blue of california

Blue Shield of California
Endorsement to Your HMO On Exchange Plans

This Endorsement should be attached to, and is made part of, your **Agreement** issued by Blue Shield of California. Please retain it for your records.

Effective **June 14, 2021**, your **Agreement** is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revisions have been made to the **Your coverage** section:

   Effective date of coverage for most special enrollment periods
   If enrolled during open enrollment, Dependents have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Subscriber submits ~~the~~ an application or request for special enrollment ~~by the 15th of the month~~, the effective date of coverage will be the 1st of the next month. ~~If the Subscriber submits the application or request after the 15th of the month, the effective date of coverage will be the 1st of the second month after the submission.~~

2. The following revisions have been made to the **Special enrollment period** section:

   The following are Triggering Events: …

   - Loss or anticipated loss of coverage under an employer-sponsored health plan as a result of: …
     - Exhaustion of COBRA or Cal-COBRA continuation coverage or complete loss employer premium contributions or governmental subsidies. …

   - National public health emergency or pandemic that results in a declaration of state of emergency at the state or national level.

Effective **January 1, 2022**, your **Agreement** is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

3. The following revisions have been made to the **Non-Participating Providers** section:

   Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges as payment in full for Covered Services. Except for Emergency Services, Urgent Services, and services received at a Participating ~~Hospital~~ Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, this plan does not cover services from Non-Participating Providers.

Non-Participating Providers at a Participating Provider facility

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

4. The following revisions have been made to the **Continuity of care** section:

Continuity of care may be available if:

- ~~Your provider leaves your Medical Group during your care;~~
- ~~Your MHSA Participating Provider becomes an MHSA Non-Participating Provider during your care;~~
- Blue Shield, the Medical Group, or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving;
- You are a newly-covered Member whose coverage choices do not include out-of-network benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

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

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

- ~~Ongoing treatment for an acute or serious chronic condition;~~
- ~~Pregnancy care, including care immediately after giving birth;~~
- ~~Treatment for a maternal mental health condition;~~
- ~~Treatment for a terminal illness;~~
- ~~Other services authorized by a now terminated provider as part of a documented course of treatment; or~~
- ~~Care for a child up to 36 months old.~~

Continuity of care with a Former Participating Provider

Qualifying conditions	***Timeframe***
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract or until the treatment concludes, whichever is sooner
Acute conditions	As long as the condition lasts

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

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

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

Under Federal law, t~~T~~he Former ~~Non-~~Participating Provider must ~~agree to~~ accept Blue Shield's, the Medical Group's, or the MHSA's Allowed Charges as payment in full for the first 90 days of your ongoing care. Once ~~If~~ the provider ~~agrees~~accepts and your request is authorized, you may continue to see the Former ~~Non-~~Participating Provider at the Participating Provider Cost Share. ~~for:~~

- ~~Up to 12 months;~~
- ~~For a maternal mental health condition, 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later; or~~
- ~~If you have a terminal illness, for the duration of the terminal illness.~~

5. The following revisions have been made to the **When coverage ends** section:

   There is no right to receive the Benefits of this plan after coverage ends, except as described in the *Continuity of care* section.

6. The following revisions have been made to the **Emergency Benefits** section:

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

7. The following revisions have been made to the **Prior authorization/exception request/step therapy process** section of the **Prescription Drug Benefits** section:

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

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

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

8. The following revisions have been made to the **Grievance process** section:

If Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may ~~submit a grievance requesting~~ request an external exception request review. Blue Shield will ensure a decision within 72 hours. Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, or when you are experiencing severe pain~~, or when you are being treated with a non-Formulary Drug~~.

Blue Shield will make a decision within three calendar days for expedited grievance requests related to:

- Medical Benefits;
- Mental Health and Substance Use Disorder services;
- Pediatric dental Benefits; and
- Pediatric vision Benefits.

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

9. The following revisions have been made to the **Non-participating providers outside of California** section of the **BlueCard® Program** section:

Coverage for health care services provided outside of California and within the BlueCard® Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Out-of-Area Covered Health Care Services as described in this paragraph.

10. The following revisions have been made to the **Allowed Charges** definition:

- For a Participating Provider: the amounts a Participating Provider agrees to accept as payment from Blue Shield.
- For a Non-Participating Provider: (1) the amounts paid by Blue Shield when services from a Non-Participating Provider are covered and are paid as a Reasonable and Customary amount, or (2) if applicable the amount determined under state and federal law.

11. The following revisions have been made to the **Emergency Services** definition:

The following services provided for an Emergency Medical Condition:

- Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility;

- Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and
- Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and
- Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

12. The following definition has been added to the **Definitions** section:

Former Participating Provider: A Former Participating Provider is a provider of services to the Member under any of the following conditions:

- A provider who is no longer available to you as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
- A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.

13. The following revisions have been made to the **Reasonable and Customary** definition:

In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider.

Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits or if applicable, the amount determined under state and federal law.

14. The following revisions have been made to the **Notices about your plan** section:

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as provided under the *Continuity of care* section when applicable.

Effective **August 1, 2022**, your **Agreement** is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

15. The following revisions have been made to the **Claims for Emergency or Urgent Services** section:

Claim forms are available at blueshieldca.com/covered-california-policies.

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Officer, to take effect on the Subscriber's Effective Date.

Patrice Bergman
Vice President and General Manager
Individual and Family Plans
Blue Shield of California