Blue Shield Life PPO Plan 1500 – G

(for Insureds selecting Guarantee Issue coverage)

Blue Shield of California
Life & Health Insurance Company

Policy

Individual and Family Plan

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Blue Shield Life PPO Plan 1500 -G

(for Insureds selecting Guarantee Issue coverage)

Policy for Individuals and Families

This Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured whose identification cards are issued with this Policy. In consideration of statements made in the application and timely payment of Premiums, Blue Shield Life agrees to provide the benefits of this Policy.

NOTICE TO NEW SUBSCRIBERS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it with the Identification Cards, within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE, 50 BEALE STREET, SAN FRANCISCO, CA 94105. Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and Premiums paid will be refunded.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your policy 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 become a policyholder or select a network provider. Call your prospective doctor or clinic, or call the health plan at Blue Shield Life's Customer Service telephone number on the Subscriber's Identification Card to ensure that you can obtain the health care services that you need.

IMPORTANT!

No Insured has the right to receive the benefits of this Plan for Services or supplies furnished following termination of coverage. Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Policy. Benefits may be modified during the term of this Plan as specifically provided under the terms of this Policy or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Plan.

IFP-DOIAS-000GF

Grandfathered Health Plan Notice

Blue Shield Life believes this policy 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 policy does not include certain consumer protections of the Affordable Care Act. Questions regarding 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 can be directed to Blue Shield Life at the Customer Service telephone number on your identification card. You may also contact the U. S. Department of Health and Human Services at www.healthcare.gov.

The Blue Shield Life PPO Plan 1500 - G

Subscriber Bill of Rights

As a Blue Shield Life PPO Plan 1500 - G Subscriber, 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 Life PPO Plan 1500 - G, the Services we offer you, the Physicians, and other practitioners available to care for you.

5. Have reasonable access to appropriate medical services.

6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.

7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

9. Receive preventive health Services.

10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.

11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.

12. Communicate with and receive information from Customer Service in a language that you can understand.

13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

14. Be fully informed about the Blue Shield Life grievance procedure and understand how to use it without fear of interruption of health care.

15. Voice complaints or grievances about the Blue Shield Life PPO Plan 1500 - G or the care provided to you.

The Blue Shield Life PPO Plan 1500 - G

Subscriber Responsibilities

As a Blue Shield Life PPO Plan 1500 - G Subscriber, you have the responsibility to:

1. Carefully read all Blue Shield Life PPO Plan 1500 – G materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield Life PPO Plan 1500 – G membership as explained in the Policy.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.

4. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.

7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.

8. Offer suggestions to improve the Blue Shield Life PPO Plan 1500 - G.

9. Help Blue Shield Life to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

10. Notify Blue Shield Life as soon as possible if you are billed inappropriately or if you have any complaints.

11. Treat all Plan personnel respectfully and courteously as partners in good health care.

12. Pay your Premiums, Copayment, Coinsurance, and charges for non-covered Services on time.

13. For all Mental Health Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Non-Emergency Inpatient Mental Health Services.

14. Follow the provisions of the Blue Shield Life Benefits Management Program.

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PPO Summary of Benefits

Note: The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this Policy carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this Plan.

Note: For Benefits that have a visit maximum, all visits count toward the visit maximum, regardless of whether the Calendar Year Deductible has been satisfied, or you have reached the Maximum Calendar Year Copayment Responsibility.

Note that certain services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in no payment by Blue Shield Life for services. Please read this Summary of Benefits and the section entitled Covered Services so you will know from which providers health care may be obtained. The Preferred Provider Directory can be located online at www.blueshielca.com or by calling Customer Service at the telephone number provided on the last page of this Policy.

Note: See the end of this Summary of Benefits for important benefit footnotes.

Summary of Benefits	BSL PPO Plan 1500 GI - G	
Insured Calendar Year Deductible [1] (Medical Plan Deductible)	**Deductible Responsibility**	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Calendar Year Medical Deductible	$1,500 per Insured / $3,000 per Family	

Insured Calendar Year Brand Name Drug Deductible [2]	Insured Deductible Responsibility	
	Participating Pharmacy	**Non- Participating Pharmacy**
Per Insured **Applicable to all Covered Brand Name Drugs, including Brand Name Home Self-Administered Injectables**	$500	Not covered

Insured Maximum Calendar Year Copayment Responsibility [3]	Insured Maximum Calendar Year Copayment Responsibility [3, 4]	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers**
Calendar Year Copayment Maximum	$4,500 per Insured / $9,000 per Family	$9,000 per Insured / $18,000 per Family

Insured Maximum Lifetime Benefits	Maximum Blue Shield Life Payment	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Acupuncture Benefits	Not covered	Not covered
Allergy Testing and Treatment Benefits		
Allergy serum purchased separately for treatment	30%	50%
Office visits (includes visits for allergy serum injections)	30%	50%
Ambulance Benefits		
Emergency or authorized transport	30% [7]	30% [7]
Ambulatory Surgical Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.		
Ambulatory Surgery Center Outpatient Surgery facility Services	30%	50% of up to $300 per day
Ambulatory Surgery Center Outpatient Surgery Physician Services	30%	50%
Bariatric Surgery All bariatric surgery Services must be prior-authorized, in writing, by Blue Shield Life's Medical Director. Prior authorization is required for all Insureds, whether residents of a designated or non-designated county.		
Bariatric Surgery Benefits for residents of designated counties in California All bariatric surgery Services for residents of designated counties in California must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See the Bariatric Surgery Benefits section, the paragraphs under Bariatric Surgery Benefits For Residents of Designated Counties in California, in Principal Benefits and Coverages (Covered Services) for a description.		
Hospital Inpatient Services	$250 per admission plus 30%	Not covered [8]
Hospital Outpatient Services	**$**250 per Surgery plus 30%	Not covered [8]
Physician bariatric surgery Services	30%	Not covered [8]
Bariatric Surgery Benefits for residents of non-designated counties in California		
Hospital Inpatient Services	$250 per admission plus 30%	50% of up to $500 per day [8]
Hospital Outpatient Services	**$**250 per Surgery plus 30%	50% of up to $500 per day [8]
Physician bariatric surgery Services	30%	50% [8]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Chiropractic Benefits [9]		
Chiropractic Services Covered Services Up to a Benefit maximum of 12 visits per Insured, per Calendar Year. Whether these Services are provided in an office location or a Hospital's outpatient department, all visits count towards the Calendar Year visit maximum. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	50% of up to $50 per visit	Not covered
Clinical Trial for Cancer Benefits		
Clinical Trial for Cancer Services Covered Services for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by the Plan. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in this Summary of Benefits.	You pay nothing	You pay nothing
Diabetes Care Benefits		
Devices, equipment and supplies	30%	50%
Diabetes self-management training provided by a Physician in an office setting	$40 per visit [10]	50% [10]
Dialysis Center Benefits		
Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	30%	50% of up to $300 per day
Durable Medical Equipment Benefits Up to a Benefit maximum of $2,000 per Insured, per Calendar Year for Durable Medical Equipment. This maximum does not apply to Services covered under the Diabetic Care benefit. The maximum does not apply to Medically Necessary oxygen covered under this section.		
Durable Medical Equipment	30%	Not covered

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Emergency Room Benefits		
Emergency room Physician Services Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Outpatient Physician Services Benefits in this Summary of Benefits and will be subject to any Calendar Year medical Deductible.	30%	30%
Emergency room Services not resulting in admission Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Hospital Benefits (Facility Services), Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies in this Summary of Benefits and will be subject to any Calendar Year medical Deductible.	$100 per visit plus 30%	$100 per visit plus 30%
Emergency room Services resulting in admission (billed as part of Inpatient Hospital Services)	$250 per admission plus 30%	$250 per admission plus 30% [11]
Family Planning Benefits [12] Note: Copayments listed in this section are for Outpatient Physician Services only. If Services are performed at a facility (Hospital, Ambulatory Surgery Center, etc), the facility Copayment listed under the appropriate facility benefit in the Summary of Benefits will also apply.		
Counseling and consulting (Including Physician office visits for diaphragm fitting or injectable contraceptives)	30%	Not covered
Diaphragm fitting procedure When administered in an office location, this is in addition to the Physician office visit Copayment.	30%	Not covered
Injectable contraceptives When administered in an office location, this is in addition to the Physician office visit Copayment.	$25 per injection	Not covered
Tubal ligation In an Inpatient facility, this Coinsurance is billed as part of Inpatient Hospital Services for a delivery/abdominal surgery.	30%	Not covered
Vasectomy	30%	Not covered

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Home Health Care Benefits Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Home health care agency Services, including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.	30%	Not covered [13]
Medical supplies	30%	Not covered [13]
Home Infusion/Home Injectable Therapy Benefits Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Hemophilia home infusion Services provided by a hemophilia infusion provider and prior authorized by the Plan. Includes blood factor product.	30%	Not covered [13]
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit.	30%	Not covered [13]
Home visits by an infusion nurse (Home infusion agency nursing visits are not subject to the Home Health Care and Home Infusion/Home Health Injectable Services Calendar Year visit limitation.)	30%	Not covered [13]
Hospice Program Benefits Covered Services for Insureds who have been accepted into an approved Hospice Program. All Hospice Program Benefits must be prior authorized by the Plan and must be received from a Participating Hospice Agency.		
24-hour Continuous Home Care	30%	Not covered [14]
General Inpatient care	30%	Not covered [14]
Inpatient Respite Care	You pay nothing	Not covered [14]
Pre-hospice consultation	You pay nothing	Not covered [14]
Routine home care	You pay nothing	Not covered [14]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	$250 per admission plus 30%	$250 per admission plus 30% [15]
Inpatient non-Emergency Facility Services Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.	$250 per admission plus 30%	50% of up to $500 per day
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a Benefit maximum of 100 days per Insured, per Calendar Year. These Services have a Calendar Year day maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	30%	50%
Inpatient Services to treat acute medical complications of detoxification	$250 per admission plus 30%	50% of up to $500 per day
Outpatient diagnostic testing X-Ray, diagnostic examination and clinical laboratory services	30%	50% of up to $500 per day [15]
Outpatient dialysis Services	30%	50% of up to $300 per day [15]
Outpatient Services for surgery and necessary supplies	$250 per Surgery plus 30%	50% of up to $500 per day [15]
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	30%	50% of up to $500 per day [15]
Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (Be sure to read the Principal Benefits and Coverages (Covered Services) section for a complete description.)		
Ambulatory Surgery Center Outpatient Surgery Facility Services	30%	50% of up to $300 per day
Inpatient Hospital Services	$250 per admission plus 30%	50% of up to $500 per day [15]
Office location	$40 per visit	50%
Outpatient department of a Hospital	$250 per Surgery plus 30%	50% of up to $500 per day [15]

Benefit	Insured Copayment/Coinsurance [4]	
Mental Health Benefits (All Services provided through the Plan's Mental Health Service Administrator (MHSA)) [16, 17]	**Services by MHSA Participating Providers**	**Services by MHSA Non-Participating Providers [18]**
Inpatient Mental Health Services		
Inpatient Hospital services	$250 per admission plus 30%	50% of up to $500 per day[18]
Inpatient Professional services	You pay nothing	50%
Residential care for Mental Health Condition	$250 per admission plus 30%	50% of up to $500 per day
Non-Routine Outpatient Mental Health Services		
Behavioral Health Treatment in home or other non-institutional setting	30%	50%
Behavioral Health Treatment in an office setting	30%	50%
Electroconvulsive Therapy (ECT) [19]	30%	50%
Intensive Outpatient Program [19]	30%	50%
Partial Hospitalization Program [20]	30% per episode	50% of up to $500 per day
Psychological testing to determine mental health diagnosis (outpatient diagnostic testing) Note: For diagnostic laboratory services, see the "Outpatient diagnostic laboratory services, including Papanicolaou test" section of this Summary of Benefits. And for diagnostic X-ray and imaging services, see the "Outpatient diagnostic X-ray and imaging services, including mammography" section of this Summary of Benefits.	30%	50%
Transcranial magnetic stimulation	30%	50%
Routine Outpatient Mental Health Services		
Professional (Physician) office visit	$40 per visit	50%

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Orthotics Benefits Up to a Benefit maximum of $1,000 per Insured, per Calendar Year for orthotics Services.		
Office visits	$40 per visit	Not covered
Orthotic equipment and devices	30%	Not covered

Benefit	Insured Copayment/Coinsurance [4]	
Outpatient Prescription Drug Benefits [21, 22, 23]	**Participating Pharmacy [24]**	**Non-Participating Pharmacy [25]**
Retail Prescriptions		
Formulary Generic Drugs	$10 per prescription	Not covered
Formulary Brand Name Drugs [26]	$35 per prescription	Not covered
Non-Formulary Brand Name Drugs [26]	The greater of $50 or 50% of Blue Shield Life's contracted rate	Not covered
Mail Service Prescriptions		
Formulary Generic Drugs	$20 per prescription	Not covered
Formulary Brand Name Drugs [26]	$70 per prescription	Not covered
Non-Formulary Brand Name Drugs [26]	The greater of $100 or 50% of Blue Shield Life's contracted rate	Not covered
Home Self-Administered Injectables	30% per prescription	Not covered
Oral Anticancer Medication	30% ($200 maximum per prescription)	Not covered
Outpatient X-Ray, Pathology, Laboratory Benefits Note: Benefits in this section are for diagnostic, non-preventive health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. For Benefits for diagnostic radiological procedures such as CT scans, MRIs, MRAs, PET scans, etc. see the Radiological and Nuclear Imaging Benefits section of this Summary of Benefits. Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.		
Outpatient X-Ray, pathology and laboratory	30% [10, 27]	50% [10, 27]
PKU Related Formulas and Special Food Products Benefits		
PKU	30%	Not covered
Podiatric Benefits		
Podiatric Services	$40 per visit	50%

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Covered Services section. When covered, Services will pay as any other surgery as noted in this Summary of Benefits.		
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	30%	50% of up to $500 per day [15]
Abortion Services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility Coinsurance/Copayment may apply.	30%	50%
Prenatal and postnatal Physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy	30%	50%
Preventive Care Benefits [28]		
Annual Physical Examination including only the annual routine physical examination office visit; urinalysis; eye and ear screening; and pediatric and adult immunizations and the immunizing agent	$40 per visit	Not covered
Annual Gynecological Examination including only the annual gynecological examination office visit; mammography; routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer screening test; and the human papillomavirus (HPV) screening test	$40 per visit	Not covered
Well Baby Examinations including only the well baby examination office visit; tuberculin test; and pediatric immunizations and the immunizing agent	$40 per visit	Not covered
Colorectal Cancer Screening Services	30%	Not covered
Osteoporosis Screening Services	30%	Not covered
NurseHelp 24/7	You pay nothing	Not covered

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Professional (Physician) Benefits		
Inpatient Physician Services For bariatric surgery Services for residents of designated counties in California, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.	30%	50%
Outpatient Physician Services, other than an office setting	30%	50%
Physician home visits	30%	50%
Physician office visits Note: For other Services with the office visit, you may incur an additional Benefit Copayment as listed for that Service within this Summary of Benefits. This additional Benefit Copayment may be subject to the Plan's medical Deductible. Additionally, certain Physician office visits may have a Copayment or Coinsurance amount that is different than the one stated here. For those Physician office visits, the Copayment or Coinsurance will be as stated elsewhere in this Summary of Benefits.	$40 per visit	50%
Prosthetic Appliance Benefits Up to a Benefit maximum of $2,000 per Insured, per Calendar Year for prosthetic appliances.		
Office visits	$40 per visit	Not covered
Prosthetic equipment and devices	30%	Not covered
Radiological and Nuclear Imaging Benefits Note: Benefits in this section are for diagnostic, non-preventive health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits.		
Outpatient, non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Blue Shield Life requires prior authorization for all these Services.	30% [27]	50% of up to $500 per day [27]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred, Participating, and Other Providers [5]	**Services by Non-Preferred and Non-Participating Providers [6]**
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation Services in the following settings:		
Office location	30% [10, 29]	50%
Outpatient department of a Hospital	30% [10, 29]	50% of up to $500 per day
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	$250 per admission plus 30%	50% of up to $500 per day
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days	30%	50%
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility Up to a Benefit maximum of 100 days per Insured, per Calendar Year. These Services have a Calendar Year day maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	30% [30]	30% [30]
Speech Therapy Benefits Speech Therapy Services in the following settings:		
Office location	30% [10, 31]	50%
Outpatient department of a Hospital	30% [10, 31]	50% of up to $500 per day
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	$250 per admission plus 30%	50% of up to $500 per day
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days	30%	50% of up to $500 per day
Transplant Benefits – Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin.		
Hospital Services	$250 per admission plus 30%	50% of up to $500 per day
Professional (Physician) Services	30%	50%
Transplant Benefits – Special [32] Note: The Plan requires prior authorization from Blue Shield Life's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield Life. Please see the Transplant Benefits portion of the Principal Benefits (Covered Services) section in the Policy for important information on this benefit.		
Facility Services in a Special Transplant Facility	$250 per admission plus 30%	Not covered
Professional (Physician) Services	30%	Not covered

Summary of Benefits

Footnotes:

[1] The Calendar Year Deductible (Medical Plan Deductible) may include Services on both a Copayment or Coinsurance basis and applies to all applicable Services except the Services listed below.

- Chiropractic Services;
- Covered travel expenses for bariatric surgery Services;
- Diabetes Self-Management Training by Preferred Providers, a registered dietician, or a registered nurse who is a certified diabetes educator;
- Injectable contraceptive when administered by a Physician as specified in the Family Planning Services section;
- Internet Based Consultations;
- Outpatient visits to a Mental Health Service Administrator (MHSA) for Severe Mental Illnesses or Serious Emotional Disturbances of a Child (including the initial visit to determine the condition and diagnosis of the Insured);
- Preventive Health Benefits;
- Preferred Physician office visits;
- Routine circumcision performed in the office by a Preferred Physician; and
- Services provided under the Outpatient Prescription Drug benefit.

[2] Charges for covered Brand Name Drugs in excess of the Participating Pharmacy contracted rate do not apply to the Insured Calendar Year Brand Name Drug Deductible.

The Insured Calendar Year Brand Name Drug Deductible must be satisfied once during each Calendar Year by or on behalf of the Insured.

The Insured Calendar Year Brand Name Drug Deductible is separate from the Insured Calendar Year Deductible (Medical Plan Deductible). The Insured Calendar Year Brand Name Drug Deductible does not count towards the Insured Calendar Year Deductible (Medical Plan Deductible) nor toward the Insured Maximum Calendar Year Copayment responsibility.

[3] The following are not included in the maximum Calendar Year Copayment amount:

- Additional and reduced payments under the Benefits Management Program;
- Charges in excess of specified benefit maximums;
- Charges for Services which are not covered and charges by non-Preferred and MHSA Non-Participating Providers in excess of covered amounts;
- Covered travel expenses for bariatric surgery Services;
- Family Planning injectable contraceptives administered by a Physician;
- Inpatient Hospital Facility Services for Mental Illness when Services are received from MHSA Non-Participating Providers;
- Internet Based Consultations;
- Non-Emergency Services from a Non-Participating Hospital;
- Non-Preferred Hospital-based Inpatient Medically Necessary skilled nursing Services including Subacute Care;
- Outpatient Mental Health Care from MHSA Participating Providers for Severe Mental Illness or Serious Emotional Disturbances of a Child, including the initial visit to determine the condition and diagnosis of the Insured;
- Outpatient Surgery from a Non-Participating Ambulatory Surgery Center;
- Physician office visit Copayment/Coinsurance;
- Preventive Health Benefits;
- Routine circumcision performed in the office by a Preferred Physician;
- Services provided under the Outpatient Prescription Drug benefit;
- The Calendar Year Medical Plan Deductible; and
- The Calendar Year Brand Name Drug Deductible.

Note: Copayments and charges for Services not accruing to the Maximum Calendar Year Copayment Responsibility continue to be the Insured's responsibility after the Calendar Year Copayment Maximum is reached.

[4] Unless otherwise specified, Copayments/Coinsurance are calculated based on the Allowable Amount.

[5] Other Providers are not Preferred Providers and so for Services by Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, nursing homes and certain labs (for a complete list of Other Providers see the Definitions section)

[6] For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[7] The Copayment will be calculated based upon the provider's billed charges or the amount the provider has otherwise agreed to accept as payment in full from the Plan, whichever is less.

[8] Bariatric Surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. See the Plan Provider Definitions section and the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for complete information and for a list of designated counties.

[9] No Benefits are provided for Chiropractic Services by Non-Preferred or Non-Participating Providers.

[10] If billed by your provider, you will also be responsible for an office visit Copayment/Coinsurance.

[11] For emergency room Services directly resulting in admission as an Inpatient to a Non-Preferred Hospital which the Plan determines are not Emergencies, your Copayment/Coinsurance will be the Non-Preferred Hospital Inpatient Services Copayment/Coinsurance.

[12] No Benefits are provided for Family Planning Services by Non-Preferred or Non-Participating Providers.

[13] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be the Participating Agency Copayment/Coinsurance.

[14] Services by Non-Participating Hospice Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be the Participating Agency Copayment/Coinsurance.

[15] For Emergency Services by Non-Preferred Providers, your Copayment/Coinsurance will be the Preferred Provider Copayment/Coinsurance.

[16] Prior authorization from the MHSA is required for all non-Emergency or non-Urgent Inpatient Services and Non-Routine Outpatient Mental Health Services. No prior authorization is required for Routine Outpatient Mental Health Services - Professional (Physician) Office Visit. For Covered Services from Non-Participating MHSA Providers, you are responsible for a Copayment/Coinsurance and all charges above the Allowable Amount.

[17] No benefits are provided for substance abuse. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment for substance abuse.

[18] For Emergency Services from a MHSA Non-Participating Hospital, the Insured's Copayment/Coinsurance will be the MHSA Participating level, based on Allowable Amount.

[19] The Insured's Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.

[20] Partial Hospitalization Program Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.

[21] This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this Plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

[22] The Insured Maximum Calendar Year Copayment responsibility does not apply to the Outpatient Prescription Drug benefit.

[23] The Insured Calendar Year Deductible does not apply to the Outpatient Prescription Drug benefit.

[24] Copayment/Coinsurance is calculated based on the Allowable Amount for covered prescriptions between the Plan and the Participating Pharmacy, including Specialty Pharmacies, or the Participating Mail Order Pharmacy.

[25] Except for covered emergencies, including Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

[26] Benefits for covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits.

[27] Your Copayment/Coinsurance will be assessed per provider per date of service.

[28] No Benefits are provided for Preventive Health Benefits by Non-Preferred or Non-Participating Providers.

[29] For Services by certified occupational therapists and certified respiratory therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[30] For Services by free-standing skilled nursing facilities (nursing homes), which are Other Providers, you are responsible for all charges above the Allowable Amount.

[31] For Services by licensed speech therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[32] Special Transplant Benefits are limited to the procedures listed in the Covered Services section. See the Transplant Benefits – Special Covered Services section for information on Services and requirements.

Your Blue Shield Life PPO Plan 1500 - G and How to Use It -

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

The Blue Shield Life PPO Plan 1500 - G has a common goal with you and with health care professionals - quality health care coverage at a reasonable cost. You can control your out-of-pocket costs by carefully choosing the providers from whom you receive covered Services.

This Plan has two different payment levels depending on the Physician or Hospital from which you receive covered Services. Blue Shield Life has a statewide network of nearly 50,000 Physician Members and contracted Hospitals known as Preferred Providers. Many other health care professionals, including optometrists and podiatrists are also Preferred Providers.

The highest benefits of the Blue Shield Life PPO Plan 1500 – G are provided when you receive covered Services from a Preferred Provider. You will incur higher out-of-pocket costs when you receive covered Services from a Non-Preferred Provider.

Note: choosing a Preferred Provider will assure the lowest level of Insured's payments available under this Plan. See the "Definitions" section for more information.

Preferred Providers have agreed to accept the Plan's payment, plus payment for any applicable Deductibles, the Insured's Copayments and Coinsurances, or amounts in excess of specified benefit maximums as payment-in-full for covered Services, except as provided under the section entitled Acts of Third Parties. This is not true of Non-Preferred Providers. If you receive Services from a Non-Preferred Provider, the Plan's payment may be substantially less than the amount the provider bills. You are responsible for the difference between the amount the Non-Preferred Provider bills and the amount the Plan pays.

In addition, certain services are not covered when received from Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Failure to meet these responsibilities may result in your Incurring a substantial financial liability. Some services may not be covered unless prior review and other requirements are met.

Blue Shield Life, or the MHSA, will render a decision on all requests for prior authorization, and pre-admission review within five (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 two (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 an Insured, or when the Insured is experiencing severe pain, Blue Shield Life, or the MHSA, will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

Providers do not receive financial incentives or bonuses from the Plan.

When you need health care, present your Blue Shield Life Identification Card to your Physician, Hospital or other licensed health care provider. Your Identification Card has your Subscriber and group number on it. Be sure to include your Insured and group numbers on all claims you submit to Blue Shield Life. Preferred Providers usually bill the Plan directly. See section on Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

The Blue Shield Life PPO Plan 1500 – G is specifically designed for you to use the Blue Shield Life Provider Network of Preferred Providers. Refer to the "Covered Services" section of this Policy for Copayment and Coinsurance information. Preferred Providers are listed in the Preferred Provider Directories.

If you wish to obtain a copy of the Preferred Provider Directory, you may request a copy by contacting the Plan's Customer Service Department at the telephone number on the Subscriber's Identification Card. You may also verify this information by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital, or Alternate Care Services provider you choose is a Preferred Provider in case there have been any changes since your Preferred Provider Directory has been published.

Insureds who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

Note: For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician's office.

For all Mental Health Services: The MHSA is a specialized health care service plan that will deliver the Plan's Mental Health Services through a separate network of Mental Health Service Administrator (MHSA) Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services to Insureds. A Blue Shield Life Provider Network Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of any applicable Deductible, Copayment, Coinsurance or amounts in excess of benefit maximums specified, as payment-in-full for covered Mental Health Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Mental Health Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Behavioral Health Provider Directory. Additionally, Insureds may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-263-9952. You may also search for an MHSA Participating Provider by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Blue Shield Life Network of Preferred Providers

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

The California Department of Insurance has regulations that establish access standards for a plan's provider network in California. For purposes of these provide network access standards, the service area for this Plan is the State of California.

This Plan is most effective and advantageous when covered Services are received from Preferred Providers. You receive the maximum benefits of the Plan when you receive Services from these providers.

Insureds are paid directly by Blue Shield Life if Services are received from a Non-Preferred Provider. Payments to Insureds for Services are in amounts identical to those made directly to providers. See the section entitled Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

Insureds are not responsible to Preferred Providers for payment for covered Services, except for payment of any applicable Deductibles, Copayments, Coinsurances, or amounts in excess of specified benefit maximums, once the Insured's Calendar Year Deductible has been satisfied, except as provided under the section entitled Acts of Third Parties.

Payment for Emergency Services rendered by a physician or hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Plan within 24 hours, or by the end of the first business day, following an emergency admission at a Non-Preferred Hospital, or as soon as is reasonably possible to do so.

Continuity of Care by a Terminated Provider

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

Financial Responsibility for Continuity of Care Services

If an Insured is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured to that provider for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area.

Premiums

Monthly Premiums are as stated in the Appendix. Blue Shield Life offers a variety of options and methods by which you may pay your Premiums. Please call Customer Service at 1-800-431-2809 to discuss these options or visit the Blue Shield Life internet site at http://www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield Life
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross receipts or any portion of either. Premiums increase according to the Subscriber's age, as stated in the Appendix. Premiums may also increase from time to time as determined by Blue Shield Life in accordance with federal and state law and regulations. You will receive 60

days written notice of any changes in the monthly Premiums for this Plan.

Plan Changes

The benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, Coinsurance, and annual copayment/coinsurance maximum amounts, are subject to change at any time. Blue Shield will provide at least 30 days written notice of any such change.

Benefits for Services or supplies furnished after the Effective Date of any change in benefits will be based on the change. There is no vested right to obtain benefits.

Conditions of Coverage
Eligibility and Enrollment

1. To enroll and continue enrollment, an Insured must meet all of the eligibility requirements of the Plan.

2. Enrollment of Subscribers or Dependents is not effective until Blue Shield Life approves an application and accepts the applicable Premiums. Only Blue Shield Life's Underwriting Department can approve applications.

3. An applicant, upon completion and approval by Blue Shield Life of the application, is entitled to the benefits of this Policy upon the Effective Date.

   By completing an application, the Subscriber and/or Dependent(s) agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Subscriber and/or Dependent(s) fail or refuse to provide these documents or information to Blue Shield Life, coverage under this plan may be cancelled.

4. The Effective Date of the benefits of a newborn child will be the date of birth if the Subscriber contacts Blue Shield Life at the Customer Service telephone number on the Subscriber's Identification Card to have the newborn child added to this Policy as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

   If the Subscriber wishes to add a newborn child as a Dependent 32 or more days after birth, Blue Shield Life will require the submission of a completed application and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield Life.

5. The Effective Date of benefits for an adopted child will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, if the Subscriber requests the child be added to this Policy as a Dependent. Such request must be made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

   To add a child placed for adoption to this Policy as a Dependent, the Subscriber must contact Blue Shield Life at the Customer Service telephone number on the Subscriber's Identification Card. The Customer Service Department will advise the Subscriber of the exact process for adding a child place for adoption as a Dependent, including, but not limited to, the necessary documentation and the documentation shall be submitted to Blue Shield Life. Enrollment requests for an adopted child must be accompanied by evidence of the Subscriber's, spouse's, or Domestic Partner's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

   If the Subscriber wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care, Blue Shield Life will require the submission of a completed application, and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield Life.

6. If a court has ordered that you provide coverage for your spouse or Domestic Partner, or Dependent child, under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 of the Welfare and Institutions Code or Medi-Cal program.

Limitation on Enrollment

1. Subscribers must be Residents of California. Upon change of residence to another jurisdiction, this Policy will terminate. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any. See the section entitled Transfer of Coverage.

2. Dependent benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:
   a. The date the Dependent child attains age 26 and
   b. The date the Dependent child attains the age of 23, if a full-time student;

c. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment or dissolution of marriage, or domestic partnership from the Subscriber.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums unless otherwise terminated as described herein. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

Termination / Reinstatement of the Policy

This Policy may be maintained, cancelled, or rescinded as follows:

1. Termination by the Subscriber:
   A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

2. Termination by Blue Shield Life through cancellation:
   Blue Shield Life may cancel this Policy immediately upon written notice for the following:

   a. Fraud or deception in obtaining, or attempting to obtain, benefits under this Policy;

   b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek benefits under this Policy, or improperly seeking payment from Blue Shield Life for benefits provided;

   Cancellation of the Policy under this section will terminate the Policy effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original Effective date of the Policy.

3. Termination by Blue Shield Life if Subscriber moves out of service area:
   Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled Transfer of Coverage for additional information.

   Within 30 days of the notice of cancellation under sections 2 or 3 above, Blue Shield Life shall refund the prepaid Premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such Premiums refund any amounts paid by Blue Shield Life for benefits paid or payable by Blue Shield Life prior to the termination date.

4. Termination by Blue Shield Life due to withdrawal of the Policy from the Market:
   Blue Shield Life may terminate this Policy together with all like Policies to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual Policy without regard to health status-related factors.

5. Cancellation of the Policy for Nonpayment of Premiums:
   Blue Shield Life may cancel this Policy for failure to pay the required Premiums, when due. If the Policy is being cancelled because you failed to pay the required Premiums when due, then coverage will end 30 days after the date for which these Premiums are due. You will be liable for all Premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

   Within five (5) business days of cancelling or not renewing the Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

   a. That the Policy has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when all coverage under this Policy ended.

6. Reinstatement of the Policy after Termination for Non-Payment:
   If the Policy is cancelled for nonpayment of Premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

Transfer of Coverage

1. If a Subscriber moves out of California, coverage under this Policy will terminate. If a Subscriber moves to an area served by another Blue Cross and/or Blue Shield Plan and notifies Blue Shield Life of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.

2. The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally

provided to subscribers who leave a group and apply for new coverage as individuals.

3. Conversion policies provide coverage without a medical examination or health statement.

4. If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this Plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.

5. The required dues or Premium amount and benefits available from the new plan may vary significantly from this Plan.

6. In addition, the new plan may offer other types of coverage outside the transfer program, which may:

   a. Require a medical examination or health statement to exclude coverage for pre-existing conditions, and

   b. Not credit the time enrolled in this Plan.

Renewal of the Policy

Blue Shield Life shall renew this Policy, except under the following conditions:

1. Non-payment of Premiums;

2. Fraud, misrepresentation, or omission;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of the service area or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

No Maximum Aggregate Payment

There is no maximum limit on the aggregate payments by the Plan for covered Services provided under the Plan.

Medical Necessity

Benefits are provided only for Services that are Medically Necessary as defined in this section.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which are:

   a. Consistent with the Plan's medical policy; and

   b. Consistent with the symptoms or diagnosis; and

   c. Not furnished primarily for the convenience of the Insured, the attending Physician or Other Provider; and

   d. Furnished at the most appropriate level which can be provided safely and effectively to the Insured.

2. If there are two (2) or more Medically Necessary services that may be provided for the illness, injury, or medical condition, Blue Shield Life will provide benefits based on the most cost-effective service.

3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the Insured's condition or the quality of medical care rendered. Inpatient Services that are not Medically Necessary and are not covered, include hospitalization:

   a. For diagnostic studies that could have been provided on an Outpatient basis;

   b. For medical observation or evaluation;

   c. For personal comfort;

   d. In a pain management center to treat or cure chronic pain; and

   e. For Inpatient Rehabilitation that can be provided on an Outpatient basis.

4. The Plan 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.

Second Medical Opinion Policy

If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan Policy benefit limitations and exclusions. Additionally, please see the section on "Your Blue Shield Life PPO Plan

1500 – G and How to Use It" regarding advantages from selecting a Preferred Physician for these services.

Utilization Review

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny health care services under the Plan. The Plan has completed documentation of this as required under Section 10123.135 of the California Insurance Code. The document describing Blue Shield's Utilization Management Program is available at www.blueshieldca.com or Insureds may call the Plan's Customer Service Department at the telephone number provided on the back page of this Policy to request a copy.

Health Education and Health Promotion

Health education and health promotion services provided by Blue Shield Life include the Member Newsletter. Additionally, Blue Shield Life's website is located at http://www.blueshieldca.com. Insureds using a personal computer with internet access may view and download healthcare information.

Retail-Based Health Clinics

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc…, which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com. See the Blue Shield Life Preferred Providers section for information on the advantages of choosing a Preferred Provider

NurseHelp 24/7

If you are unsure about what care you need, you should contact your physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

1. Symptoms you are experiencing, including whether you need emergency care;
2. Minor illnesses and injuries;
3. Chronic conditions;
4. Medical tests and medications; or
5. Preventive care

If your physician's office is closed, just call NurseHelp 24/7 at 877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is on the Subscriber's Identification Card.

The NurseHelp 24/7 program provides the Insured with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health issues. Insured may obtain this service by calling a 24-hour, toll-free telephone number. There is no charge for this service.

This program includes:

NurseHelp 24/7 – Insured may call a registered nurse toll free via 1-877-304-0504, a 24-hours a day, to receive confidential support and information about minor illnesses and injuries, chronic conditions, fitness, nutrition, and other health related topics.

Benefits Management Program

The Benefits Management Program applies utilization management and case management principles to assist Insureds and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this health plan.

The Benefits Management Program includes prior authorization requirements for inpatient admissions, selected inpatient and outpatient services, office-administered injectable drugs, and home-infusion-administered drugs, as well as emergency admission notification, and inpatient utilization management. The program also includes Insured services such as, discharge planning, case management and, palliative care services.

The "Prior Authorization List" is a list of medical services and drugs that require prior authorization. Insureds are encouraged to work with their providers to obtain prior authorization. Insureds and providers may call Customer Service at the number provided on the back page of this Policy to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

The following sections outline the Insured's responsibilities under the Benefits Management Program. The Benefits Management Program applies to all Insureds.

Prior Authorization

Prior authorization allows the Insured and provider to verify with Blue Shield that (1) the proposed services are a Benefit of the Insured's plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Insured and provider when Benefits are limited to services ren-

dered by a Participating Provider (See the Summary of Benefits).

The Insured or provider should call Customer Service at the number provided on the back page of this Policy for prior authorization of non-emergency medical Hospital admissions and all medical services and drugs included in the Prior Authorization List (except for radiological and nuclear imaging procedures). Prior authorization for radiological and nuclear imaging procedures and Mental Health Services is addressed separately in the following *Prior Authorization for Radiological and Nuclear Imaging Procedures* and *Prior Authorization for Mental Health Hospital Admissions and Non-routine Outpatient Services* sections.

A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Insured and provider within two business days of the decision. For urgent services when the routine decision making process might seriously jeopardize the life or health of a Insured or when the Insured is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Insured's condition, not to exceed 72 hours from receipt of the request. (See the *Outpatient Prescription Drug Benefits* section for specific information about prior authorization for outpatient prescription drugs).

If prior authorization is not obtained and services provided to the Insured are determined not to be a Benefit of the plan, coverage will be denied

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Insured or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed on an outpatient, non-emergency basis:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedure utilizing Nuclear Medicine

For authorized services from a Non-Participating Provider, the Insured will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If the radiological or nuclear imaging services provided to the Insured are determined not to be a Benefit of the plan, coverage will be denied.

Prior Authorization for Medical Services and Drugs Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical services and Drugs that require prior authorization. Insureds are encouraged to work with their providers to obtain prior authorization. Insureds and providers may call Customer Service at the telephone number provided on the back page of this Policy to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

For authorized services and Drugs from a Non-Participating Provider, the Insured will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to services rendered by a Participating Provider. If the medical services or Drugs provided to the Insured are determined not to be a Benefit of the plan or are not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, special transplant and bariatric surgery. The Insured or provider should call Customer Service at least five business days prior to the admission. Failure to obtain prior authorization for a covered Hospital admission will result in additional cost to the Insured. In most instances a per-admission surcharge of $250 will be added to the Insured's share of cost. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When admission is authorized to a Non-Participating Hospital, the Insured will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If the Hospital admission is determined not to be a Benefit of the plan, coverage will be denied.

The per-admission surcharge is not included in the calculation of the Insured's Calendar Year Out-of-Pocket Maximum.

Prior authorization is not required for an emergency admission; See the *Emergency Admission Notification* section for additional information.

Prior Authorization for Mental Health Hospital Admissions and Non-Routine Outpatient Services

Prior authorization is required for all non-emergency mental health Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Non-Routine Outpatient Mental Health Services, including but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Office-Based Opioid Treatment (OBOT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA. Failure to obtain prior authorization for mental health Hospital admissions or Non-Routine Outpatient Mental Health Services may result in denial of coverage by the MHSA.

If prior authorization is not obtained for a mental health inpatient admission or for any Non-Routine Outpatient Mental Health and the services provided to the Insured are determined not to be a Benefit of the plan, coverage will be denied.

For an authorized admission to a Non-Participating Hospital or authorized Non-Routine Outpatient Mental Health Services from a Non-Participating Provider, the Insured is responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency admission; See the Emergency Admission Notification section for additional information.

Emergency Admission Notification

When an Insured is admitted to the Hospital for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Blue Shield monitors most inpatient Hospital admissions for length of stay; exceptions are noted below. The length of an inpatient Hospital stay may be extended or reduced as warranted by the Insured's condition. When a determination is made that the Insured no longer requires an inpatient level of care, written notification is given to the attending Physician and the Insured. If discharge does not occur within 24 hours of notification, the Insured is responsible for all inpatient charges accrued beyond the 24 hour time frame.

Maternity Admissions: the minimum length of the inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter inpatient stay is adequate.

Mastectomy: The length of the inpatient stay is determined post-operatively by the attending Physician in consultation with the Insured.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield will work with the Insured, the attending Physician, and the Hospital discharge planners to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Insured access necessary services and to make the most efficient use of plan Benefits. The Insured's case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Insured, the provider, and Blue Shield, and will not exceed the standard Benefits available under this plan.

The approval of alternative case benefits is specific to each Insured for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this health plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other person in any other instance.

Palliative Care Services

In conjunction with Covered Services, Blue Shield provides palliative care services for Insureds with serious illnesses. Palliative care services include access to physicians and nurse case managers who are trained to assist Insureds managing symptoms, maximizing comfort, safety, autonomy and well-being, and navigating a course of care. Insureds can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Insureds may call the Customer Service Department at the number provided on the back page of this Policy to request more information about these services.

Deductible

Calendar Year Medical Plan Deductible

The Calendar Year per Insured medical plan Deductible amounts are shown in the Summary of Benefits. After the Calendar Year per Insured medical plan Deductible is satisfied for those Services to which the appropriate Deductible applies, Benefits will be provided for covered Services. The Calendar Year per Insured medical plan Deductible amount must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the

Deductibles. The medical plan Deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately, except that the medical plan Deductible shall be deemed satisfied with respect to the Subscriber and all of his covered Dependents collectively after the Family Deductible amount has been satisfied. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan. The Calendar Year medical plan Deductible amount does not count toward the Maximum Calendar Year Copayment/Coinsurance responsibility.

Calendar Year Brand Name Drug Deductible

The Calendar Year per Insured Brand Name Drug Deductible is shown in the Summary of Benefits. After the Calendar Year per Insured Brand Name Drug Deductible is satisfied for those Drugs to which the Deductible applies, Benefits will be provided for covered Drugs. The Calendar Year Brand Name Drug Deductible amount is made up of charges covered by the Plan. Charges in excess of the contracted rate do not apply toward the Deductible and the Deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately.

The Calendar Year medical Deductible applies to all covered Services Incurred during a Calendar Year except for those Services shown in the Summary of Benefits.

Note: The Calendar Year Deductible is separate from the Brand Name Drug Deductible included in the Outpatient Prescription Drug Benefit.

The Brand Name Drug Deductible does not count toward the Medical Plan Deductible nor toward the Insured's Maximum Calendar Year Copayment / Coinsurance responsibility.

Payment

The Insured's Copayment and Coinsurance amounts, applicable Deductibles, and copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on benefit and Copayment/Coinsurance maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Out-of-Area Programs

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and the U. S. Virgin Islands. The Plan calculates the Insured's Coinsurance as a percentage of the Allowable Amount, as defined in this Policy. When covered Services are received in another state, the Insured's Copayment and Coinsurance will be based on the local Blue Cross Blue and/or Shield plan's arrangement with its providers. See the BlueCard Program section in this booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or to Blue Shield Life for payment. Blue Shield Life will notify you of its determination within thirty (30) days after the receipt of the claim. Blue Shield Life will pay you at the Non-Preferred Provider benefit level. Remember that your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield Life and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Insured's responsibility and are not included in Copayment and Coinsurance calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require Covered Services while temporarily traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate physicians and hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,

2. visit the participating physician or hospital and present your membership card.

The participating physician or hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the participating physician or hospital is paid directly. You may be asked to pay for your applicable Copayment, Coinsurance, and plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits, which will show your payment responsibility. You are responsible for the Copayment, Coinsurance, and plan Deductible amounts shown in the Explanation of Benefits.

Pre-admission review is required for all inpatient hospital services and notification is required for inpatient emergency services. Prior Authorization is required for selected inpatient and outpatient services, supplies, and durable medical equipment. To receive pre-admission review from Blue Shield Life, the out-of-area provider should call the Customer Service telephone number as indicated on the back of the Insured's identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this plan will be provided for Covered Services received anywhere in the world for the emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services outside the United States

Benefits will also be provided for Covered Services received while temporarily traveling outside of the United States, Puerto Rico, and the U. S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires pre-certification or prior authorization, you should also call Blue Shield Life at the Customer Service telephone number as indicated on the back of the Insured's identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, Coinsurance, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers or you can go on-line at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide".

Inter-Plan Programs

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

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

BlueCard Program

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

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

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

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Claims for Covered Emergency Services are paid based on the Allowable Amount as defined in this Policy.

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility

1. The per Insured and per Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by Preferred Providers,

MHSA Participating Providers, and Other Providers is show in the Summary of Benefits.

2. The per Insured and per Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers, MHSA Participating and Non-Participating Providers, and Other Providers is shown in the Summary of Benefits.

Once the Insured's maximum responsibility has been met 8, the Plan will pay 100% of the Allowable Amount for that Insured's covered Services for the remainder of that Calendar year, except as described below. Once the Family maximum responsibility has been met *, the Plan will pay 100% of the Allowable Amount for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as noted below.

* Note: Certain Services and amounts are not included in the calculation of the Maximum Calendar Year Copayment/Coinsurance. These are items shown in the Summary of Benefits.

Charges for these items may cause an Insured's payment responsibility to exceed the maximums.

Copayments, Coinsurance, and charges for Services not accruing to the Insured's maximum Calendar Year Copayment/Coinsurance Responsibility continue to be the Insured's responsibility after the Calendar Year Copayment/Coinsurance Maximum is reached.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary covered Services, subject to the applicable Deductibles, Copayments and Coinsurance, and charges in excess of the Benefit maximums, Preferred Provider provisions, and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Policy, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions, and Reductions listed in this Policy.

The Copayments and Coinsurance, if applicable, are shown in the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non- Preferred and Non-Participating Providers, Insureds will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Insured Copayment.

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

Ambulance Benefits

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport an Insured from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

Ambulatory Surgery Center Benefits

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine circumcisions are circumcisions performed within 18 months of birth.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an Ambulatory Surgery Center because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This Benefit excludes dental procedures and Services of a dentist or oral surgeon.

Note: Reconstructive Surgery is only covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Woman's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;

- Surgery to reform or reshape skin or bone;

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

- Hair transplantation; and

- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

Bariatric Surgery Benefits

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, by Blue Shield Life's Medical Director. Prior authorization is required for all Persons, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California

For Insureds who reside in a California county designated * as having facilities contracting with Blue Shield Life to provide bariatric Services, Blue Shield Life will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1. Services are performed at a Preferred Bariatric Surgery Services Hospital or an Ambulatory Surgery Center and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shield Life to provide the procedure; and

2. Services are consistent with Blue Shield Life's medical policy; and

3. Prior authorization is obtained, in writing, from Blue Shield Life's Medical Director.

* See the list of designated counties below.

The Plan reserves the right to review all requests for prior authorization for these bariatric benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and the Plan's medical policy.

For Insureds who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred Bariatric Surgery Services Hospital by a Preferred Bariatric Surgery Services Physician will result in denial of claims for this benefit.

Note: Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must be provided by a Preferred Bariatric Surgery Services Physician, whether performed in a Preferred Bariatric Surgery Services Hospital, a qualified Ambulatory Surgery Center, or in the Preferred Bariatric Services Physician's office.
The following are designated counties in which the Plan has contracted with facilities to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expenses Reimbursement for Residents of Designated Counties in California

Insureds who reside in designated counties and who have obtained written authorization from Blue Shield Life to receive bariatric Services at a Preferred Bariatric Surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Insured's home must be 50 or more miles from the nearest Preferred Bariatric Surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield Life. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:

    a. For the Person for a maximum of three (3) trips;

        i. One (1) trip for a pre-surgical visit,

        ii. One (1) trip for the surgery, and

        iii. One (1) trip for a follow-up visit.

    b. For one (1) companion for a maximum of two (2) trips;

        i. One (1) trip for the surgery, and

        ii. One (1) trip for a follow-up visit.

2. Hotel accommodations not to exceed $100 per day:

    a. For the Person and one (1) companion for a maximum of two (2) days per trip,

        i. One (1) trip for a pre-surgical visit, and

ii. One (1) trip for a follow-up visit.

b. For one (1) companion for a maximum of four (4) days for the duration of the surgery admission.

All hotel accommodation is limited to one (1), double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3. Related expenses judged reasonable by Blue Shield Life not to exceed $25 per day per Person up to a maximum of four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Calendar Year Deductible and do not accrue to the maximum Calendar Year Copayment responsibility.

Note: bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

1. Services are consistent with the Plan's medical policy; and,

2. Prior authorization is obtained, in writing, from the Plan's Medical Director.

For Insureds who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

Chiropractic Benefits

Benefits are provided forchiropractic services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, adjustments, and conjunctive therapy and X-ray services..

Covered X-Ray Services provided in conjunction with this Benefit have an additional Copayment/Coinsurance as shown in the section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Clinical Trial for Cancer Benefits

Benefits are provided for routine patient care for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by Blue Shield Life, and:

1. The clinical trial has a therapeutic intent and the Insured's treating Physician determines that Participation in the clinical trial has a meaningful potential to benefit the Person with a therapeutic intent; and

2. The Insured's treating Physician recommends participation in the clinical trial; and

3. The Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other covered Services shown in the Covered Services section.

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

1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Insured;

4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan; or

5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

An approved clinical trial is limited to a trial that is approved by one of the following:

1. One of the National Institutes of Health;

2. The federal Food and Drug Administration (FDA), in the form of an investigational new drug application;

3. The United States Department of Defense;

4. The United States Department of Veterans Affairs; or

5. Involves a drug that is exempt under federal regulations from a new drug application.

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices, equipment, and supplies, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary:

a. Blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary supplies;
c. Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. Visual aids, excluding eyewear, and/or video-assisted devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and/or urine testing strips or tablets, lancets and lancet puncture devices and pen delivery systems for the administration of Insulin, refer to the section entitled Outpatient Prescription Drugs.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable an Insured to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Insured's Physician. 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.

Dialysis Benefits

Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis, and related procedures.

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

Durable Medical Equipment Benefits

Medically Necessary Durable Medical Equipment (DME) for Activities of Daily Living supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function are covered. When authorized as DME, other covered items include peak flow monitor for self-management of diabetes, apnea monitor for management of newborn apnea, and home prothrombin monitor for specific conditions as determined by Blue Shield Life. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards or practice. If there are two or more professionally recognized appliance equally appropriate for a condition, Benefits will be based on the most cost effective appliance. See General Exclusions under the Principal Limitation, Exceptions, and Reductions section.

Medically Necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. *

* This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma.

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifies, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

There is a per Insured per Calendar Year maximum on all Services covered under the Durable Medical Equipment Benefit. The Benefit maximum is shown in the Summary of Benefits. This maximum does not apply to oxygen or those Services covered under the diabetes care Benefit.

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

For Insureds in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency.

Emergency Room Benefits

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician's office.

Emergency Services are Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's

health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Plan determines are not emergencies will be paid as part of the Inpatient Hospital Services. The Insured Copayment/Coinsurance for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown in the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Insured is responsible for the emergency room Insured Copayment/Coinsurance plus the appropriate admitting Hospital Services Insured Copayment/Coinsurance as shown in the Summary of Benefits.

Family Planning Benefits

Benefits are provided for the following Family Planning Services without illness or injury being present.

Note: No benefits are provided for Family Planning Services from Non-Participating Providers.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fittings or injectable contraceptives:

2. Injectable contraceptives when administered by a Physician;

3. Voluntary sterilization (tubal ligation and vasectomy) and No benefits are provided for contraceptives, except as may be provided under the Outpatient Prescription Drug Benefit section;

4. Diaphragm fitting procedure.

Home Health Care Benefits

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by an attending Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing, and stand-alone health aide services must be prior authorized by Blue Shield Life.

Covered Services are subject to any applicable Deductible, Copayments, and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Insured, per Calendar Year visit maximum as shown in the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

1. Registered nurse;

2. Licensed vocational nurse;

3. Physical therapist, Occupational therapist, or Speech therapist;

4. Certified home health aide in conjunction with the services of 1, 2 or 3 above;

5. Medical social worker.

For the purposes of this Benefit, visits from home health aides of 4 hours or less shall be considered 1 visit.

In conjunction with professional Services by a home health agency, medical supplies used during covered visits by home health agency necessary for the home health care treatment plan and related laboratory Services are covered to the extent the Benefits would have been provided had the Insured remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs, or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the supplemental Benefit for Outpatient Prescription Drugs.

Skilled Nursing Services are defined as a level of care that includes services that can only be preformed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

(Note: See the Hospice Program Services Benefits section for information about when an Insured is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.)

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

Home Infusion / Home Injectable Therapy Benefits

Benefits are provided for home infusion and IV injectable therapy, including home infusion agency Skilled Nursing visits, parenteral nutrition Services, enteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary and FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency.

Covered Services are subject to any applicable Deductible, Copayments, and Coinsurance. Visits by home infusion/injectable agency providers will be payable up to a combined per Insured, per Calendar Year visit maximum as shown in the Summary of Benefits.

This Benefit does not include medications, drugs, Insulin, disposable Insulin syringes, and certain Home Self-Administered Injectables covered under the Outpatient Prescription Drug Benefit section.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: Benefits are provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.
Note: Services rendered by Non-Participating Home Health Care and Home Infusion agencies must be prior authorized by Blue Shield Life.

Hospice Program Benefits

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Insured requests admission to and is formally admitted to an approved Hospice Program. The Insured must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Plan. (Note: Insured with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Insureds can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when authorized by Blue Shield Life.

All of the Services listed below must be received through a Participating Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning (Persons do not have to be enrolled in the Hospice Program to receive this Benefit).

2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.

3. Skilled Nursing Services, certified health aide Services, and homemaker Services under the supervision of a qualified registered nurse.

4. Bereavement Services.

5. Social Services / Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Insured to the extent that these needs are not met by the Insured's other providers.

7. Volunteer Services.

8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Nursing care Services that are covered on a continuous basis for as much as 24-hours a day during Periods of Crisis as necessary to maintain an Insured at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either Homemaker Services or Home Health Aide Services or both, may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.

12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Insureds are allowed to change their Participating Hospice Agency only once during each Period of Care. Persons can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Insured is Terminally Ill.

Definitions:

Bereavement Services – services available to the immediate surviving family members for a period of at least one (1) year after the death of the Insured These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Insured.

Continuous Home Care – home care provided during a Period of Crisis. A minimum of eight (8) hours of continuous care, during the 24-hour day, beginning and ending at midnight is required. This care could be four (4) hours in the morning and another four (4) hours in the evening. Nursing

care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed vocational nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than eight (8) hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

Home Health Aide Services - services providing for the personal care of the Terminally Ill Insured and the performance of related tasks in the Insured's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services – services that assist in the maintenance of a safe and healthy environment and services to enable the Insured to carry out the treatment plan.

Hospice Service or Hospice Program – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physician, emotional, social, and spiritual discomforts of a Insured who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

a. Considers the Insured and the Insured's family in addition of the Insured, as the unit of care.

b. Utilizes and Interdisciplinary Team to assess the physical, medical, psychological, and social and spiritual needs of the Insured and their family.

c. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Persons who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

e. Provides for Bereavement Services following the Insured's death to assist the family to cope with social and emotional needs associated with the death.

f. Actively utilizes volunteers in the delivery of Hospice Services

g. Provides Services in the Insured's home or primary place of residence to the extent appropriate based on the medical needs of the Insured.

h. Is provided through a Participating Hospice.

Interdisciplinary Team – the hospice care team that includes, but is not limited to, the Insured and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction – Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Insured's Participating Provider, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period of Care – the time when the Participating Provider recertifies that the Insured still needs and remains eligible for hospice care even if the Insured lives longer than one (1) year. A Period of Care starts the day the Insured begins to receive hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis – a period in which the Insured requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of an Insured and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

Respite Care Services – short-term Inpatient care provided to the Insured only when necessary to relieve the family members or other persons caring for the Insured.

Skilled Nursing Services – nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Insured's provider to the Insured and his family that pertain to the palliative, supportive services required by the Insured with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing

needs of the Insured, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Insured and his family and are available on a 24-hour on-call basis.

Social Service / Counseling Services – those counseling and spiritual Services that assist the Insured and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilization appropriate community resources, and maximize positive aspects and opportunity for growth.

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course.

Volunteer Services – services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Insured and his family during the remaining days of the Insured's life and to the surviving family following the Insured's death.

Hospital Care Benefits (Facility Services)

Other than Mental Health Services, Skilled Nursing Facility Services, and Hospice Program Services which are described n subsequent sections.

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.

2. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

   Emergency Services and Complications of Pregnancy are paid just as any other illness.

   No benefits are provided for services subsequent to termination of coverage under this Policy.

3. Use of operating room and specialized treatment rooms.

4. In conjunction with a covered delivery, routine nursery care for a newborn of the Insured or covered spouse or Domestic Partner.

5. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers in more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to repair and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

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

7. Rehabilitation when furnished by the Hospital, and Rehabilitative Care when furnished by the Hospti9al and approved in advance by the Plan under its Benefits Management Program.

8. Drugs and oxygen.

9. Administration of blood and blood plasma, including the cost of blood, blood plasma, and blood processing.

10. X-Ray examination and laboratory tests.

11. Radiation therapy and chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

12. Use of medical appliances and equipment.

13. Subacute Care.

14. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Insured in under the age of seven or developmentally disables regardless of age or when the Insured's health is compromised ad for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

15. Medically Necessary Inpatient substance abuse detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when an Insured is admitted through the emergency room, or when Medically Necessary Inpatient substance abuse detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury or for Surgery

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.

2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.

3. Radiation therapy and chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.

4. Reconstructive Surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to repair and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

   - Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment of symptomatology.

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Insured is under age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

6. Outpatient routine newborn circumcisions. *
   * For the purpose of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Covered lab and X-Ray Services provided in an Outpatient Hospital setting are paid as descried under the Outpatient/Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits, Outpatient Rehabilitation Benefits, and Speech Therapy Benefits sections.

Medical Treatment of the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits

Benefits are provided for Hospital and professional Services for conditions of the teeth, gums, or jaw joints and jaw bones including adjacent tissues only to the extent that they are provided for:

1. The treatment of tumors of the gums;

2. The treatment of damage to the natural teeth caused solely by an Accidental Injury is limited to Medically Necessary services until the services result in initial, palliative stabilization of the Insured as determined by the Plan;
   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and/or cosmetic services are not covered. This benefit does not include

damage to the natural teeth that is not accidental, e.g. resulting from chewing or biting;

3. Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;

5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones);

6. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or

7. Dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

1. Services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic Services, preventive or periodontic Services, dental orthoses and prostheses, including hospitalization incident thereto;

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair), including treatment to alleviate TMJ;

3. Dental implants (endosteal, subperiosteal or transosteal);

4. Any procedure (e.g. vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

5. 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;

6. Fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions, and Reductions, General Exclusions for additional Services that are not covered.

Mental Health Benefits

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services for Blue Shield Insureds within California. See the *Out-Of- Area Program, BlueCard Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health Services, including Residential Care and Non-Routine Outpatient Mental Health Services are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the Benefits Management Program section for complete information.

Routine Outpatient Mental Health Services

Benefits are provided for professional (Physician) office visits for the diagnosis and treatment of Mental Health Conditions in the individual, family or group setting.

Non-Routine Outpatient Mental Health Services

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

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

   BHT is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by the MHSA.

   Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.
2) Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.
3) Intensive Outpatient Program - an outpatient mental health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
4) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Insureds may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.
5) Psychological Testing - testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

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

Inpatient Services

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

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

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

Orthoses Benefits

Benefits are provided for orthotic appliances, including:

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

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. No benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet. No benefits are provided for backup or alternate items.

Benefits are limited to per Insured, per Calendar Year maximum as shown in the Summary of Benefits. This maximum does not apply to Services covered under the Diabetic Care benefit.

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

Outpatient or Out-of-Hospital X-Ray, Pathology, and/or Laboratory Benefits

Benefits are provided for diagnostic X-Ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Certain routine laboratory Services performed as part of a preventative health screening are covered under the Preventive Care Benefits section.

Benefits are also provided for genetic testing for certain conditions when the Insured has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention, and determined to be Medically Necessary and appropriate in accordance with Blue Shield Life medical policy. See the section on Pregnancy Benefits for information on genetic testing disorders of the fetus.

See the section on Radiological and Nuclear Imaging Benefits and Benefit Management Program section for information on procedures that require prior authorization by the Plan.

Outpatient Rehabilitation Benefits

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan, when Medically Necessary and up to the benefit maximum. Benefits for Speech Therapy are described in the section on Speech Therapy benefits. The Plan reserves the right to periodically review the provider's treatment plan and records for Medical Necessity.
Note: See the Home Health Care, Home Infusion Care Benefits and PKU Related Formulas and Special Food Products and the Hospice Program Services sections for information on coverage for Outpatient Rehabilitation Services rendered in the home, including visit limits.

Note: Covered lab and X-Ray Services provided in conjunction with this Benefit, are paid as shown under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Outpatient Prescription Drug Benefits

This benefit includes access to Blue Shield's Participating Pharmacy Network. By presenting your Blue Shield Identification Card to a Participating Pharmacy you will pay Blue Shield's contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see the section entitled "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

The following prescription drug benefit is separate from the Blue Shield Life PPO Plan 1500 – G coverage.

The Calendar Year Maximum Copayment and Coinsurance and Medical Plan Deductible do not apply to the outpatient prescription drug benefit; however, the general provisions and exclusions of the Blue Shield Life PPO Plan 1500 – G shall apply.

Benefits for covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits.

Note: Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

1. Outpatient Prescription Drug Benefit
   Subject to the terms and conditions of this Section, benefits are provided for Outpatient prescription Drugs, which are prescribed by a licensed Physician and are obtained from a Participating Pharmacy. Benefits are provided for Formulary Drugs, which are Drugs listed on Blue Shield's Drug Formulary. Blue Shield's Pharmacy and Therapeutics Committee update this Formulary on a periodic basis. Benefits may also be provided for Non-Formulary Drugs subject to higher Coinsurance/Copayments. Select Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield. Coverage for selected Drugs may be limited to specific quantity as described in the section entitled Limitation on Quantity of Drugs that May be Obtained per Prescription or Refill.

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

   Insureds may call Blue Shield's Customer Service Department at the number listed on their Blue Shield Life Identification Card to inquire if a specific drug is included in the Formulary. The Customer Service Department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the Blue Shield Life web site at http://www.blueshieldca.com.

Definitions

Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name. Note: covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin and disposable Insulin needles and syringes; (3) pen delivery systems for the administration of Insulin as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); (5) oral contraceptives and diaphragms; (6) inhalers and inhaler spacers for the management and treatment of asthma.; and (7) smoking cessation Drugs which require a prescription. Coverage for such Drugs is limited to a single 12-week course of treatment per lifetime of the Insured.

Note: No Prescription is necessary to purchase the items shown in (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Formulary Brand Name Drug equivalent.

Home Self-Administered Injectables - Home Self-Administered Injectable medications are defined as those Drugs that are Medically Necessary; administered more often than once a month by the patient or family member; administered subcutaneously or intramuscularly; deemed safe for self-administration as determined by Blue Shield Life's Pharmacy and Therapeutics Committee; prior authorized by Blue Shield: and obtained from a Blue Shield Life Specialty Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable drugs. Home Self-Administered Injectables are listed in Blue Shield's Prescription Drug Formulary.

There is a maximum of $200 per prescription for oral anti-cancer medications.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy that does not participate in the Blue Shield Life Pharmacy Network.

Participating Pharmacy — a pharmacy that participates in the Blue Shield Life Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Life Subscribers and Dependents.

To select a Participating Pharmacy, Insureds may access this information at http://www.blueshieldca.com or call the toll-free Customer Service telephone number on their Blue Shield Life Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield Life to provide covered Home Self-Administered Injectables. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, the Insured may access this information at http://www.blueshieldca.com or call the toll-free Customer Services telephone number on their Blue Shield Life Identification Card.

3. Obtaining Outpatient Prescription Drugs from Participating Pharmacies
   a. To obtain prescription Drugs, the Insured must present his Blue Shield Life Identification Card. Note: Except for covered emergencies and Drugs for emergency contraception, claims for drugs obtained without using the Blue Shield Identification Card will be denied.

   b. Benefits are provided for Home Self-Administered Injectables only when obtained from a Blue Shield Life Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Home Self-Administered Injectables that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary, from a Non-Participating Pharmacy.

   c. Formulary Generic Drugs -
   The Insured is responsible for paying the Formulary Generic Drug Copayment/Coinsurance for each new and refill Formulary Generic Drug prescription. The pharmacist will collect from the Insured the Copayment/Coinsurance at the time the Drugs are obtained. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Formulary Generic Drugs is shown in the Summary of Benefits.

   d. Brand Name Drugs -
   Brand Name Drugs are subject to the per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits. Until the Brand Name Drug Deductible is satisfied, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Life Participating Pharmacy at the time the Drug is obtained. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Brand Name Drugs is shown in the Summary of Benefits.

   Note: Both the Formulary Brand Name Drug Copayment/Coinsurance and the Brand Name Drug Deductible apply for diaphragms.

   e. If the Insured or Physician requests a Brand Name Drug when a Generic Drug equivalent is available, and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

   f. Prescription drugs obtained at a non-participating pharmacy are not covered unless Medically Necessary for a covered emergency. If the Insured must obtain drugs from a non-participating pharmacy due to a covered emergency, the submission of a Prescription Drug Claim form noting "Emergency Request" on the form is required. Claim forms are provided upon request from the Blue Shield Life Service Center. Claims must be submitted to:

   Blue Shield Life
   Pharmacy Services
   P.O. Box 7168
   San Francisco, CA 94120

Claims must be received within 1 year from the date of service to be considered for payment. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any Brand Name Drug Deductible and applicable Copayments(s)/Coinsurance.

When the Plan receives Notice of Claim, the Plan will send you an Insured's Statement of Claim form for filing proof of a claim. For consideration of a claim due to a covered emergency, you must note "Emergency Request" on the Insured's Statement of Claim form and it should be submitted to:

Blue Shield Life
Pharmacy Services
P.O. Box 7168
San Francisco, CA 94120

The Plan must receive written proof of claim within 90 days after the date of service for which claim is being made. Send a copy of your itemized bill or pharmacy statement along with your completed Insured's Statement of Claim form.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify the Plan. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any Brand Name Drug Deductible and applicable Copayments(s) and Coinsurance.

g. The Insured is responsible for paying Copayment/Coinsurance as shown in the Summary of Benefits for Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs.

4. Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program
   a. For the Insured's convenience, when Drugs have been prescribed for a chronic condition, the Insured may obtain the Drugs through Mail Service Prescription Drug Program. The Insured should submit the applicable mail service Copayment/Coinsurance, an order form, and the Blue Shield Life Identification number to the address indicated on the Mail Service envelope. Insureds should allow 14 days to receive the Drugs. The Insured's Physician must indicate a prescription quantity, which is equal to the amount to be dispensed. Home Self-Administered Injectables, except for Insulin, are not covered through the Mail Service Prescription Drug Program.

   b. Mail Service Generic Drugs –
   The Insured is responsible for the Mail Service Formulary Generic Drug Copayment for each covered prescription. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Mail Service Generic Drugs is shown in the Summary of Benefits.

   c. Mail Service Brand Name Drugs -
   Mail Service Brand Name Drugs are subject to the per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits. Until the Brand Name Drug Deductible is satisfied, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Mail Service Pharmacy prior to your prescription being sent to you. To obtain the Participating Pharmacy contracted rate amount, please contact the Mail Service Pharmacy at 1-866-346-7200. The TTY telephone number is 1-866-346-7197. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Mail Service Brand Name Drugs is shown in the Summary of Benefits

   Note: Both the Formulary Brand Name Drug Copayment/Coinsurance and the Brand Name Drug Deductible apply for diabetic supplies including disposable Insulin needles and syringes.

   d. If the Insured or Physician requests a Brand Name Drug when a Generic Drug is available and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

6. Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables -

   Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective.

Compound drugs are covered only if the requirements listed under the Exclusions in the Outpatient Drug Benefits section are met.

Your Physician may request prior authorization by submitting supporting information to Blue Shield Life. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within two business days.

7. Limitation on Quantity of Drugs That May Be Obtained Per Prescription or Refill
   a. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield Life's Pharmacy and Therapeutics Committee.

   b. Mail Service Prescription Drugs are limited to a quantity not to exceed a 60 day supply. If the Insured's Physician indicates a prescription quantity of less than a 60-day supply that amount will be dispensed and refill authorizations cannot be combined to reach a 60-day supply.

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

8. Exclusions for Outpatient Prescription Drug Benefit - No benefits are provided under the Outpatient Prescription Drug Benefit for the following (please note, certain Services excluded below may be covered under other benefits/portions of your Policy - you should refer to the applicable section to determine if Drugs are covered under that Benefit):

   a. Any Drugs provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefit and Hospital Benefits sections of your Policy);

   b. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits and skilled Nursing Facilities Benefits sections of your Policy);

   c. Drugs, (except as specifically listed as covered under this Outpatient Prescription Drug section), which can be obtained without a prescription or for which there is a non-prescription Drug that is an identical chemical equivalent (i.e. same active ingredient and dosage) to a prescription Drug;

   d. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;

   e. Drugs that are considered to be experimental or investigational;

   f. Medical devices or supplies except as specifically listed as covered herein (see the Prosthetic Appliance and Durable Medical Equipment Benefits section and the Orthoses Benefits section of your Policy);

   g. Blood or blood products (see the Hospital Benefits section of your Policy);

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

   i. Dietary or Nutritional Products see the PKU Related Formulas and Special Food Products Benefits section of your Policy;

   j. Injectable Drugs which are not self-administered, and all injectable Drugs for the treatment of infertility. Other Injectable Medications may be covered under the Home Health Care Benefits, Family Planning Service, Hospice Program Services, and Home Infusion/Home Injectables Therapy Benefits sections of the Plan;

   k. Appetite suppressants, or Drugs for weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the Drug will be subject to prior authorization from Blue Shield Life;

   l. Contraceptive devices (except diaphragms), injections and implants;

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

   n. Replacement of lost, stolen, or destroyed Prescription Drugs;

   o. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage;

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

   q. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an

Insured enrolled in a Hospice Program through a Participating Hospice Agency; or

r. Immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

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

PKU Related Formulas and Special Food Product Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. All benefits must be prescribed and/or ordered by the appropriate health care professional.

Podiatric Benefits

Podiatric Services include office visits and other covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services are customarily provided by a licensed doctor of podiatric medicine. Covered lab, pathology, and X-Ray Services provided in conjunction with this Benefit, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Pregnancy Benefits

Benefits are provided for maternity services, which include prenatal care, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy, outpatient maternity services, involuntary complications of pregnancy, abortion services, and inpatient hospital maternity care including labor, delivery, and post-delivery care. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

(Note: See the section on Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for Services after termination of coverage under this Plan.

Note: The Newborns' and Mothers' Health Protection Act requires individual and family health plans to provide a minimum hospital stay for the mother and newborn child of forty-eight (48) hours after a normal, vaginal delivery and ninety-six (96) hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

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

Preventive Health Benefits

Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

The specific benefits listed below for Preventive Care are not subject to the Calendar Year Deductible.

Note: No benefits for Preventive Care Services are provided from Non-Preferred Providers.

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

1. Annual Physical Examination:
   For the Subscriber and Dependents age three (3) and over, benefits are provided for one (1) health appraisal examination in each Calendar Year.

   Benefits for the Annual Physical Examination include <u>only</u> the following Services:

   a. Annual routine physical examination office visit;

   b. Urinalysis;

   c. Eye and ear screenings, provided by a family practitioner or general practitioner, for Subscribers and dependent children through age 16 to determine the need for referral to a specialist for eye refraction or audiogram. No benefits are provided for routine examinations by Optometrists or Audiologists, or for routine eye refraction.; and

   d. Pediatric and adult immunizations and the immunizing agent based on Blue Shield's Preventive Health Guidelines. These guidelines regarding immunizations and vaccinations are derived from the most recent recommendations of, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)

including frequency and patient age recommendations. No benefits are provided for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, laboratory, or pathology Services beyond those listed in this Annual Physical Examination benefit, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in the section titled Outpatient or Out-of-Hospital, X-ray, Pathology, and/or Laboratory Benefits.

2. Annual Gynecological Examination:
Benefits for the annual gynecological exam include only the following Services:

   a. Annual gynecological examination office visit:

   b. Mammography, and

   c. Routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer and human papillomavirus virus (HPV) screening tests.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Annual Gynecological Examination benefit, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

3. Colorectal Cancer Screening:
For Subscribers or Dependents age 50 and older, benefits are provided based on Blue Shield Life's Preventive Health Guidelines. These guidelines regarding examinations and tests are derived from the most recent version with all updates of the Guide to Preventive Services of the U. S. Preventive Services Task Force as convened by the U. S. Public Health Service and those of the American Cancer Society, including frequency and patient age recommendations.

   Colorectal cancer screening examinations and test for diagnostic rather than preventive purposes, or any covered Outpatient or our-of-Hospital X-ray, laboratory, or pathology Services will be subject to the per Insured, per Calendar Year Deductible and the Insured will be responsible for additional Copayment(s)/Coinsurance as outlined in the Outpatient or Out-of-Hospital X-ray, Pathology, and Laboratory Benefits or Ambulatory Surgery Center Benefits sections.

   The facility Copayment/Coinsurance for Colorectal Cancer Screening Service(s) is applied in addition to the Copayment/Coinsurance for any associated office visit(s), Copayment/Coinsurance amounts for Colorectal Cancer Screening Services performed in an Outpatient facility or Ambulatory Surgery Center are described in the Outpatient or Out-of-Hospital X-ray, Pathology, and Laboratory Benefits or Ambulatory Surgery Center Benefits sections.

4. Osteoporosis Screening:
Benefits are provided for osteoporosis screening for Subscribers and Dependents age 65 and older, or age 60 and older if the Insured is at increased risk.

5. Well-Baby Examination:
Benefits are provided when a Physician provides routine pediatric care to a Subscriber less than three (3) years of age.

   Benefits are provided when a Physician provides routine pediatric care to a newborn or Dependent child that is less than three (3) years of age, of the Subscriber or covered spouse or Domestic Partner.

   Well-baby examination benefits include only the following Services:

   a. Well baby examination office visits;

   b. Tuberculin test; and

   c. Pediatric immunizations and the immunizing agent based on Blue Shield's Preventive Health Guidelines. These guidelines regarding immunizations and vaccinations are derived from the most recent recommendations of the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) including frequency and patient age recommendations. No benefits are provided for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Well-Baby Examination, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) and/or Coinsurance as outlined in the section entitled Outpatient or Out-

of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

Professional (Physician) Benefits

Other than Preventive Care, Mental Health care, Hospice Program Services, Dialysis Benefits, and Bariatric Surgery which are described in other sections.

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab, pathology, and X-Ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician Office Visits. A list of urgent care providers may be found in the Blue Shield Life Preferred Provider Directory. This information may also be viewed by accessing the Plan's Internet site located at http://www.blueshieldca.com.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;

2. Services of consultants, including those for second medical opinion consultations;

3. Mammography and Papanicolaou test or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

4. Asthma self-management training and education to enable an Insured to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers, and peak flow monitors;

5. Visits to the home, Hospital, Skilled Nursing Facility, and Emergency Room;

6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;

7. Surgical procedures. When multiple surgical procedures are performed during the same operation, Benefits for the secondary procedure(s) will be determined based on the Plan's Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;

8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas Benefits will be provided in accordance with the guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10. Extra time spent when a Physician is detained to treat an Insured in critical condition;

11. Necessary preoperative treatment;

12. Treatment of burns; and

13. Allergy testing and treatment.

14. Medically Necessary consultations with Internet Ready Preferred Physicians via Blue Shield Life approved Internet portal. Internet based consultations are available to Insured only through Preferred Physicians who have agreed to provide Internet based consultations via the Blue Shield Life approved Internet portal ("Internet Ready"). Insured must be current patients of the Preferred Physician. Refer to the Online Physician Directo-

ry to determine whether a Preferred Physician is Internet Ready and how to initial an Internet based consultation. This information may be accessed at http://www.blueshieldca.com.

Internet based consultations are not available to Insureds accessing care outside of California.

15. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

    Emergency Services and Complications of Pregnancy are paid just as any other illness.

    No benefits are provided for services subsequent to termination of coverage under this Policy.

16. Outpatient routine newborn circumcisions. *

    * For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

17. Diagnostic audiometry examinations.

Prosthetic Appliance Benefits

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions, and Reductions section for a listing of excluded speech and language assistance devices.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Benefits are provided for Medically Necessary Prostheses for Activities of Daily Living including the following:

1. Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;

2. Artificial limbs and eyes;

3. Supplies necessary for the operation of Prostheses;

4. Initial fitting and replacement after the expected life of the item; and

5. Repairs, even if due to damage.

No benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided). No benefits are provided for backup or alternate items.

Benefits are provided for contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca, or aphakia following cataract surgery when no intraocular lens has been implanted.

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

Radiological and Nuclear Imaging Benefits

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by the Plan under the Benefits Management Program.

1. CT (Computerized Tomography) scans;

2. MRIs (Magnetic Resonance Imaging);

3. MRAs (Magnetic Resonance Angiography);

4. PET (Positron Emission Tomography) scans; and/or

5. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

Skilled Nursing Facility Benefits

Other than Hospice Program Services which are described in a subsequent section.

Benefits are provided for Medically Necessary Services Provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown in the Summary of Benefits. The Benefit maximum is per Insured per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Speech Therapy Benefits

Benefits are provided for medically necessary outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist/pathologist, or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

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

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

Note: See the Home Health Care Benefits section for information on coverage for Speech Therapy Services rendered in the home.

See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits and the Hospice Program Services section.

Transplant Benefits

Organ Transplants

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants, only to the extent that:

1. They are provided in connection with the transplant of a cornea, kidney, or skin; and

2. The recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant "bank".

Special Transplant Benefits

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting as a Blue Shield Life Provider to provide the procedure or in the case of Insureds accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield Life, (2) prior authorization is obtained, in writing, from the Plan's Medical Director, and (3) the recipient of the transplant is a Subscriber or Dependent.

The Plan reserves the right to review all requests for prior authorization of these Special Transplant Benefits, and to make a decision regarding benefits based on (1.) the medical circumstances of each Insured, and (2.) consistency between the treatment proposed and the Plan's medical policy.

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

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;

2. Human lung transplants;

3. Human heart and lung transplants in combination;

4. Human liver transplants;

5. Human kidney and pancreas transplants in combination;

6. Human bone marrow transplants; including, autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;

7. Pediatric human small bowel transplants; and

8. Pediatric and adult human small bowel and liver transplants in combination.

Principal Limitations, Exceptions, Exclusions, and Reductions

General Exclusions

Unless exceptions to the following exclusions are specifically made elsewhere in this Policy, no benefits are provided for the following Services:

1. For or incident to Services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including, but not limited to, diagnostic, preventive, orthodontic, and other Services such as dental cleaning, tooth whitening, X-Rays, topical fluoride treatment except when used with radiation ther-

apy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extractions; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints, or Jaw Bones Benefits;

2. For or incident to Services rendered in the home or hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except those benefits which would have been provided had the individual been treated on an Outpatient basis. For example, charges for room and board during such hospitalization are not a benefit except as Medically Necessary;

3. For Rehabilitation except as specifically provided under Hospital Benefits, Home Health Care Benefits, or Outpatient Rehabilitation Benefits:

4. For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Services (see Hospice Program Services Benefits for exception);

5. Performed in a Hospital by Hospital officers, residents, interns and others in training;

6. For routine eye refraction, surgery to correct refractive error (such as but not limited to radial keratotomy / refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided in the Prosthetic Appliances Benefits section), and video-assisted visual aids or video magnification equipment for any purposes;
7. For eyeglasses, and contact lenses except as specifically listed in the sections entitled Durable Medical Equipment and Prosthetic Appliances Benefits, or hearing aids, cochlear implants, bone-anchored hearing aids, and auditory brainstem implants;

8. For or incident to acupuncture;

9. For or incident to Speech Therapy, speech correction, or speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness except as specifically listed under Home Health Care Benefits and Speech Therapy Benefits;

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

11. For callus, corn paring or excision, toenail trimming and 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; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed as covered herein; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;

12. Which are Experimental or Investigational in Nature, except for Services for Insureds who have been accepted into an approved clinical trial for cancer as provided under Covered Services;

13. For 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 the Plan is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

14. For or incident to hospitalization primarily for radiological, laboratory, or any other diagnostic studies or medical observation;

15. For convenience items such as telephones, TVs, guest trays, and personal hygiene items;

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

17. Incident to an organ transplant, except as specifically listed;

18. 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 the reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

19. For any services to assist reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization. Gamete Intrafallopian Transfer (G. I. F. T.) 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 Benefits under a Blue Shield Life Plan;

20. For Papanicolaou (Pap) Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, mammography and colorectal cancer screenings, except as specifically listed;

21. For routine health appraisals, well-baby care, vision and hearing tests, physical examinations and immunizations, except as specifically listed under Preventive Care; for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel; or for physical examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Physical Examination;

22. For or incident to sexual dysfunction, sexual inadequacies; except as provided for treatment of organically based conditions;

23. For or incident to family planning, except as specifically listed;

24. 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 sections entitled Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints, or Jaw Bones Benefits;

25. Performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;

26. 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 the Plan provides payment for such Services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of such injury or disease;

27. In connection with private duty nursing, except as provided under the Home Health Care Benefits and Home Infusion/Home Injectable Therapy Benefits and except as provided through a Participating Hospice Agency;

28. For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain except as Medically Necessary;

29. For substance abuse treatment or rehabilitation on an inpatient, partial hospitalization or outpatient basis, except as specifically listed;

30. For Outpatient Mental Health Services, except as specifically listed;

31. For which the Insured is not legally obligated to pay or Services for which no charge is made to the Insured;

32. For or incident to out-of-country services; for medical equipment, drugs and other substances obtained outside the United States except as provided for covered emergency or urgent care;

33. For Reconstructive Surgery and procedures where there is another more appropriate covered surgical or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee e.g., spider veins. In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

    - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
    - Surgery to reform or reshape skin or bone;
    - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
    - Hair transplantation; and
    - Upper eyelid blepharoplasty without documented significant visual impairment or symptomology.

    This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry

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

35. For drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); 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 Insurance Code, Section 10123.195 have been met;

36. For home testing devices and monitoring equipment except as specifically provided in Durable Medical Equipment Benefits in the Covered Services section;

37. For contraceptives and contraceptive devices, except as specifically included in the sections entitled Family Planning Services and Outpatient Prescription Drugs Benefits; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Benefit; no benefits are provided for contraceptive implants;

38. For genetic testing except as described in the section entitled Outpatient or Out-of-Hospital X-ray, Laboratory, and/or Pathology Services Benefits;

39. For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under in the sections entitled Durable Medical Equipment Benefits and Prosthetic Appliances Benefits;

40. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, bath chairs, and breast pumps, 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 Diabetes Care Benefits, Durable Medical Equipment Benefits, Home Health Care Benefits, Home Injectable/Home Infusion Therapy Benefits, and Prosthetic Appliances;

41. Incident to bariatric surgery services except as specifically provided under the section entitled Bariatric Surgery Services Benefits;

42. For services provided by an individual or entity that is not appropriately licensed, certified, or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification, or state authorization, except specifically stated herein;

43. massage therapy that is not Physical Therapy or a component of a multiple-modality rehabilitation treatment plan; and

44. Not specifically listed as a benefit.

See the Grievance Process section for information on filing a grievance, your right to seek assistance from the State of California Department of Insurance, and your rights to external independent medical review.

Medical Necessity Exclusion

All services must be Medically Necessary. The fact that a Physician or Other Provider may prescribe, order, recommend, or approve a service does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The Plan may limit or exclude benefits for services that are not Medically Necessary.

Pre-Existing Conditions

Pre-existing Conditions are covered only after you have been continuously covered for six (6) consecutive months, including your waiting period. Your waiting period begins on the date the Plan receives your applicationHowever, if you or your Dependents had prior Creditable Coverage and you applied for this Plan within sixty-three (63) days after termination of the prior Creditable Coverage, then the Plan will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan's Pre-existing Condition exclusion.

To receive credit for your prior Creditable Coverage, submit to Blue Shield Life a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact the Plan's Customer Service area for assistance.

Limitations for Duplicate Coverage

1. After coverage in this plan has begun, Blue Shield Life plan will provide benefits if the Member is enrolled under Medicare but Medicare will be the primary payor and Blue Shield Life will:
   a. Estimate what Medicare would have paid for services received (based upon the reasonable value or Blue Shield Life's Allowable Amount), and
   b. Provide your Blue Shield Life plan benefits as if you were enrolled to receive benefits from Medicare.

The combined benefits from Medicare and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive Medicare benefits (payment will be based on an amount that may be lower than, but will not exceed the Medicare allowed amount). Your Blue Shield Life plan Deductible, copayments, and/or coinsurance will be applied before plan benefits are provided.

When you are eligible for Medi-Cal

Your Blue Shield Life plan always provides benefits first.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another governmental agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county, or other political subdivision:

1. The combined benefits from that coverage and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield Life's Allowable Amount).

2. Your Blue Shield Life plan Deductible, copayments, and/or coinsurance will be applied before payment of plan benefits.

Contact the Customer Service department at the telephone number shown on the Subscriber's Identification Card if you have any questions about how Blue Shield Life coordinates your plan benefits in the above situations.

Exception for Other Coverage

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Policy.

Claims Review

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

Reductions - Third Parties Liability

If an Insured is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the benefits of this Policy and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for Services provided to the Insured on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Insured from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery the Insured receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party of third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Insured has been "made whole" by the Recovery.. Blue Shield's right to restitution, reimbursement, or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The Insured is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan to execute any forms or documents needed to enable Blue Shield to enforce its right to restitution, reimbursement, or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide the Plan with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

An Insured's failure to comply with items 1. through 5. above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

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

General Provisions

Non-Assignability

Coverage or any benefits of this Policy may not be assigned without the written consent of Blue Shield Life.

Possession of a Blue Shield Life identification care confers no right to Services or other benefits of this Policy. To be entitled to Services, the Insured must be a Subscriber who has been enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Policy.

Preferred Providers are paid directly by the Plan. The Insured or the provider of Service may not request that payment be made directly to any other party.

If the Insured receives covered Services from a Non-Preferred Provider, payment will be made directly to the Insured, and the Insured is responsible for payment to the Non-Preferred Provider. The Insured or the provider of Service

may not request that the payment be made directly to the provider of Service.

Confidentiality of Personal and Health Information

Blue Shield Life protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or Social Security Number. Blue Shield Life will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the telephone number on the Subscriber's Identification Card or accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:
Blue Shield Life Privacy Official
P. O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information

Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life 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 Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Independent Contractors

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

Entire Policy: Changes

This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No representative has authority to change this Policy or to waive any of its provisions. Blue Shield Life will provide at least 60 days written notice of any changes to this Policy.

Time Limit on Certain Defenses

After an Insured has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any omission, misrepresentation, or inaccuracy made by the Applicant in an individual application to limit, cancel or rescind the Policy, deny a claim, or raise Premiums.

Grace Period

After payment of the first Premium, the Subscriber is entitled to a grace period of 30 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Policy continues in force.

Notice and Proof of Claim

Notice and Claim Forms

In the event the provider of Services does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of Service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim

without using a claim form by sending Blue Shield Life written proof of claim as described below.

Proof of Claim

Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a contracted professional provider and no later than 180 days for claims from a non-contracted professional provider. Send a copy of your itemized bill to the Blue Shield Life service center listed on the last page of this Policy.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify Blue Shield Life.

Payment of Benefits

Time of Payment of Claims

Claims will be paid immediately upon receipt of proper written proof and determination that benefits are payable.

Payment of Claims

Participating Providers and Preferred Providers are paid directly by Blue Shield Life.

If the Insured receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Insured is responsible for payment to the Non-Preferred Provider, except that Hospital charges are generally paid directly to the Hospital.

Refer to the section entitled Outpatient Prescription Drugs for information on reimbursement of prescription drug claims.

Legal Actions:

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished.

Organ and Tissue Donation

Many residents in the state of California are eligible to become organ and tissue donors. By deciding to be an organ and tissue donor, you can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at http://www.ctdn.org or Donate Life California's internet site at http://www.donatelifecalifornia.org. You may also call the regional organ procurement agency in the city nearest you for additional information on organ and tissue donation.

Choice of Providers

An Insured may select any Hospital or Physician to provide covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Preferred Provider or a Non-Preferred Provider is selected. It is to the Insured's advantage to select Preferred Providers whenever possible. See the Definitions section for more information. A Directory of Preferred Physicians and Preferred Hospitals has been provided to the Insured. A listing of Participating Physicians and Preferred Hospitals may be viewed by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com. An extra copy is available upon request by calling the Plan at the telephone number on the Subscriber's Identification Card or writing to:

Blue Shield Life
PO Box 272610
Chico, CA 95927-2610

If the inability to perform by a Preferred Provider, the breach of the contract to furnish Services by a Preferred Provider, or the termination of a Preferred Provider's contract with Blue Shield Life may materially and adversely affect the Insured, Blue Shield Life will, within a reasonable time, advise the Insured in writing of such inability to perform, breach, or termination.

Endorsements and Appendices

Attached to and incorporated in this Policy by reference are appendices pertaining to Deductibles and Premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Policy. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices

Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
50 Beale Street
San Francisco, CA 94105

Commencement or Termination of Coverage

Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Identification Cards

Identification cards will be issued by Blue Shield Life to all Insureds.

Legal Process

Legal process or service upon Blue Shield Life must be served upon a corporate officer of Blue Shield Life.

Notice

The Subscriber hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Subscriber and Blue Shield Life (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Customer Service

For all Services other than Mental Health -

An Insured who has a question about services, providers, benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, may call the Plan's Customer Service Department at the telephone number on the Subscriber's Identification Card.

The hearing impaired may contact the Plan's Customer Service Department through the Plan's toll-free TTY telephone number at:

1-800-241-1823

Customer Service can answer many questions over the telephone. Insureds may also submit questions to Customer Service by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: Blue Shield Life has established a procedure for our Subscribers and Dependents to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the telephone number on the Subscriber's Identification Card.

Blue Shield Life may refer inquiries or appeals to a local medical society, hospital utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer review committee for an opinion to assist in the resolution of these matters.

For all Mental Health Services -

The Plan's Mental Health Service Administrator (MHSA) should be contacted for questions about Mental Health Services, MHSA network Providers, or Mental Health benefits. You may contact the MHSA at the telephone number or address, which appear below:

1-877-263-9952

Blue Shield of California
Life and Health Insurance Company
Mental Health Service Administrator
PO Box 719002
San Diego, CA 92171-9002

The MHSA can answer many questions over the telephone.

The MHSA has established a procedure for our Insureds to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. The MHSA shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the telephone number listed above.

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving and tracking Insured's grievances with Blue Shield Life.

For all Services other than Mental Health -

The Insured, a designated representative, or a provider on behalf of the Insured, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim of Service. The Insured may contact Blue Shield Life at the telephone number on the Subscriber's Identification Card. If the telephone inquiry to Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or completed "Grievance Form". The Insured may request this Form from Customer Service at the address as noted in this Policy. The completed Form should be submitted to:

Blue Shield Life
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762-0011

The Insured may also submit the grievance online by visiting the web site at http://www.blueshieldca.com.
Blue Shield Life will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health Services -

The Insured, a designated representative, or a provider on behalf of the Insured, may contact the MHSA by telephone, letter, or online to request an initial determination concerning a claim or Service. The Insured may contact the MHSA at the telephone as noted below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Insured may request this Form from the MHSA's Customer Service Department. If the Insured wishes, the MHSA's Customer Service staff will assist in the completing of the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Insured may also submit the grievance to the MHSA online by visiting http://www.blueshieldca.com.

1-877-263-9952

Blue Shield of California
Life and Health Insurance Company
Mental Health Service Administrator
Attn: Customer Services
PO Box 719002
San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction.

If the grievance involves an MHSA Non-Participating Provider, the Insured should contact the appropriate Blue Shield Life Customer Service Department.

For all Services - External Independent Medical Review

If your grievance involves a claim or services for which coverage was denied by Blue Shield Life or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield Life and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental / investigational; you may immediately request an external review following receipt of notice of denial.

You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Insurance will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review.

You and your Physician will receive copies of the opinions of the external review agency. The decision of the external re-

view agency is binding on Blue Shield Life; if the external reviewer determines that the service is Medically Necessary, Blue Shield Life will promptly arrange for the service to be provided or the claim in dispute to be paid.

This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

California Department of Insurance Review

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8:00 a.m. to 6:00 p.m., Monday through Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013 or through the website www.insurance.ca.gov..

Definitions

Plan Provider Definitions

Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Doctor of Medicine — a licensed medical doctor (M.D.) or doctor of osteopathic medicine (D.O.).

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA); licensed professional clinical counselor (LPCC); massage therapist.

Hospice or Hospice Agency – an entity which provides Hospice Services to Terminally Ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital —

1. A licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, or nursing home, or home for the aged is not included.

2. A psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. A "psychiatric health facility" as defined in Section 1250.2 of the California Health and Safety Code.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health Services. Note: MHSA Non-Participating Providers may include Blue Shield Life Preferred/Participating Providers if the Provider does not also have an agreement with the MHSA.

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

Non-Participating Home Health Care and Home Infusion Agency — agencies which have not contracted with Blue Shield Life Provider Network and whose services are not covered unless prior authorized by the Plan.

Non-Participating / Non-Preferred Provider — any provider who has not contracted with Blue Shield Life to accept Blue Shield Life's payment, plus any applicable Deductible, Copayment, Coinsurance or amount in excess of specified benefit maximums, as payment-in-full for covered Services, except as provided in the section entitled Preventive Care Benefits.

Note: this definition does not apply to Mental Health and Services. For Non-Participating Providers for Mental Health Services see the Mental Health Service Administrator (MHSA) Non-Participating Providers definition.

Non-Preferred Bariatric Surgery Services Providers – any provider that has not contracted with Blue Shield Life to furnish bariatric surgery services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery services provider by Blue Shield Life. Non-Preferred Bariatric Surgery Services Providers may include Blue Shield Life Preferred / Participating Providers if the Provider does not also have an agreement with Blue Shield Life to provide bariatric surgery services.

Note: bariatric surgery services are not covered for Persons who reside in designated counties in California if the service is provided b a Non-Preferred Bariatric Surgery Services Provider. (See the section entitled Bariatric Surgery Benefits for more information.)

Other Provider —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; certified acupuncturist; dental technicians; and laboratory technicians.

2. Healthcare Organizations — nurses registries; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable x-ray companies; blood banks, speech and hearing centers; dental labs; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society; Catholic Charities; and Skilled Nursing Facilities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical Services on an Outpatient basis.

Participating Ambulatory Surgery Center – an Outpatient surgery facility which:

1. Is either licensed by the State of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and

2. Provides Services as a free-standing ambulatory surgery center which licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and

3. Has contracted with Blue Shield Life to provide Services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with Blue Shield Life Provider Network to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion Agency by the Plan. (See Non-Participating Home Health Care and Home Infusion Agency definition.

Participating Provider — All Preferred Providers are Participating Providers. These providers include Physicians, Hospitals, Alternate Care Services Providers, Ambulatory Surgery Centers, a Certified Registered Nurse Anesthetist, and Home Health Care and Home Infusion agencies that have contracted with Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, plus applicable Deductibles, Copayments and Coinsurance, or amounts in excess of specified benefit maximums, as payment in full for covered Services, except as provided under in the section entitled Professional (Physician) Benefits.

Note: this definition does not apply to Mental Health Services or Hospice Program Services. For Participating Providers for Mental Health Services and Hospice Program Services, see the Mental Health Service Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definition.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has contracted with Blue Shield Life Provider Network, has agreed to furnish Services to Insureds covered by Blue Shield Life, and has agreed to accept Blue Shield Life's payment as payment-in-full for covered Services, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

Preferred Bariatric Surgery Services Provider – a Preferred Hospital or a Physician Member that has contracted with Blue Shield Life to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield Life.

Preferred Dialysis Center – a dialysis services facility contracted as a Blue Shield Life Network Provider to provide dialysis services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hospital — a Hospital which has contracted with Blue Shield Life Provider Network and which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Plan.

Preferred Provider – A Preferred Provider is a Participating Provider who has contracted with the Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

Note: for Participating Providers for Mental Health Services, see the Mental Health Service Administrator (MHSA) Participating Providers definition.

Preferred Physicians — a Physician who has agreed to accept Blue Shield Life's payment, plus any Insured payments of any applicable Deductible, Copayment, and/or Coinsurance as payment-in-full for covered Services. Please refer to the Summary of Benefits for Copayment and/or Coinsurance information.

Skilled Nursing Facility — a facility licensed by the California Department of Health Services as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

All Other Definitions

Whenever any of the following terms are capitalized in this Policy, the terms will have the meaning below:

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Allowable Amount — the Blue Shield Life Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Blue Shield Life Allowance, unless otherwise specified for a particular Service elsewhere in this Policy, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield Life have agreed by contract will be accepted as payment in full for the Services rendered; or

2. For a non-participating provider anywhere within or outside of the United States who provides Emergency Services:

   a. For physicians and hospitals – the Out-of-Network Emergency Allowable;
   b. For other providers - 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

3. For a non-participating provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield Life would have allowed for a Participating Provider performing the same service in the same geographical area; or

4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local plan has no non-participating provider allowance, Blue Shield Life will assign the Allowable Amount used for a non-participating provider in California.

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

Blue Shield Life — the Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

Calendar Year — a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may

be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by reoccurrence requiring continuous or periodic care as necessary.

Close Relative — the spouse or Domestic Partner, child, brother, sister or parent of a Subscriber or Dependent.

Coinsurance — the percentage of the Allowable Amount or billed charges that an Insured is required to pay for certain Services after meeting any applicable Deductible.

Copayment — the dollar amount that an Insured is required to pay for certain Services after meeting any applicable Deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. Title XVIII of the Social Security Act, e.g., Medicare.
3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored or funded program of medical care.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Doctor of Medicine); or care furnished to an Insured who is mentally or physically disabled, and:

1. Who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the individual to live outside an institution providing such care; or
2. When, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount you must pay for specific Covered Services that are a benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dependent —

1. A Subscriber's legally married spouse who is:
   a. Resident of California; and
   b. Not covered for benefits as a Subscriber; and
   c. Not legally separated from the Subscriber; or

2. A Subscriber's Domestic Partner, who is:
   a. Not covered for Benefits as a Subscriber; and
   b. A Resident of California.
3. A Subscriber's, spouse's, or Domestic Partner's child (including any stepchild or 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), not covered for benefits as a Subscriber who is:
   a. A Resident of California (unless a full-time student); and
   b. Less than 26 years of age, or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship; and
   c. Who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with this Policy.

Note: Children of Dependent children (i.e. grandchildren of the Subscriber, spouse, or Domestic Partner) are not Dependents unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26 and the Dependent child is disabled, benefits for such Dependent will be continued upon the following conditions:
   a. The child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition;
   b. The Subscriber, spouse, or Domestic Partner submits to the Plan a Physician's written certification of disability within 60 days from the date of the Plan's request; and
   c. Thereafter, certification from a Physician is submitted to the Plan on the following schedule:
      i. Within 24 months after the month when the Dependent would otherwise have been terminated; and
      ii. Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child

becomes ineligible for coverage under this plan for any reason other than attained age.

Domestic Partner - an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are:
   a. 18 years of age or older; and
   b. Of the same or different sex; and
   c. Residents of California.

2. The partners share:
   a. An intimate and committed relationship of mutual caring; and
   b. The same principal residence.

3. The partners are:
   a. Not currently married; and
   b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the individual's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the individual's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

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

1. Placing the patient's health in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part.

Experimental or Investigational in Nature — Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Family — the Subscriber and all enrolled Dependents.

Hospital Services — Services provided under the direction of a Physician, in a licensed Hospital to treat illness or injury and which require the facilities of a Hospital.

Incurred — a charge shall be deemed to be "Incurred" on the date the particular Service, which gives rise to it, is provided or obtained.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving Services under the direction of a Doctor of Medicine.

Insured — either a Subscriber or Dependent.

Intensive Outpatient Care Program — an Outpatient Mental Health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Mental Health Condition — mental disorders listed in the "Diagnostic & Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)", including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Services — see definition of Psychiatric Care.

Mental Health Service Administrator (MHSA) —The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health Services through a separate network of MHSA Participating Providers.

Negotiated Rate — the amount a Preferred Hospital has agreed to accept as payment-in-full for covered Services, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided under the section entitled Covered Services.

Non-Routine Outpatient Mental Health Services – Outpatient Facility and professional services for the diagnosis and treatment of Mental Health Conditions, including but not limited, to the following:

1) Partial Hospitalization

2) Intensive Outpatient Program

3) Electroconvulsive Therapy

4) Transcranial Magnetic Stimulation

5) Behavioral Health Treatment

6) Psychological Testing

These services may also be provided in the office, home, or other non-institutional setting.

Occupational Therapy - treatment under the direction of a Doctor of Medicine and provided by an occupational therapist or other appropriately licensed or certified Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Orthosis — an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Out-of-Country Services — Medical services received outside the United States of America.

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

Outpatient — an Insured receiving Services, but not as an Inpatient.

Partial Hospitalization Program (Day Treatment) — an outpatient treatment program that may be freestanding or Hospital-based and provides Services at least five (5) hours per day four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following stabilization.

Physical Therapy - treatment provided by a physical therapist, occupational therapist, or other appropriately licensed or certified Health Care Provider Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

Plan — the Blue Shield of California Life & Health Insurance Company and/or the Blue Shield Life PPO Plan 1500 - G.

Policy — this Policy, the appendices, all endorsements to it, and all applications for coverage and health statements.

Pre-Existing Condition — an illness, injury, or condition (including disability) which existed during the six (6) months prior to the Effective Date with Blue Shield Life if, during that time, any medical advice, diagnosis, care, or treatment was recommended or received from a licensed health practitioner.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

Psychiatric Care (Mental Health Services) — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury or other condition.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: 1) to improve functions, or 2) to create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of this surgery for cleft palate procedures.

Rehabilitation — Inpatient or Outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Resident of California — an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Residential Care – Mental Health services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Insured who do not require acute inpatient care.

Respiratory Therapy - treatment under the direction of a Doctor of Medicine and provided by a respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Routine Outpatient Mental Health Services – professional office visits for the diagnosis and treatment of Mental Health Conditions including the individual, family, or group setting.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1. Have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. Meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

    a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment;

    b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — Medically Necessary health care Services and Medically Necessary supplies furnished incident to those Services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo-affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or Nurse Practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;

2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist or speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by a diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing Services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility, which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber — an individual who is a Resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield Life, and has maintained Blue Shield Life membership in accord with this Policy.

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357.
English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請撥打1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신1-866-346-7198 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は, 1-866-346-7198 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره 1-866-346-7198تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357تلفن کنید. Persian

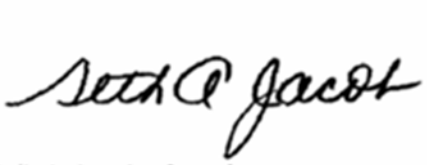
ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم 1-866-346-7198. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Subscriber's Effective Date.



Seth A. Jacobs, Secretary
Blue Shield of California Life & Health Insurance Company

Ken Wood
President & Chief Executive Officer
Blue Shield of California Life & Health Insurance Company

For claims submission and information contact:

Blue Shield of California Life and Health Insurance Company
P. O. Box 272540
Chico, CA 95927-2540

You may call Customer Service toll free at 1-800-431-2809

The hearing impaired may call Blue Shield Life's
Customer Service Department through
Blue Shield Life's toll-free TTY number at
1-800-241-1823.

Benefits Management Program
for Pre-admission and/or Prior Authorization,
please call the Customer Service telephone number
as indicated on the back of the Insured's identification card.

Benefits Management Program
for Prior-Authorization of Radiological Services:
1-888-642-2583

For Prior Authorization for Inpatient Mental Health services,
contact the Mental Health Service Administrator at:
1-877-263-9952

Please see the section entitled Benefits Management Program
for additional information.

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