidence of Coverage.
3. Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug.
4. Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary and by submitting an exception request to from Blue Shield. See the *Prior Authorization/Exception Request*

Process/Step Therapy section of this Evidence of Coverage.

5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
6. Drugs that are considered to be experimental or investigational.
7. Medical devices or supplies except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits, and the Orthotics Benefits* sections of this Evidence of Coverage.
8. Blood or blood products (see the *Hospital Benefits (Facility Services)* section of this Evidence of Coverage).
9. Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.
10. Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.
11. Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, Hospice Program Benefits, or Family Planning Benefits* sections of this Evidence of Coverage.
12. All Drugs for the treatment of Infertility.
13. Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases prior authorization by Blue Shield is required.
14. Contraceptive drugs or devices which do not meet all of the following requirements:

- Are FDA-approved,
- Are ordered by a Physician or Health Care Provider,
- Are generally purchased at an outpatient pharmacy, and
- Are self-administered.

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

15. Compounded medication(s) which do not meet all of the following requirements:

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

16. Replacement of lost, stolen or destroyed Drugs.

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

18. Drugs prescribed for treatment of dental conditions. This exclusion does not apply to:

- antibiotics prescribed to treat infection,
- Drugs prescribed to treat pain, or
- Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.

19. Except for a covered emergency, Drugs obtained from a pharmacy:

- Not licensed by the State Board of Pharmacy, or
- Included on a government exclusion list.

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

21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

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

Pediatric Dental Benefits

Blue Shield has contracted with a Dental Plan Administrator (DPA). All pediatric dental Benefits will be administered by the DPA. Pediatric dental Benefits are available for Members through the end of the month in which the Member turns 19. Dental services are delivered to our Members through the DPA's Dental PPO ("DPPO") network of Participating Providers. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

If the Member purchased a family dental plan that includes a supplemental pediatric dental Benefits on the Health Benefits Exchange, the pediatric dental Benefits covered under this Plan will be paid first, and the family dental plan will cover additional dental Benefits not covered under this pediatric dental Benefits and/or cost sharing as described in the Member's family dental evidence of coverage.

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

Before Obtaining Dental Services

The Member is responsible for assuring that the Dentist he/she chooses is a Participating Dentist. Note: A Participating Dentist's status

may change. It is the Member's obligation to verify whether the Dentist the Member chooses is currently a Participating Dentist in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in the Member's area, can be obtained by contacting the DPA at 1-800-286-7401. The Member may also access a list of Participating Dentists through Blue Shield of California's internet site located at <http://www.blueshieldca.com>. The Member is also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

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

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

Participating Dentists

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

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

advantage to obtain dental services from Participating Dentists.

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

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

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

Emergency Dental Care Services

A dental emergency means, "an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the member to undue suffering."

If the Member is in need of emergency treatment, the Member should contact a Dentist of their choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. The Member will be directly reimbursed for this treatment up to the maximum allowed under their Plan Benefits.

General Exclusions and Limitations

Unless exceptions to the following general exclusions are specifically made elsewhere

under this plan, this plan does not provide Benefits for:

1. Dental services not appearing on the Summary of Benefits;
2. Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage;
3. Services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Participating Dentist and authorized by the Plan, or when required in a covered emergency;
4. Any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member's effective date of coverage;
5. Any dental services received subsequent to the time the Member's coverage ends;
6. Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
7. Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
8. Procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits;
9. Cosmetic dental care;
10. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit under the Summary of Benefits or is given by a Dentist for a covered oral surgery;
11. Hospital charges of any kind;
12. Loss or theft of dentures or bridgework;
13. Malignancies;
14. Dispensing of drugs not normally supplied in a dental office;
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;
16. The cost of precious metals used in any form of dental benefits;
17. Services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Participating Dentist or for Medically Necessary Dental Services or his or her Participating Dentist is a pedodontist/pediatric Dentist;
18. Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;
19. Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
20. Treatment for which payment is made by any governmental agency, including any foreign government;
21. Charges for second opinions, unless previously authorized by the DPA;
22. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.

Pediatric Dental Benefits Orthodontic Limitations & Exclusions

Orthodontic procedures are Benefits for Medically Necessary handicapping malocclusion, cleft palate and facial growth management cases for Members under the age of 19 and shall be prior authorized.

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

Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

Those immediate qualifying conditions are:

1. Cleft lip and or palate deformities.
2. Craniofacial Anomalies including the following:
 - a. Crouzon's syndrome,
 - b. Treacher-Collins syndrome,
 - c. Pierre-Robin syndrome,
 - d. Hemi-facial atrophy, Hemifacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).

4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.
6. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

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

Excluded are the following conditions:

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

Pediatric Vision Benefits

Blue Shield covers pediatric vision Benefits for individuals through the end of the month in which the Member turns 19 years of age. For Pediatric Vision Plan Copayments, please refer to the Summary of Benefits, which is included

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

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

Covered Services are limited to the following:

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

When contact lenses are selected in lieu of eyeglasses, the comprehensive examination Benefit and Allowance covers in full the fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses (hard or soft) or Elective Contact Lenses (standard hard or soft) by VPA Participating Providers. For Specialty contact lenses (non-standard hard or soft), the comprehensive examination Benefit and Allowance covers the fitting and

evaluation equal to the standard hard or soft contact lenses fitting and evaluation by VPA Participating Providers. The Member is responsible for the difference between the amount Blue Shield pays and the amount billed by the VPA Participating Provider.

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

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

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

Pediatric Vision Plan Exclusions

The Pediatric Vision Plan does not provide benefits for:

- a. Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;
- b. Replacement or repair of lost or broken lenses or frames, except as provided in the EOC;
- c. Any eye examination required by the employer as a condition of employment;
- d. Medical or surgical treatment of the eyes;
- e. Services performed by a Close Relative or by an individual who ordinarily resides in the Subscriber or Dependent's home;
- f. Services performed incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by Blue Shield for the treatment of the injury or disease;
- g. Contact lenses, except as specifically provided under the Evidence of Coverage and in your plan's Summary of Benefits;
- h. Services required by any government agency or program, Federal, state or subdivision thereof;
- i. Services and materials for which the Member is not legally obligated to pay, or services and materials for which no charge is made to the Member;
- j. Services not specifically listed as a Benefit;
- k. Services, procedures, or supplies which are not reasonably necessary for the Member's

condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;

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

Prepayment Fees

The monthly dues (premiums) for a Subscriber and any enrolled dependents are indicated in the Group Health Services Contract. Members should check with their employer regarding the share they may be required to pay. The initial dues are payable on the effective date of this health plan, and subsequent dues are payable on the same date of each succeeding month.

All dues required for coverage for the Subscriber and Dependents will be handled through the Employer and must be paid to Blue Shield. Employers purchasing coverage through Covered California for Small Business (CCSB) will pay premiums directly to CCSB and CCSB will forward the premiums to Blue Shield.

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

Other Charges

Deductibles, Benefit Levels and Maximums

Certain benefits of this health plan require the application of Calendar Year Deductibles, Copayments, Coinsurance and charges in excess of benefit maximums and/or may be subject to maximum payments. Please refer to the Summary of Benefits, which is a part of this Disclosure Form, to find information regarding

any Member share-of-costs or maximums that are applicable to the health plan.

Renewal Provisions

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

1. Non-payment of dues (see the "Termination of Benefits" section of the EOC);
2. Fraud, misrepresentations, or omissions;
3. Failure to comply with Blue Shield's applicable eligibility, participation, or contribution rules;
4. Termination of plan type by Blue Shield;
5. Employer relocates outside of California;
6. Employer is an association and association membership ceases; or
7. Employer purchases coverage through CCSB and the Employer is no longer eligible to purchase coverage through CCSB.

All group contracts will renew subject to the above.

Plan Changes

The Benefits of this health plan, including but not limited to Covered Services, Deductibles, Copayments, Coinsurance and annual out of pocket maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days' written notice of any such change to your Employer.

Termination of Benefits

Group Termination

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

If the employer fails to pay the required Premiums when due, coverage will terminate upon the expiration of a 30-day grace period following notice of termination for non-payment of premium. The employer will be liable for all

Premiums accrued while this coverage continues during the grace period.

If the Contract is terminated, a Member enrolled through the Contract will no longer receive benefits – including COBRA (groups with 20 or more employees) or Cal-COBRA (groups with 2-19 employees). Exceptions due to a disability are specifically outlined in the Extension of Benefits provision in the EOC.

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

Individual Termination

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

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

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

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

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

Continuation of Benefits: COBRA

Certain qualifying events may cause group coverage to terminate for a Subscriber and/or Dependents covered under the health plan. In such instances, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 provides for the continuation of group coverage for a period of time. The section in the EOC entitled Group Continuation Coverage has information on COBRA continuation coverage.

Grievance Process

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

External Independent Medical Review

State law requires Blue Shield to disclose to Members the availability of an external independent review process when the grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider, in whole or in part on the grounds that the service is not Medically Necessary, or is experimental/investigational.

Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. For further information about this review process, see the External Independent Medical Review section in the EOC.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-888-319-5999** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for Emergency or

urgent medical services. The Department also has a toll-free telephone number (1-888-466-2219) and a TDD line (**711**) for the hearing and speech impaired. The Department's Internet Web site (<http://www.dmhc.ca.gov>) has complaint forms, IMR application forms, and instructions online.

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

Confidentiality of Personal and Health Information

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

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

Blue Shield also participates in quality measurement activities that may require us to access a Member's personal and health information. We have policies to protect this information from inappropriate disclosure and we release this information only if aggregated or encoded. We will not disclose, sell, or otherwise use a Member's personal and health information unless permitted by law and to the extent necessary to administer the health plan. We will obtain written authorization from the Member to use his or her personal and health information for any other purpose. For any of our prospective or current Members unable to give consent, we have a policy in place to protect that

Member's rights and that permits the Member's legally authorized representative to give consent on his or her behalf. Blue Shield also will not release the Member's personal and health information to the employer without his or her specific authorization, unless such release is permitted by law.

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

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

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

Definitions

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

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

local Blue Cross Blue Shield Plan have agreed upon some other amount.

3. For a Non-Participating provider in California (including an Other Provider) who provides services (other than Emergency Services) - the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
 - a. Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable & Customary Charge.
4. For a provider outside of California (within or outside of the United States) that has a contract with the local Blue Cross or Blue Shield Plan, the amount that the provider and the local Blue Cross or Blue Shield Plan have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.
5. For a Non-participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield Plan, who provides services (other than Emergency Services) - the amount that the local Blue Cross and/or Blue Shield Plan would have allowed for a non-participating provider performing the same services. Or, if the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

Coinsurance – the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Copayment – the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

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

Deductible – the Calendar Year amount which the Member must pay for specific Covered

Services before Blue Shield pays for Covered Services pursuant to the Group Health Service Contract.

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

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

Emergency Services – the following services provided for an Emergency Medical Condition:

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

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

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

Emergency Services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition. If the Member reasonably should have known that an Emergency Medical Condition did not exist, the services will be covered at the applicable Participating or Non-Participating Provider level of Benefits.

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

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

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

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

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

2. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.
3. Hospital inpatient Services that are Medically Necessary include only those Services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and that could not have been provided in the physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.
4. Inpatient services not Medically Necessary include hospitalization:
 - a. for diagnostic studies that could have been provided on an outpatient basis;
 - b. for medical observation or evaluation;
 - c. for personal comfort;
 - d. in a pain management center to treat or cure chronic pain; and
 - e. for inpatient Rehabilitative Services that can be provided on an outpatient basis.

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

Mental Health Service Administrator (MHSA) – The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver the Blue Shield's Mental Health Services, Behavioral Health Treatment, 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 Services, Behavioral Health Treatment 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 Services, Behavioral Health Treatment, or Substance Use Disorder Services.

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

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

Reasonable & Customary Charge —

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

Notes

Pending Regulatory Approval

Pending Regulatory Approval

Pending Regulatory Approval

Blue Shield of California

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.

Notice of the Availability of Language Assistance Services

Blue Shield of California

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。如需免費幫助，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' ákohwiindzindoogí: Díí naaltsoosísh yíiniłta'go bíinígah? Doo bíinígahgóó éí, naaltsoos nich'í' yiidóoltahígíí łá' nihee hółó. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoolníł nínízíngó bíighah. Doo bąąh ílínígó shiká' adoowoł nínízíngó nihich'í' béesh bee hodíilnih dóó námboo éí díí Blue Shield bee néfho'díłzínígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jí' hodíilnih. (Navajo)

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

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

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

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

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

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

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

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

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

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

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

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)