Evidence of Coverage and Disclosure Form

Effective January 1, 2027

Blue Shield of California Trio HMO Basic Plan

Health Maintenance Organization (HMO)

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

We have included a Summary of Covered Benefits for the Trio Basic Plan with a comprehensive description following. It will be to your advantage to familiarize yourself with this booklet before you need services.

Take time to review this booklet. The information contained will be useful throughout the year.

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health plan.

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

If you have questions about the benefits to your plan, or if you would like additional information, please contact Blue Shield Member Services at the address or telephone number listed on the back cover of this booklet.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at Blue Shield's Member Services telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Blue Shield Trio HMO Health Plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. However, the statement of benefits, exclusions and limitations in this Evidence of Coverage is complete and is incorporated by reference into the contract.

The contract is on file and available for review in the office of the CalPERS Health Plan Research and Administration Division, 400 Q Street, Sacramento, CA 95811, or P.O. Box 720724, Sacramento, CA 94229-0724. You may purchase a copy of the contract from the CalPERS Health Plan Research and Administration Division for a reasonable duplicating charge.

Notice About Contracted Providers

The Trio HMO plan offers a limited selection of independent practice associations (IPAs) and medical groups from which Members must choose, and a limited network of hospitals. Except for emergency services, urgent services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member's Personal Physician.

Health Information Exchange Participation

Blue Shield participates in the Manifest MedEx Health Information Exchange ("HIE") making its Members' health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

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

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx, should fill out the online form at www.manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142

Effective July 1, 2027: Notice about Infertility and fertility services

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining infertility treatment services.

Notice about fertility preservation services

You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network costsharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Notice about telehealth

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

You can receive Covered Benefits on an in-person basis or via telehealth, if available, from your Personal Physician, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with existing timeliness and geographic access standards. See the Timely Access to Care section for more information.

If your plan includes Covered Benefits from Non-Participating Providers, you can receive the Covered Benefit either on an in-person basis or via telehealth.
Please see the How to Use this Plan section for additional information.

Notice about confidential communication requests

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

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

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

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

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

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to [blueshieldca.com/privacy] and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

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

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

Mail: Blue Shield of California Privacy Office, P.O. Box 272530, Chico CA, 95927-2530

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

Notice about Mental Health or Substance Use Disorder services

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Your Introduction to the Blue Shield Trio HMO Health Plan

Welcome to Blue Shield's Trio HMO Plan. Members enrolled in the Trio Basic Plan may find the description of their plan beginning on page 10.

Your interest in the Blue Shield Trio HMO Health Plan is appreciated. Blue Shield has served Californians for more than 60 years, and we look forward to serving your health care needs.

Unlike some HMOs, the Trio HMO offers you a health plan with a limited selection of independent practice associations (IPAs) and medical groups from which you must choose, and a limited network of hospitals. The independent practice associations and medical groups in the Trio HMO network participate in accountable care organization collaborations with Blue Shield. Trio HMO Members may take advantage of special features such as Trio+ Specialist and Trio+ Satisfaction. These features are described fully in this booklet.

It is important for you to review the list of providers within the Trio HMO physician and hospital directory before enrolling in this health plan. In many areas, there may only be one (1) independent practice association or medical group from which to select a Personal Physician or to receive Covered Benefits.

You will be able to select your own Personal Physician from the Blue Shield HMO Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Each of your eligible family members may also select a Personal Physician. All Covered Benefits must be provided by or arranged through your Personal Physician, except for the following: services received during a Trio+ Specialist visit, or obstetrical/gynecological (OB/GYN) services provided by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as your Personal Physician, urgent care provided in your Personal Physician service area by an urgent care clinic when instructed by your assigned medical group or IPA, or emergency services, or Mental Health or Substance Use Disorder services. See the How to Use the Plan section for information. Note: A decision will be rendered on all requests for prior authorization of services as follows: for urgent services and in-area urgent care, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request; for other services, within 5 business days, but not to exceed 7 calendar 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 Member within 2 business days of the decision.

You will have the opportunity to be an active participant in your own health care. Working with the Blue Shield Trio HMO, we'll help you make a personal commitment to maintain and, where possible, improve your health status. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

As a partner in health with Blue Shield, you will receive the benefit of Blue Shield's commitment to service ... an unparalleled record of more than 60 years.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Trio HMO.

If you have any questions regarding the information, you may contact us through our Member Services Department at 1-800-334-5847. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free text telephone (TTY) number, 711.

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TRIO BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Summary of Covered Benefits

Category Description	Member Copayment & Limitations
Hospital Inpatient (includes blood and blood products - collection and storage of autologous blood) Outpatient Upper and lower gastrointestinal endoscopy, cataract surgery, and spinal injection	No Charge No Charge
Physician Services Office/Home Visits Urgent Care Visits Allergy Testing/Treatment Inpatient Hospital Visits Surgery/Anesthesia	$15/visit $15/visit No Charge No Charge No Charge
Preventive Services Preventive Services Diagnostic X-ray/Lab	No Charge No Charge
Diagnostic X-ray/Lab	No Charge
Durable Medical Equipment (including breast pump, orthoses and prostheses)	No Charge
Pregnancy & Maternity Prenatal and Postnatal Physician Office Visits	No Charge
Family Planning Counseling	No Charge
Infertility Testing & Treatment	Effective 1/1/27-6/30/27: 50% of Allowed Charges Effective 7/1/27-12/31/27: $15/treatment bundle
Ambulance Services	No Charge
Emergency Care/Services	$50/visit (waived if admitted)
Home Health Services	No Charge
Physical/Occupational/Speech Therapy	No Charge for inpatient visits at a hospital or skilled nursing facility. $15/visit for outpatient and home visits.
Skilled Nursing Care	No Charge - up to 100 days per calendar year.
Hospice	No Charge
Calendar Year Out-of-Pocket Maximum **Member** **Family** **Includes the $1,000 maximum annual out-of-pocket payments for home delivery Formulary prescription drugs per Member**	 $12,000 • Medical - $1,500 maximum • Pharmacy - $10,500 maximum $24,000 • Medical - $3,000 maximum • Pharmacy - $21,000 maximum

TRIO BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Prescription Drugs			
	Up to 30-day supply	**Up to 90-day supply**	**Up to 90-day supply**
	Participating Retail Pharmacy (short-term use medications)	SELECT[1] Retail Pharmacy (long-term use medications)	Home Delivery (long-term use medications)
Tier 1	$5	$10	$10
Tier 2	$20	$40	$40
Tier 3	$50	$100	$100
Tier 4 Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.	$30	$60	$60
Partial Copay Waiver of Tier 3	$40	$70	$70
Brand Drugs with Generic equivalents	Member pays the difference in cost between the brand name drug and the generic equivalent or biosimilar drug, plus the brand copayment (The difference in cost does not accrue towards the Member out-of-pocket maximum)	Member pays the difference in cost between the brand name drug and the generic equivalent or biosimilar drug, plus the brand copayment (The difference in cost does not accrue towards the Member out-of-pocket maximum)	Member pays the difference in cost between the brand name drug and the generic equivalent or biosimilar drug, plus the brand copayment (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum or the $1,000 home delivery out of pocket maximum)
Sexual Dysfunction Drugs	50% coinsurance	Not Applicable	Not Applicable
Maximum annual out-of-pocket payments for home delivery prescription drugs	Not Applicable	Not Applicable	$1,000 per Member (Non-Formulary Drugs, Tier 3 Drugs, and drugs to treat sexual dysfunction do not accumulate towards the $1,000 home delivery out-of-pocket maximum)

[1] For a list of select pharmacies, please visit the Pharmacy Resources page at blueshieldca.com/calpers

TRIO BASIC PLAN

Benefit Changes for Current Year

Member Calendar Year
Out-of-Pocket Maximum

Out of pocket maximum for both pharmacy and medical expenses will be $12,000 per individual (Medical: $1,500 / Pharmacy: $10,500) and $24,000 per family (Medical: $3,000 / Pharmacy: $21,000).

Infertility Benefits

Effective July 1, 2027: In accordance with state mandate SB 729, Section G. Family Building Benefits has been updated to reflect increased coverage for Infertility services.

BENEFITS OF THIS PLAN ARE AVAILABLE ONLY FOR SERVICES AND SUPPLIES FURNISHED DURING THE TERM THE PLAN IS IN EFFECT AND WHILE THE INDIVIDUAL CLAIMING BENEFITS IS ACTUALLY COVERED BY THE GROUP AGREEMENT.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
Or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's Service Area. When you use your work ZIP Code, all enrolled dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's Service Area, even if they do not reside in that area.

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician.

Vested Rights

There is no vested right to receive any particular benefit set forth in the plan. plan benefits may be modified. any modified benefit (such as the elimination of a particular benefit or an increase in the member's copayment) applies to services or supplies furnished on or after the effective date of the modification.

How to Use the Plan

Choice of Physicians and Providers

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

Please note services performed by yourself, your spouse, Domestic Partner, child, brother, sister, or parent are not covered. In addition, services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program are not covered.

Payment of Providers

Blue Shield generally contracts with groups of physicians to provide services to Members. A fixed, monthly fee is paid to these groups of physicians for each Member whose Personal Physician is in the group. This payment system, capitation, includes incentives to the groups of physicians to manage all services provided to Members in an appropriate manner consistent with the Agreement.

If you want to know more about this payment system, contact Member Services at the number listed on the back cover of this booklet or talk to your Plan provider.

Selecting a Personal Physician

A close physician-to-patient relationship is an important ingredient that helps to ensure the best medical care. Each Member is therefore required to select a Personal Physician at the time of enrollment. Family members can choose different Personal Physicians in different medical groups or IPAs, except as described for newborns below. This decision is an important one because your Personal Physician will:

- Help you decide on actions to maintain and improve your total health;
- Coordinate and direct all of your medical care needs;
- Authorize emergency services when appropriate;
- Work with your medical group or IPA to arrange your referrals to specialty physicians, hospitals and all other health services, including requesting any prior authorization you will need;
- Prescribe those lab tests, x-rays and services you require; and
-
- Assist you in applying for admission into a hospice program through a participating hospice agency when necessary.

To ensure access to services, each Member must select a Personal Physician who is located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If you do not select a Personal Physician at the time of enrollment, the Plan will designate a Personal Physician for you and you will be notified of the name of the designated Personal Physician. This designation will remain in effect until you notify the Plan of your selection of a different Personal Physician.

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption, but always within 31 days from the date of birth or placement for adoption. You may designate a pediatrician as the Personal Physician for your child. The Personal Physician selected for the month of birth must be in the same medical group or IPA as the mother's Personal Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the subscriber for adoption, the Personal Physician selected must be a physician in the same medical group or IPA as the subscriber. If you do not select a Personal Physician within 31 days following the birth or placement for adoption, the Plan will designate a Personal Physician from the same medical group or IPA as the natural mother or the subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Personal Physician for the child after the month of birth or placement for adoption, see the section below on Changing Personal Physicians or Designated Medical Group or IPA. If your child is ill during the first month of coverage, be sure to read the information about changing Personal Physicians during a course of treatment or hospitalization.

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you should contact CalPERS –Health Account Management Division and Blue Shield to add your child to your coverage.

Role of the Medical Group or IPA

Most Blue Shield Trio HMO Personal Physicians contract with medical groups or IPAs to share administrative and authorization responsibilities with them. (Of note, some Personal Physicians contract directly with Blue Shield.) Your Personal

Physician coordinates with your designated medical group or IPA to direct all of your medical care needs and refer you to specialists or hospitals within your designated medical group or IPA unless because of your health condition, care is unavailable within the medical group or IPA.

Your designated medical group or IPA (or Blue Shield when noted on your identification card) ensures that a full panel of specialists is available to provide your health care needs and helps your Personal Physician manage the utilization of your health plan benefits by ensuring that referrals are directed to providers who are contracted with them. Medical groups or IPAs also have admitting arrangements with hospitals contracted with Blue Shield in their area and some have special arrangements that designate a specific hospital as "in network." Your designated medical group or IPA works with your Personal Physician to authorize services and ensure that that service is performed by their in-network provider.

Your PCP will refer you to other providers in your Medical Group for the care you need. If these services cannot reasonably be obtained from a Plan Provider, you can ask your Medical Group for authorization to see a non-Plan Provider. They will review your request for Medical Necessity, and if approved, your Medical Group will pay for Covered Benefits from the non-Plan Provider. You will only be responsible for the Plan Provider Cost Share. If the Medical Group cannot provide the necessary care, you can call Shield Concierge for help finding a Plan Provider who can provide the requested services.

The name of your Personal Physician and your designated medical group or IPA (or, "Blue Shield Administered") is listed on your Trio HMO identification card. The Blue Shield HMO Member Services Department can answer any questions you may have about changing the medical group or IPA designated for your Personal Physician and whether the change would affect your ability to receive services from a particular specialist or hospital.

Changing Personal Physicians or Designated Medical Group or IPA

The Trio HMO plan offers a limited selection of IPAs and medical groups from which you must choose. You may change your Personal Physician to another Personal Physician within your selected medical group/IPA by calling Shield Concierge at the Member Services Department at 1-800-334-5847.

It is important for you to review the list of providers within the Trio HMO Physician and Hospital Directory before enrolling in this health plan. In many areas, there may only be one (1) IPA or medical group from which to select a Personal Physician or to receive Covered Benefits.

In scenarios where there is only one (1) IPA or medical group, you may not change your Trio HMO medical group/IPA except by enrolling in a different health plan product, either at open enrollment or as the result of a qualifying event.

In some circumstances, however, more than one medical group/IPA serves a particular area. In such situations, you may change your selected medical groups/IPA to another medical group/IPA the same way you change your Personal Physician. If the selected medical group/IPA does not have an affiliation with your Personal Physician, a change in medical groups/IPA may also require the Member to select a new Personal Physician.

You or your dependent may change Personal Physicians or designated medical group or IPA by calling the Member Services Department at 1-800-334-5847. Some Personal Physicians are affiliated with more than one medical group or IPA. If you change to a medical group or IPA with no affiliation to your Personal Physician, you must select a new Personal Physician affiliated with the new medical group or IPA and transition any specialty care you are receiving to specialists affiliated with the new medical group or IPA. The change will be effective the first day of the month following notice of approval by Blue Shield. Once your Personal Physician

change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN services provided by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as your Personal Physician and Trio+ Specialist visits. Once your medical group or IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new medical group or IPA, even if you remain with the same Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician or medical group or IPA.

Voluntary medical group or IPA changes are not permitted during the third trimester of pregnancy or while confined to a hospital. The effective date of your new medical group or IPA will be the first of the month following discharge from the hospital, or when pregnant, following the completion of post-partum care.

Additionally, changing your Personal Physician or designated medical group or IPA during a course of treatment may interrupt the quality and continuity of your health care. For this reason, the effective date of your new Personal Physician or designated medical group or IPA, when requested during a course of treatment, will be the first of the month following the date it is medically appropriate to transfer your care to your new Personal Physician or designated medical group or IPA, as determined by the Plan.

Any requested changes to your Medical Group during an ongoing course of treatment requires an exception. Exceptions must be approved by the Blue Shield Medical Director and will be effective when medically appropriate to transfer care. For information about approval for an exception to the above provision, please contact Member Services.

If your Personal Physician discontinues participation in the Plan, Blue Shield will notify you in writing and designate a new Personal Physician for you in case you need immediate medical care. You will also be given the opportunity to select a new Personal Physician of your own choice within 15 days of this notification. Your selection must be approved by Blue Shield prior to receiving any services under the Plan. In the event that your selection has not been approved and an emergency arises, see I. Emergency Services in the Benefit Descriptions section for information.

IT IS IMPORTANT TO KNOW THAT WHEN YOU ENROLL IN THE BLUE SHIELD TRIO HMO, SERVICES ARE PROVIDED THROUGH THE PLAN'S DELIVERY SYSTEM, BUT THE CONTINUED PARTICIPATION OF ANY ONE DOCTOR, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

Continuity of Care

Continuity of care with a non-Plan Provider may be available if:

- Blue Shield or the Medical Group, no longer contracts with your Former Plan 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.

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

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

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

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

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

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

Under Federal law, the Former Plan Provider must accept Blue Shield's or the Medical Group's Allowed Charges as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Plan Provider at the Plan Provider Copayment or Coinsurance.

When authorized, the Member may continue to see the non-Plan Provider for up to 12 months. For a maternal mental health condition, the Member may continue to see the non-Plan Provider for 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later.

How to Receive Care

Use of Personal Physician

At the time of enrollment, you will choose a Personal Physician who will coordinate all Covered Benefits. You must contact your Personal Physician for all health care needs, including preventive services, routine health problems, consultations with Plan specialists (except as provided under Obstetrical/Gynecological (OB/GYN) Physician Services, Trio+ Specialist, and Mental Health or Substance Use Disorder services), admission into a hospice program through a participating hospice agency, emergency services, urgent services and for hospitalization. The Personal Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care services and requesting any needed prior authorization. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Personal Physician and self-arranged appointments to a Trio+ Specialist or for OB/GYN services. Because your physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time

slot to another patient who needs to see the physician. Some offices may advise you that a fee will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Personal Physician for any reason, you must contact Member Services at 1-800-334-5847, Monday through Friday, between 7 a.m. and 7 p.m. to select a Personal Physician to obtain benefits.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or a family practice physician who is not her designated Personal Physician. A referral from your Personal Physician or from the affiliated medical group or IPA is not needed. However, the obstetrician/gynecologist or family practice physician must be in the same medical group or IPA as her Personal Physician.

Obstetrical and gynecological services are defined as:

- Physician services related to prenatal, perinatal and postnatal (pregnancy) care,
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia,
- Physician services for treatment of disorders of the breast,
- Routine annual gynecological examinations/annual well-woman examinations.

It is important to note that services by an obstetrician/gynecologist or a family practice physician outside of the Personal Physician's medical group or IPA without authorization will not be covered under this Plan. Before making the appointment, the Member should call the Member Services Department at 1-800-334-5847 to confirm that the obstetrician/gynecologist or family practice physician is in the same medical group or IPA as her Personal Physician.

The OB/GYN physician services are separate from the Trio+ Specialist feature described below.

Referral to Specialty Services and Second Medical Opinions

Although self-referrals to Plan specialists are allowed through the Trio+ Specialist feature described below, Blue Shield encourages you to receive specialty services through a referral from your Personal Physician. The Personal Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty services. Your Personal Physician will generally refer you to a Plan specialist or Plan non-physician health care practitioner in the same medical group or IPA as your Personal Physician, but you can be referred outside the medical group or IPA if the type of specialist or non-physician health care practitioner needed is not available within your Personal Physician's medical group or IPA. Your Personal Physician will request any necessary prior authorization from your medical group or IPA. For Mental Health or Substance Use Disorder services, see the Mental Health or Substance Use Disorder Services paragraphs in the How to Use the Plan section for information regarding how to access care. The Plan specialist or Plan non-physician health care practitioner will provide a complete report to your Personal Physician so that your medical record is complete.

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, or if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Personal Physician to refer you to another physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from your Personal Physician, the second opinion will be provided by a physician within the same medical group or IPA as your Personal Physician. If you are requesting a second opinion about care received from a specialist, the second opinion may be provided by any Plan specialist of the

same or equivalent specialty. All second opinion consultations must be authorized. Your Personal Physician may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Member Services Department at the number listed on the back cover of this booklet.

If your Personal Physician belongs to a medical group or IPA that participates as a Trio Provider, you may also arrange a second opinion visit with another physician in the same medical group or IPA without a referral, subject to the limitations described in the Trio+ Specialist paragraphs later in this section.

To obtain referral for specialty services, including lab and x-ray, you must first contact your Personal Physician. If the Personal Physician determines that specialty services are medically necessary, the physician will complete a referral form and request necessary authorization. Your Personal Physician will designate the Plan provider from whom you will receive services. When no Plan provider is available to perform the needed service, the Personal Physician will refer you to a non-Plan Provider after obtaining authorization. This authorization procedure is handled for you by your Personal Physician.

In certain situations where the Member's medical disease or condition is Life-Threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time, the Personal Physician may make a standing referral (more than one visit) to an appropriate specialist.

Referral by a Personal Physician does not guarantee coverage for referral services. The eligibility provisions, exclusions and limitations will apply.

Trio+ Specialist

You may arrange an office visit with a Plan specialist in the same medical group or IPA as your Personal Physician without a referral from your Personal Physician, subject to the limitations described below. Trio+ Specialist office visits are available only to Members whose Personal Physicians belong to a medical group or IPA that participates as a Trio Provider. Refer to the HMO Physician and Hospital Directory or call Blue Shield Member Services at 1-800-334-5847 to determine whether a medical group or IPA is a Trio Provider.

When you arrange for Trio+ Specialist visits without a referral from your Personal Physician, you will be responsible for a $30 copayment for each Trio+ Specialist office visit. You can self-refer to a Trio+ Specialist for:

- An examination or other consultation; and
- In-office diagnostic procedures or treatment.

You cannot self-refer to an Trio+ Specialist for:

- Allergy testing;
- Endoscopic procedures;
- Advanced imaging, including CT, MRI, or bone density measurement;
- Injectables, chemotherapy, or other infusion Drugs, other than vaccines and antibiotics;
- Infertility services;
- Inpatient services or any services that result in a facility charge, except for routine X-ray and laboratory services; or
- Services for which the Medical Group routinely allows you to self-refer without authorization from your Personal Physician.

NurseHelp 24/7 and LifeReferrals 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 telephone 24 hours a day, 7 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;
5. Preventive care.

If your physician's office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) Or you can call Member Services at the telephone number listed on your identification card.

NurseHelp 24/7 and LifeReferrals 24/7 programs provide Members with no charge, confidential telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

These programs include:

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

Psychosocial support through LifeReferrals 24/7 - Members may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling. Note: See the following Mental Health or Substance Use Disorder Services paragraphs for important information concerning this feature.

Evaluations and Services under the CARE Act

Blue Shield covers the cost of developing an evaluation and the provision of all health care services for an enrollee when required or recommended pursuant to a CARE (Community Assistance, Recovery, and Empowerment) agreement or CARE plan approved by a court in accordance with the CARE Act. The evaluation and services, other than prescription Drugs, are covered at no charge whether they are provided by a Plan Provider or non-Plan Provider. You do not need prior authorization for services, other than prescription Drugs, provided under a court-approved CARE agreement or CARE plan.

Mental Health or Substance Use Disorder Services

Blue Shield of California underwrites and delivers all Mental Health or Substance Use Disorder services.

All Mental Health or Substance Use Disorder services, except for emergency or urgent services, must be provided by a Plan Provider. Mental Health or Substance Use Disorder services received from a health professional who is a non-Plan Provider at a facility that is a Plan Provider will also be covered. A list of Plan Providers is available in the online Blue Shield of California Provider Directory.

Non-emergency Mental Health or Substance Use Disorder services received from a provider who does not participate in the Plan Provider network will not be covered, except as stated herein, and all charges for these services will be the Member's responsibility. This limitation does not apply with respect to emergency services. In addition, when no Plan Provider is available to perform the needed service, Blue Shield will refer you to a non-Plan Provider and authorize services to be received. If a Plan Provider is not available, the Member can ask to see a non-Plan Provider at the Plan Provider Cost Share. If the services cannot reasonably be obtained from a Plan Provider, Blue Shield will approve the request and the Member will only be responsible for the Plan Provider Cost Share.

For complete information regarding benefits for Mental Health or Substance Use Disorder services, see R. Inpatient Mental Health or Substance Use Disorder Services and S. Outpatient Mental Health or Substance Use Disorder Services in the Benefit Descriptions section.

1. Prior Authorization

   Prior authorization is required for all nonemergency Mental Health Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield at 1-800-334-5847 at least five business days prior to the admission. Other Outpatient Mental Health Services include Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Neuropsychological and Psychological Testing, and Transcranial Magnetic Stimulation (TMS), and must also be prior authorized.

   Blue Shield will render a decision on all requests for prior authorization of services as follows:

   - for urgent services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request. A written notice will be sent to the Member and the provider within 72 hours of the decision;
   - for other services, within 5 business days, but not to exceed 7 calendar 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 Member within five calendar days of the decision.

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

Prior authorization is not required for an emergency admission.

2. Psychosocial Support through LifeReferrals 24/7

   Notwithstanding the benefits provided under S. Outpatient Mental Health or Substance Use Disorder Services, the Member also may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

   In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-to-face visits within a 6-month period.

   In the event that the services required of a Member are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Member will be referred to Blue Shield to access his Mental Health or Substance Use Disorder services which are described under S. Outpatient Mental Health or Substance Use Disorder Services.

What to do in case of Emergency:

Life Threatening

Obtain care immediately.

Contact your Personal Physician no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening

Consult your Personal Physician, anytime day or night, regardless of where you are prior to receiving medical care.

Follow-Up Care

Follow-up care, which is any care provided after the initial emergency room visit, must be provided or authorized by your Personal Physician.

For a complete description of the Emergency Services benefit and applicable copayments, see I. Emergency Services in the Benefit Descriptions section.

Urgent Services

The Blue Shield Trio HMO provides coverage for you and your family for your urgent service

needs when you or your family are temporarily traveling outside of your Personal Physician service area.

Urgent services are defined in Section 3, under Definitions. Out-of-area follow-up care is defined in Section 3, under Definitions.

(Urgent care) While in your Personal Physician Service Area

If you require urgent, same-day care for a condition that could reasonably be treated in your Personal Physician's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), you must first call your Personal Physician. However, you may go directly to an urgent care clinic when your assigned medical group or IPA has provided you with instructions for obtaining care from an urgent care clinic in your Personal Physician service area.

Outside of California

The Blue Shield Trio HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. Urgent Services may be obtained from any provider; however, using the Inter-Plan or Blue Shield Global® Core programs can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. See the Inter-Plan Programs section of this Evidence of Coverage for more information on the Inter-Plan or Blue Shield Global® Core programs.

Out-of-Area Follow-up Care is also covered and services may be received through the Inter-Plan or Blue Shield Global® Core programs. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Personal Physician.

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician service area, if possible you should call Shield Concierge at 1-800-334-5847 for assistance in receiving urgent services through a Blue Shield of California Plan provider. You may also locate a Blue Shield Plan provider by visiting our web site at http://www.blueshieldca.com. However, you are not required to use a Blue Shield of California Plan provider to receive urgent services; you may use any California provider.

Out-of-Area Follow-up Care is also covered through a Blue Shield of California provider and may also be received from any provider. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Personal Physician.

If services are not received from a Blue Shield of California Plan provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for urgent services obtained outside of your Personal Physician service area within California will be reviewed retrospectively for coverage. Blue Shield will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information. Once the missing information is received, Blue Shield will have 30 calendar days to process your claim.

When you receive covered urgent services outside your Personal Physician service area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated based on Blue Shield's allowed charges.

See J. Urgent Services in the Benefit Descriptions section for benefit description, applicable copayment information, and information on payment responsibility and claims submission.

Out-of-Area Services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees

referred to generally as Inter-Plan Programs. These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain health care services outside of California, the claims for those services may be processed through one of these Inter-Plan Programs.

When you access services outside of California you may obtain care from one of two kinds of providers. Most providers are participating providers and contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers are non-participating providers because they don't contract with the Host Blue. Blue Shield's payment practices in both instances are described in this section.

The Blue Shield Trio HMO plan provides limited coverage for health care services received outside of California. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Program unless the services and out-of-state provider are authorized by Blue Shield.

Inter-Plan Programs

Emergency Services

Members who experience an Emergency Medical Condition or a Psychiatric Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition or a Psychiatric Emergency Medical Condition.

Away from Home Care

Subscribers or their Dependents may be able to enroll in Away from Home Care when they are on an extended stay within the Service Area of another Blue Cross or Blue Shield plan outside of California. Away from Home Care may be available for Dependents who are full-time students, Dependents of Subscribers who are required by court order to provide coverage, and long-term travelers. For more information on the program and which states participate, visit blueshieldca.com or call the Blue Shield of California Away from Home Care coordinators at (800) 622-9402.

Inter-Plan Programs

Under the Inter-Plan Programs, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Evidence of Coverage. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers, including direct payment to the provider.

The Inter-Plan Program enables you to obtain Out-of-Area Covered Health Care Services outside of California, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment, coinsurance and deductible amounts, if any, as stated in this booklet.

When you receive Out-of-Area Covered Health Care Services outside of California and the claim is processed through the Inter-Plan Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Out-of-Area Covered Health Care Services; or

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that considers special arrangements with your health care 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 health care providers after considering the same types of transactions as with an estimated price.

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

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully-insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee as part of the claim charges passed on to you.

Claims for covered emergency services are paid based on the allowed charges as defined in this booklet.

Non-participating Providers Outside of California

Coverage for health care services provided outside of California and within the Domestic Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will be based on either the Host Blue's non-participating healthcare 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. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

If you do not see a participating provider through the Inter-Plan Program, you will have to pay 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 of California for reimbursement. Blue Shield will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

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

Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (Domestic Service Area), you may be able to take advantage of Blue Shield Global® Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global® Core is not served by a Host Blue. As such, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the Domestic Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global® Core".

Submitting a Blue Shield Global® Core Claim

When you pay directly for Out-of-Area Covered Health Care Services outside the Domestic Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. The claim form is available from Blue Shield Customer Service, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Inpatient, Home Health Care and Other Services

The Personal Physician is responsible for obtaining prior authorization before you can be admitted to the hospital or a skilled nursing facility, including subacute care admissions, except for Mental Health or Substance Use Disorder services which are described in the previous Mental Health or Substance Use Disorder Services section. The Personal Physician is responsible for obtaining prior authorization before you can receive home health care and certain other services or before you can be admitted into a hospice program through a participating hospice agency. If the Personal Physician determines that you should receive any of these services, he or she will request authorization. Your Personal Physician will arrange for your admission to the hospital, skilled nursing facility, or a hospice program through a participating hospice agency, as well as for the provision of home health care and other services.

For hospital admissions for mastectomies or lymph node dissections, the length of hospital stays will be determined solely by the Member's physician in consultation with the Member. For information regarding length of stay for maternity or maternity-related services, see F. Pregnancy and Maternity Care, for information relative to the Newborns' and Mothers' Health Protection Act.

Member Calendar Year Out-of-Pocket Maximum

Out of pocket maximum for both pharmacy and medical expenses will be $12,000 per individual (Medical: $1,500 / Pharmacy: $10,500) and $24,000 per family (Medical: $3,000 / Pharmacy: $21,000).

Once a Member's maximum copayment responsibility has been met, the Plan will pay 100% of the allowed charges for that Member's Covered Benefits for the remainder of that calendar year, except as described below. Additionally, for Plans with a Member and a family maximum copayment responsibility, once the family maximum copayment responsibility has been met, the Plan will pay 100% of the allowed charges for the subscriber's and all covered dependents' Covered Benefits for the remainder of that calendar year, except as described below. Covered Benefits received at a facility that is a Plan Provider will accrue to the Calendar Year Out-of-Pocket Maximum whether Services are provided by a health professional who is a Plan Provider or non-Plan Provider.

Charges for services not covered and services not prior approved by the Personal Physician, except those meeting the emergency and urgent care requirements, are your responsibility, do not apply towards the Member calendar year out-of-pocket maximum responsibility, and may cause your payment responsibility to exceed the Member calendar year out-of-pocket maximum responsibility defined above.

Note that copayments and charges for services not accruing to the Member calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached.

Note: It is your responsibility to maintain accurate records of your copayments and to determine and notify Blue Shield when the Member calendar year out-of-pocket maximum responsibility has been reached.

You must notify Blue Shield Member Services in writing when you feel that your Member calendar year out-of-pocket maximum responsibility has been reached. At that time, you must submit complete and accurate records to Blue Shield substantiating your copayment expenditures for the period in question. Member Services address and telephone number may be found on the back cover of this booklet.

Liability of Member for Payment

It is important to note that all services except for those meeting the emergency and out of Service Area urgent services requirements, Trio+ Specialist visits, hospice program services received from a participating hospice agency after the Member has been accepted into the hospice pro-

gram, OB/GYN services by an obstetrician/gynecologist or a family practice physician who is in the same medical group or IPA as the Personal Physician, and all Mental Health or Substance Use Disorder services, must have prior authorization by the Personal Physician, medical group or IPA. The Member will be responsible for payment of services that are not authorized or those that are not an emergency or covered out of Service Area urgent service procedures. (See the previous Urgent Services paragraphs for information on receiving urgent services out of the Service Area but within California.) Members must obtain services from the Plan providers that are authorized by their Personal Physician, medical group or IPA. Hospice services must be received from a participating hospice agency.

If your condition requires services which are available from the Plan, payment for services rendered by non-Plan Providers will not be considered unless the medical condition requires emergency or urgent services.

You are responsible for paying a minimum charge (copayment) to the physician or provider of services at the time you receive services. The specific copayments, as applicable, are listed after the benefit description. There are no deductibles to be met.

Accrual balance

Blue Shield provides a summary of your accrual balances toward your Calendar Year Deductible, if any, and Out-of-Pocket Maximum for every month in which your Benefits were used until the full amount has been met. This summary will be mailed to you unless you opt to receive it electronically or have already opted out of paper mailings. You can opt back in to receive paper mailings at any time or elect to receive your balance summary electronically by logging into your member portal online and updating your communication preferences, or by calling Customer Service at the number on the back of your ID card. You can also check your accrual balances at any time by logging into your member portal online, which is updated daily, or calling Customer Service. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

Limitation of Liability

Members shall not be responsible to Plan providers or health professionals who are non-Plan Providers rendering Services at a Plan Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) for payment for services if they are a benefit of the Plan, unless the non-Plan Provider provides the Member with written notice of what they may charge and the Member consents to those terms. When Covered Benefits are rendered by a Plan provider or rendered by a health professional who is a non-Plan Provider at a Plan Provider facility, the Member is responsible only for the applicable copayments, except as set forth in the Third Party Recovery Process and the Member's Responsibility section. Members will not be responsible for additional charges above the Allowed Charges without written notice and consent. Members are responsible for the full charges for any non-covered services they obtain.

Member Identification Card

You will receive your Blue Shield Trio HMO identification card after enrollment. If you do not receive your identification card or if you need to obtain medical or prescription services before your card arrives, contact the Blue Shield Member Services Department so that they can coordinate your care and direct your Personal Physician or pharmacy.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Sub-

scriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Member Services Department

If you have 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, you should call the Blue Shield Member Services Department at 1-800-334-5847. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free TTY number, 711. Member Services can answer many questions over the telephone.

Expedited Decision

Blue Shield of California has established a procedure for our Members to request an expedited decision (including those regarding grievances). A Member, physician, or representative of a Member may request an expedited decision when the routine decision-making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other health care 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 Member Services Department at 1-800-334-5847.

Rates for Trio Basic Plan

State Employees and Annuitants

The rates shown below are effective January 1, 2027 and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	$971.24
Employee and one dependent	$1,942.48
Employee and two or more dependents	$2,525.22

Contracting Agency Employees and Annuitants

The rates charged are based on the pricing region in which the employee/annuitant resides. See below a description of the pricing regions. If the employee/annuitant lives outside of the Plan's Service Area and is enrolled based on place of employment, then the pricing region for the place of employment will apply. If the employee/annuitant moves from one pricing region to another, rates will change on the first of the month following the change of residence. The rates shown below are effective January 1, 2027 and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among public agencies. For assistance on calculating your net contribution, contact your agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	
Region 1	$1,202.57
Region 2	$971.24
Region 3	$908.01
Employee and one dependent	
Region 1	$2,405.14
Region 2	$1,942.48
Region 3	$1,816.02
Employee and two or more dependents	
Region 1	$3,126.68
Region 2	$2,525.22
Region 3	$2,360.83

Pricing Regions for Contracting Agency Employees and Annuitants

1 Butte, Contra Costa, El Dorado, Nevada, Placer, Sacramento, Santa Cruz, Shasta, Stanislaus, and Yolo

2 Kern, Kings, Orange, San Luis Obispo, Santa Barbara, Tulare, and Ventura

3 Los Angeles, Riverside, and San Bernardino

Rate Change

The plan rates may be changed as of January 1, 2028, following at least 60 days' written notice to the Board prior to such change.

Benefit Descriptions

The Plan benefits available to you are listed in this section. The copayments for these services, if applicable, follow each benefit description.

The following are the basic health care services covered by the Blue Shield Trio HMO without charge to the Member, except for copayments where noted, and as set forth in the Third Party Recovery Process and the Member's Responsibility section. These services are covered when medically necessary, and when provided by the Member's Personal Physician or other Plan provider or authorized as described herein, or received according to the provisions described under Obstetrical/Gynecological (OB/GYN) Physician Services, Trio+ Specialist, and Mental Health or Substance Use Disorder services. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the benefit descriptions below, and to the Exclusions and Limitations set forth in this booklet.

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.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Plan Providers:

Urgent Care	**Access to Care**
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	**Access to Care**
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health or substance use disorder provider (who is not a physician)	Within 10 business days
Follow-up appointment with a mental health or substance use disorder health provider (who is not a physician)	Within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	**Access to Care**
Access to a health professional for telephone triage or screening services by calling Shield Concierge	24 hours/day, 7 days/week

Call Shield Concierge if you need help finding a Plan Provider or if a Plan Provider is not available. Please see the Role of the Medical Group or IPA section for more information.

Note: For availability of interpreter services at the time of the Member's appointment, consult the list of Blue Shield Trio HMO Providers available at www.blueshieldca.com or by calling Shield Concierge at the telephone number provided on the back page of this Evidence of Coverage. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this Evidence of Coverage.

A. Hospital Services

The following hospital services customarily furnished by a hospital will be covered when medically necessary and authorized.

1. Inpatient hospital services include:

    a. Semi-private room and board, unless a private room is medically necessary;

    b. General nursing care, and special duty nursing when medically necessary;

    c. Meals and special diets when medically necessary;

    d. Intensive care services and units;

    e. Operating room, special treatment rooms, delivery room, newborn nursery and related facilities;

    f. Hospital ancillary services including diagnostic laboratory, x-ray services and therapy services;

    g. Drugs, medications, biologicals, and oxygen administered in the hospital, and up to 3 days' supply of drugs supplied upon discharge by the Plan physician for the purpose of transition from the hospital to home. Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Plan Provider.

        For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for that disease will be covered without a Cost Share;

    h. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses, other medical supplies and medical appliances and equipment administered in hospital;

    i. Processing, storage and administration of blood, and blood products (plasma), in inpatient and outpatient settings. Includes the storage and collection of autologous blood;

    j. Radiation therapy, chemotherapy and renal dialysis;

    k. Respiratory therapy and other diagnostic, therapeutic and rehabilitative services as appropriate;

    l. Coordinated discharge planning, including the planning of such continuing care as may be necessary;

    m. Inpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon;

    n. Subacute care;

    o. Medically necessary inpatient substance use disorder withdrawal management (detoxification) services required to treat potentially Life-Threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room or when medically necessary inpatient substance use disorder withdrawal management (detoxification) is prior authorized;

    p. Rehabilitative services when furnished by the hospital and authorized.

See Section O. for inpatient hospital services provided under the "Hospice Program Services" benefit.

Copayment: No charge.

2. Outpatient hospital services include:

   a. Services and supplies for treatment or surgery in an outpatient hospital setting or ambulatory surgery center;

   b. Outpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon.

   Copayment: No charge except for $15 per visit for physical, occupational, and speech therapy performed on an outpatient basis

3. Transgender Benefit

   The Plan provides coverage for Medically Necessary services for the treatment of gender dysphoria. Medical necessity determinations for transgender services take into account the Standards of Care of the World Professional Association for Transgender Health. This includes both medical and mental health Benefits. Travel and lodging expenses may also be covered when necessary to obtain Covered Benefits and authorized in advance by Blue Shield. See section Z. 10. Travel expense reimbursement for more information.

Benefits do not include:

- Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
- Hospital care programs or services provided in a home setting (Hospital-at-home programs).
- Domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
- Custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Inpatient Hospital care.

B. Physician Services (Other Than for Mental Health or Substance Use Disorder Services)

1. Physician Office Visits

   Office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations, administration of injectable medications that must be administered by a Health Care Provider, medical nutrition therapy, diabetic counseling, and OB/GYN services from an obstetrician/gynecologist or a family practice physician who is within the same medical group or IPA as the Personal Physician. Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person. Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow meter.

Copayment: $15 per visit. No additional charge for surgery or anesthesia; radiation or renal dialysis treatments; medications administered in the physician's office, including chemotherapy.

2. Allergy Testing and Treatment

   Office visits for the purpose of allergy testing on and under the skin such as prick/puncture, patch and scratch tests, and treatment, including injectables and serum. This Benefit does not include blood testing for allergies.

   Copayment: No charge.

3. Inpatient Medical and Surgical Services

   Physicians' services in a hospital or skilled nursing facility for examination, diagnosis, treatment, and consultation, including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist. Inpatient physician services are covered only when hospital and skilled nursing facility services are also covered.

   Copayment: No charge.

4. Medically necessary home visits by Plan physician

   Copayment: $15 per visit.

5. Treatment of physical complications of a mastectomy, including lymphedemas

   Copayment: No charge.

C. Preventive Health Services

1. Preventive health services, as defined, when rendered by a physician are covered.

2. Eye refraction to determine the need for corrective lenses for all Members upon referral by the Personal Physician. (Limited to one visit per calendar year, for Members aged 18 and over. No limit on number of visits for Members under age 18.)

   Copayment: No charge.

D. Diagnostic X-ray/Lab Services

1. X-ray, Laboratory, Major Diagnostic Services. All outpatient diagnostic x-ray and clinical laboratory tests and services, diagnostic imaging, electrocardiograms, diagnostic clinical isotope services, bone mass measurements, and periodic blood lipid screening. COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing. Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month, subject to a maximum reimbursement of $12 per test. Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of your disease or condition to guide treatment decisions (Benefits must be prior authorized).

2. Genetic Testing and Diagnostic Procedures. Genetic testing for certain conditions when the Member 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 of California medical policy.

See Section F. for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

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

Blue Shield encourages Members to seek services from Participating Providers to avoid paying extra fees. Some Non-Participating Providers may charge extra fees that are not covered by Blue Shield. Any fees not covered by Blue Shield will be the Member's responsibility.

See the How to Use this Plan section for information about Participating and Non-Participating Providers.

Copayment: No charge.

E. Durable Medical Equipment, Prostheses and Orthoses and Other Services

Medically necessary durable medical equipment, prostheses and orthoses for activities of daily living, and supplies needed to operate durable medical equipment; oxygen and oxygen equipment and its administration; blood glucose monitors (including continuous blood glucose monitor) and all related necessary supplies for the self-management of diabetes, as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; required dialysis equipment and medical supplies; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. When authorized as durable medical equipment, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standard of practice.

1. Durable Medical Equipment

    a. 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. (See Section Q. for benefits for asthma inhalers and inhaler spacers.)

    b. Medically necessary repairs and maintenance of durable medical equipment, as authorized by Plan provider. Repair is covered unless necessitated by misuse or loss.

    c. Rental charges for durable medical equipment in excess of the purchase price are not covered.

    d. Benefits do not include environmental control equipment or generators. No benefits are provided for backup or alternate items. Benefits do not include home testing devices and monitoring equipment except for over-the-counter at-home COVID-19 tests and sexually transmitted disease home testing kits. Benefits do not include any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other speech or language assistance devices, except as specifically listed.

    e. Breast pump rental or purchase.
    Breast pump rental or purchase is only covered if obtained from a designated Plan provider in accordance with Blue Shield medical policy. For further information call Member Services or go to http://www.blueshieldca.com.

    f. Pasteurized donor human milk.

See Section V. for devices, equipment and supplies for the management and treatment of diabetes.

If you are enrolled 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. For information see Section O.

2. Prostheses

    a. Medically necessary prostheses for activities of daily living, including the following:

        1) Supplies necessary for the operation of prostheses;

2) Initial fitting and replacement after the expected life of the item;

3) Repairs, even if due to damage;

4) Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;

5) Prosthetic devices used to restore a method of speaking following laryngectomy, including initial and subsequent prosthetic devices and installation accessories. This does not include electronic voice producing machines;

6) Cochlear implants;

7) Contact lenses if medically necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia. Cataract spectacles or intraocular lenses that replace the natural lens of the eye after cataract surgery. If medically necessary with the insertion of the intraocular lens, one pair of conventional eyeglasses or contact lenses;

8) Artificial limbs and eyes.

b. Routine maintenance is not covered.

c. Benefits do not include wigs for any reason, self-help/educational devices or any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other speech or language assistance devices, except as specifically provided above. See the Exclusions and Limitations section for a listing of excluded speech and language assistance devices. No benefits are provided for backup or alternate items.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Section W. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

3. Orthoses

a. Medically necessary orthoses for activities of daily living, including the following:

1) Special footwear required for foot disfigurement which includes but is not limited to foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes or by accident or developmental disability;

2) 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;

3) Medically necessary knee braces for postoperative rehabilitative services following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis.

b. Benefits for medically necessary orthoses are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. Routine maintenance is not covered. No benefits are provided for backup or alternate items.

c. 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.

Copayment: No charge.

See Section V. for devices, equipment and supplies for the management and treatment of diabetes.

F. Pregnancy and Maternity Care

The following pregnancy and maternity care is covered subject to the General Exclusions and Limitations.

1. Prenatal and Postnatal Physician Office Visits

   See Section D. for information on coverage of other genetic testing and diagnostic procedures.

   Copayment: No charge.

2. Inpatient Hospital and Professional Services. Hospital and Professional services for the purposes of a normal delivery, C-section, complications or medical conditions arising from pregnancy or resulting childbirth.

   Copayment: No charge.

3. Includes providing coverage for all testing recommended by the California Newborn Screening Program and for participating in the statewide prenatal testing program, administered by the State Department of Health Services, known as the Expanded Alpha Feto Protein Program.

   Copayment: No charge.

The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section 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. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. 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.

4. Abortion Services. Abortion is covered for all pregnant persons including, but not limited to, transgender individuals.

   Copayment: No charge.

5. Doula Services. Services include health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons. Support is provided before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doula services can be provided virtually or in person with locations in any setting including, but not limited to homes, office visits, hospitals, or alternative birth centers.

   This service includes a minimum of 11 visits plus labor and delivery:
   a. Initial visit;
   b. Up to 8 prenatal or postpartum visits,
   c. Up to 2 extended three-hour postpartum visits.

   All visits are limited to one prenatal or postnatal visit per day, per member. Visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support.

   This Benefit does not include belly binding (traditional/ceremonial), birthing ceremonies (i.e. sealing, closing the bones, etc.), group classes on babywearing, massage (maternal or infant), photography, placenta encapsulation, shopping, vaginal steams, or yoga.

   In-person doula services are reimbursable up to $1100 per pregnancy. Please submit a medical services claim, including the Blue Shield claim form and the itemized bill from your provider, to:

Blue Shield of California
P.O. Box 272530
Chico, CA 95927

G. Family Building Benefits

1. Family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; and follow-up services related to contraceptive Drugs, devices, products, and procedures, including but not limited to management of side effects, counseling for continued adherence, and device removal.

   Copayment: No charge.

EFFECTIVE JANUARY 1, 2027- JUNE 30, 2027:

2. Infertility Services. Artificial insemination and the diagnosis and treatment of the cause of Infertility, including professional, hospital, ambulatory surgery center, related services to diagnose and treat the cause of infertility with the exception of what is excluded in the General Exclusions and Limitations.

   Copayment: 50% of allowed charges for all services.

EFFECTIVE JULY 1, 2027- DECEMBER 31, 2027:

2. Infertility Services. Benefits are provided for the diagnosis and treatment of Infertility, including professional, Hospital, Ambulatory Surgery Center, and related services to diagnose and treat Infertility.

Benefits include:

- Artificial insemination, including intrauterine insemination (IUI);
- Oocyte (egg) retrievals (limit of 3 completed retrievals);
- Sperm retrievals;
- In vitro fertilization (IVF);
- Unlimited embryo transfers;
- Cryopreservation storage of sperm, reproductive tissue, oocytes, embryos (lifetime limit of 5 years from the time the genetic material is first cryopreserved);
- Intracytoplasmic sperm injection (ICSI) for male factor Infertility;
- Preimplantation genetic testing;
- Gamete intrafallopian Transfer (GIFT) procedure;
- Zygote intrafallopian Transfer (ZIFT); and
- Treatment of low sperm count.

Benefits do not include:

- Services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan. When a Member utilizes a gestational carrier or surrogate, embryo transfers to the gestational carrier or surrogate shall be treated the same as embryo transfers to the Member for purposes of administering the three completed oocyte retrieval benefit and shall not reduce, limit, or otherwise adversely affect coverage eligibility; and
- Services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.

Self-administered Drugs prescribed to induce fertilization are covered under the Prescription Drug Benefit.

Blue Shield will provide written notice explaining the covered storage period within 30 business days after receipt of a claim for cryopreservation services.

Blue Shield will provide written notice 90 calendar days prior to the expiration of the storage periods.

Copayment: $15 per treatment bundle. Treatment bundles may include Medically Necessary tests, services, and medication.

3. Vasectomy services and procedures

   Copayment: No charge.

4. Voluntary tubal ligation and other similar sterilization procedures

   Copayment: No charge.

5. Contraceptive Device Fitting

   Copayment: No charge.

6. Contraceptive Drugs & Devices

   Copayment: No charge.

7. Injectable Contraceptives

   Copayment: No charge.

8. Implantable Contraceptives

   Copayment: No charge.

H. Fertility Preservation Services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Benefits that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, Standard Fertility Preservation Services provided for fertility preservation, including retrieval and cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos, are a Covered Benefit and do not fall under the scope of Infertility Services described in Section G.

Blue Shield will provide written notice explaining the covered storage period within 30 business days after receipt of a claim for cryopreservation services.

Blue Shield will provide written notice 90 calendar days prior to the expiration of the storage periods.

I. Ambulance Services and Emergency Medical Services Programs

The Plan will pay for ambulance services as follows:

1. Emergency Ambulance Services

   For transportation to the nearest hospital which can provide such emergency care only if you reasonably believed that the medical condition was an Emergency Medical Condition or a Psychiatric Emergency Medical Condition which required ambulance services, as described in Section I.

2. Non-Emergency Ambulance Services

   Medically necessary ambulance services to transfer the Member from a non-Plan hospital to a Plan hospital, between Plan facilities, or from facility to home when in connection with authorized confinement/ admission and the use of the ambulance is authorized.

3. Emergency Medical Services Programs

   Covered Benefits provided by community paramedicine programs, triage to alternate destination programs, and mobile integrated health programs developed by local Emergency Medical Services (EMS) agencies. Covered Benefits provided by these EMS programs are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

   Copayment: No charge.

Benefits do not include:

Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).

J. Emergency Services

An Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. If you receive services in a situation that the Blue Shield Trio HMO determines did not require emergency services, or you did not reasonably believe that an emergency condition existed, you will be responsible for the costs of those services.

1. Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the Personal Physician by phone within 24 hours of the commencement of the emergency services, or as soon as it is medically possible for the Member to provide notice. Failure to provide notice as stated will result in the services not being covered.

2. Whenever possible, go to the emergency room of your nearest Blue Shield Trio HMO hospital for medical emergencies. A listing of Blue Shield Trio HMO hospitals is available in your HMO Physician and Hospital Directory.

3. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an Emergency Medical Condition or a Psychiatric Emergency Medical Condition.

   Copayment: $50 per visit in the hospital emergency room. (Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit.)

4. Continuing or Follow-up Treatment. If you receive emergency services from a hospital which is a non-Plan hospital, follow-up care must be authorized by Blue Shield or it may not be covered. If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating health care provider at the non-Plan hospital believes that you require additional medically necessary hospital services, the non-Plan hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued medically necessary hospital services by the non-Plan hospital. If Blue Shield determines that you may be safely transferred to a hospital that is contracted with the Plan and you refuse to consent to the transfer, the non-Plan hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the non-Plan hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Plan hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan hospital, you should contact Blue Shield at the telephone number on your identification card.

5. Emergency Services and follow-up health care treatment are provided without a Cost Share for Members treated following a rape or sexual assault for the first nine months after the Member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

   The Cost Share waiver is applicable to follow up health care treatment provided by a Participating Provider, any provider of Emergency Services, or a Non-Participating Provider when Blue Shield has approved your request to receive services from the Non-Participating Provider at the Participating Provider Cost Share. For more information, please see the If you cannot find a Participating Provider section. The Cost

Share waiver will only apply to services the treating provider has identified in their claim submission using accurate diagnosis codes specific to rape or sexual assault.

K. Urgent Services

Urgent services are provided in response to the patient's need for a prompt diagnostic workup and/or treatment.

These services are applicable for a medical or mental disorder that: (1) could become an emergency if not diagnosed and/or treated in a timely manner, (2) is likely to result in prolonged temporary impairment, (3) could increase the risk of necessitating more complex or hazardous treatment, and (4) could develop in a chronic illness or inordinate physical or psychological suffering of the patient.

To receive urgent care within your Personal Physician service area, call your Personal Physician's office or follow instructions given by your assigned medical group or IPA in accordance with all the conditions of the Agreement.

When outside the Plan Service Area, Members may receive care for Urgent Services as follows:

1. Inside California. For Urgent Services within California but outside of your Personal Physician service area, if possible contact Blue Shield Member Services at 1-800-334-5847 for assistance in receiving urgent services. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Plan provider. Members may also locate a Blue Shield Plan provider by visiting Blue Shield's internet site at http://www.blueshieldca.com. You are not required to use a Blue Shield of California Plan provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

2. Outside California or the United States. When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest Inter-Plan or Blue Shield Global® Core participating provider. When an Inter-Plan or Blue Shield Global® Core participating provider is available, you should obtain Urgent Services and Out-of-Area Follow-up Care from a participating provider whenever possible, but you may also receive care from a non-participating provider. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

   For information on Urgent Services received outside of California see the Inter-Plan Programs section of the Evidence of Coverage.

   Up to two medically necessary Out-of-Area Follow-up Care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits. Blue Shield may direct the Member to receive the additional follow-up care from the Personal Physician. Copayment: $15 per visit.

L. Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy

1. Home Health Care Services

   Benefits are provided for home health care services when the services are medically necessary, ordered by the Personal Physician and authorized.

   a. Home visits to provide skilled nursing services* and other skilled services by any of the following professional providers are covered:

      1) Registered nurse;

      2) Licensed vocational nurse;

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

      4) Medical Social Worker.

Copayment: No charge.

5) Physical therapist, occupational therapist, or speech therapist.

Copayment: $15 per visit for therapy provided in the home.

b. In conjunction with the professional services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan, to the extent the benefit would have been provided had the Member remained in the hospital or skilled nursing facility, except as excluded in the General Exclusions and Limitations.

Copayment: No charge.

This benefit does not include medications, drugs, or injectables covered under Section L. or Q.

See Section P. for information about when a Member is admitted into a hospice program and a specialized description of skilled nursing services for hospice care.

For information concerning diabetes self-management training, see Section W.

2. PKU-Related Formulas and Special Food Products

Benefits are provided for enteral formulas, parenteral nutrition formulations, 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. These benefits must be prior authorized and must be prescribed or ordered by the appropriate health care professional.

Copayment: No charge.

3. Home Infusion/Home Injectable Therapy Provided by a Home Infusion Agency

Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency. Note: For services related to hemophilia, see item 4. below.

Services include home infusion agency skilled nursing services, administration of parenteral nutrition formulations, administration of enteral nutrition formulas, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory services and for medically necessary, FDA approved injectable medications, when prescribed by the Personal Physician and prior authorized, and when provided by a home infusion agency.

This benefit does not include medications, drugs, insulin, insulin syringes, specialty drugs covered under Section Q., and services related to hemophilia which are covered as described below.

Copayment: No charge.

*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).

4. Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by the Plan and must be provided by a participating Hemophilia Infusion Provider. (Note: Most participating home health care and home infusion agencies are not participating Hemophilia Infusion Providers.) A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. You may also verify this information by calling Member Services at the telephone number shown on the back cover of this booklet.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following evaluation by your physician, a prescription for a blood factor product must be submitted to and approved by the Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in Section J.)

Included in this benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a participating Hemophilia Infusion Provider, and medically necessary services to treat complications of hemophilia replacement therapy are not covered under this benefit but may be covered under other medical benefits described elsewhere in this Benefit Descriptions section.

This benefit does not include:

a. Physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;

b. Services from a hemophilia treatment center or any provider not prior authorized by the Plan; or,

c. Self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services and certain drugs may be covered under Section M., Section Q., or as described elsewhere in this Benefit Descriptions section.

Copayment: $15 per visit.

M. Physical and Occupational Therapy

Rehabilitative services include physical therapy, occupational therapy, and/or respiratory therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient Department of a Hospital. Benefits for speech therapy are described in Section N. Medically necessary services will be authorized for an initial treatment period and any additional subsequent medically necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is medically necessary.

1. Physical therapy

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

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider. Massage is not covered when performed as the solitary treatment or prescribed to an individual who presents with no complications.

2. Occupational therapy

Occupational therapy uses physical agents, therapeutic is treatment, and modalities to develop, improve, and maintain the skills you need for activities of daily living, such as dressing, eating, and drinking. Testing for intelligence or learning disabilities is not covered. Physical agents, therapeutic treatments, and modalities include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage performed as part of a rehabilitative or habilitative occupational therapy treatment

plan by a licensed or certified Health Care Provider. Massage is not covered when performed as the solitary treatment or prescribed to an individual who presents with no complications.

Copayment: No charge for inpatient therapy. $15 per visit for therapy provided in the home or other outpatient setting.

See Section L. for information on coverage for rehabilitative services rendered in the home.

N. Speech Therapy

Outpatient benefits for Medically Necessary speech therapy services when diagnosed and ordered by a physician and provided by an appropriately licensed speech therapist/pathologist, 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 for medically necessary services as long as continued 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. When continued treatment is not medically necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Member will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under Section L., no outpatient benefits are provided for speech therapy, speech correction, or speech pathology services.

Copayment: No charge for inpatient therapy. $15 per visit for therapy provided in the home or other outpatient setting.

See Section L. for information on coverage for speech therapy services rendered in the home. See Section A. for information on inpatient benefits and Section P. for hospice program services.

O. Skilled Nursing Facility Services

Subject to all of the inpatient hospital services provisions under Section A., medically necessary skilled nursing services, including subacute care; will be covered when provided in a skilled nursing facility and authorized. This benefit is limited to 100 days during any calendar year except when received through a hospice program provided by a participating hospice agency. Custodial care is not covered.

This Plan does not cover domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Skilled Nursing services.

For information concerning "Hospice Program Services" see Section P.

Copayment: No charge.

P. Hospice Program Benefits

Benefits are provided for the following services through a participating hospice agency when an eligible Member requests admission to and is formally admitted to an approved hospice program. The Member must have a terminal illness as determined by his Plan provider's certification and the admission must receive prior approval from Blue Shield. (Note: Members 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 Benefits 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. Members can continue to receive Covered Benefits that are not related to the palliation and management of the terminal illness from the appropriate Plan provider. Member copayments when applicable are paid to the participating hospice agency.

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. If Blue Shield prior authorizes hospice program services from a non-contracted hospice, the Member's copayment for these services will be the same as the copayments for hospice program services when received and authorized by a participating hospice agency.

All of the services listed below must be received through the participating hospice agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Members 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 Members to the extent that these needs are not met by the Personal Physician.

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. Continuous Nursing Services are covered for as much as 24 hours a day during periods of crisis as necessary to maintain a Member 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 5 consecutive days at a time.

Members are allowed to change their participating hospice agency only once during each period of care. Members 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 Plan provider recertifies that the Member is terminally ill.

Benefits do not include:

- Domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live

alone because of age-related impairments or physical, mental, or visual disabilities.

- Custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as part of a Hospice program.

Definitions

Bereavement Services - services available to the immediate surviving family members for a period of at least 1 year after the death of the Member. 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 Member.

Continuous Home Care - home care provided during a period of crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 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 practical nurse. Homemaker services or home health aide services may be provided to supplement the nursing care. When fewer than 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 Member and the performance of related tasks in the Member'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 California 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 Member 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 physical, emotional, social and spiritual discomforts of a Member 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:

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.

2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and the Member's family.

3. 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 Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. 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.

5. Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.

6. Actively utilizes volunteers in the delivery of hospice services.

7. Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

8. Is provided through a participating hospice agency.

Interdisciplinary Team - the hospice care team that includes, but is not limited to, the Member and the Member's 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 Member's Personal Physician, 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 Personal Physician recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than 1 year. A period of care starts the day the Member begins to receive hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis - a period in which the Member 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 a Member 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 Member only when necessary to relieve the family members or other persons caring for the Member.

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 Member's Plan provider to a Member and his family that pertain to the palliative, supportive services required by a Member with a terminal illness. Skilled nursing services include, but are not limited to, Member assessment, evaluation and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member 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 Member 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 Member and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Terminal Disease or Terminal Illness - a medical condition resulting in a prognosis of life of 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 Member and his family during the remaining days of the Member's life and to the surviving family following the Member's death.

Copayment: No charge.

Q. Prescription Drugs

Except for the Coordination of Benefits provision, the general provisions and exclusions of the HMO Health Plan Agreement shall apply.

The following applies to Medicare-qualified members only. 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 a Medicare prescription drug plan 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 anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Benefits are provided for outpatient prescription drugs which meet all of the requirements specified in this section, are prescribed by a physician or other licensed health care provider within the scope of his or her license as long as the prescriber is a Plan provider, are obtained from a participating pharmacy, and are listed in the Drug Formulary. Blue Shield's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Blue Shield Outpatient Prescription Drug Benefit. Select drugs and drug dosages and most specialty drugs require prior authorization by Blue Shield for medical necessity, including appropriateness of therapy and efficacy of lower cost alternatives. Over-the-counter and prescription smoking cessation drugs are covered for Members when ordered by a Physician. See Section Y. for more information about smoking cessation. Outpatient Prescription Drugs do not include Drugs used for hemophilia, blood or blood products and any Drugs which are not considered to be safe for self-administration. These products and Drugs may be covered under the *Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy*, *Hospice program services*, or *Family Planning and Infertility Services* sections.

Prescription Drug information is available by logging into your member portal at blueshieldca.com and selecting "Price Check My Rx". This tool can show you:

- Your eligibility for a prescription Drug;
- The current cost of the prescription Drug;
- Any available lower cost alternative(s) to the prescription Drug based on your plan Formulary and the pharmacy that fills your prescription;
- Any limits, restrictions, or requirements for each Drug, if applicable; and
- Your current plan Formulary.

"Price Check My Rx" prices are based on your Deductible and Out-of-Pocket Maximum accruals (if applicable) at the time you view the prescription Drug price. Costs may be different at the time you fill your prescription due to claims processing. You or your Physician or Health Care Provider can also request this Prescription Drug information by calling Shield Concierge.

Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Plan Provider.

For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for that disease will be covered without a Cost Share.

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most Generic Drugs. Drugs not listed

on the Formulary may be covered when approved by Blue Shield through the exception request process. The fact that a Drug is listed on the Blue Shield Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

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

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

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

Formulary Drug Tiers	
Drug Tier	Description
Tier 1	• Most Generic Drugs or low cost preferred Brand Drugs
Tier 2	• Non-preferred Generic Drugs • Preferred Brand Drugs • Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
Tier 3	• Non-preferred Brand Drugs • Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
	• Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	• Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than $600 (net of rebates) for a one-month supply

Members may access the Drug Formulary at blueshieldca.com/calpers. Members may also call Shield Concierge at the number provided on the back of the Evidence of Coverage or Member ID card to inquire if a specific drug is included in the Formulary or to obtain a printed copy.

Definitions

Biosimilar Drugs - Drugs that are FDA approved that are highly similar to an FDA approved biologic (reference product) with no clinically meaningful differences in terms of safety, purity, strength and effectiveness.

Brand Drugs - Drugs which are FDA approved after a new drug application and/or registered under a brand or trade name by its manufacturer.

Formulary - a comprehensive list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program, which is designed to assist physicians in prescribing drugs that are medically necessary and cost effective. The Formulary is updated periodically.

Generic Drugs - Drugs that are approved by the Food Drug Administration (FDA) or other authorized government agency as a therapeutic

equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs.

Maintenance Drugs - covered outpatient prescription drugs prescribed to treat chronic or long-term conditions including conditions such as diabetes, asthma, hypertension and chronic heart disease.

Network Specialty Pharmacy - select participating pharmacies contracted by Blue Shield to provide covered specialty drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of specialty drugs.

To select a specialty pharmacy, the Member may visit blueshieldca.com/calpers or call the Shield Concierge number on the Blue Shield member ID card.

Non-Formulary Drugs - drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over Formulary Drug alternatives and are not listed on the Outpatient Drug Formulary.

Non-Participating Pharmacy - a pharmacy which does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.

Outpatient Prescription Drug - means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or home delivery pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Participating Pharmacy - a pharmacy which participates in the Blue Shield Pharmacy Network. These participating pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members.

To select a participating pharmacy, the Member may visit blueshieldca.com/calpers or call the Shield Concierge number on your Blue Shield member ID card.

Prescription Drug (Drug) - Means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes:

- disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs;
- syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes;
- drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and
- at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Schedule II Controlled Substance — prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain drugs at a participating pharmacy, the Member must present his Blue Shield identification card. Note: Except for covered emergencies, claims for drugs obtained without using the identification card will be denied.

Benefits are provided for specialty drugs only when obtained from a Network Specialty Pharmacy, except in the case of an emergency, and

limited to a 30-day supply. If you obtain a Specialty Drug anywhere other than at a Network Specialty Pharmacy, you may be responsible for the entire cost of the Drug. In the event of an emergency, covered specialty drugs that are needed immediately may be obtained from any participating pharmacy, or, if necessary from a non-participating pharmacy.

Copayment: $30 per prescription for a 30-day supply.

The Member is responsible for paying the applicable copayment for each covered prescription Drug at the time the Drug is obtained.

Copayment: You pay nothing for contraceptive drugs and devices*, $5 Tier 1, $20 Tier 2, $50 Tier 3, $30 Tier 4, 50% of the Blue Shield contracted rate for drugs for sexual dysfunction per prescription for the amount prescribed not to exceed a 30-day supply; after 3 months, the copayment for Maintenance drugs is $10 Tier 1, $40 Tier 2, $100 Tier 3, $60 Tier 4 per prescription for each subsequent 30-day supply. Brand Drug when Generic Drug equivalent or Biosimilar Drug is available, Brand Drug Copayment plus difference in cost between Generic Drug equivalent or Biosimilar Drug and Brand Drug. (The difference in cost that the Member must pay is not applied to the Calendar Year Out-of-Pocket Maximum).

* See below for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

If the participating pharmacy contracted rate charged by the participating pharmacy is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

Prescription drugs administered in a physician's office, except immunizations, are covered by the $15 copayment for the office visit and do not require another copayment. Drugs dispensed by a Physician or Physician's office for outpatient use are not covered.

Some prescriptions are limited to a maximum allowable quantity based on medical necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.

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

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

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

Drug manufacturers or other third parties may offer Drug discounts or copayment assistance for certain Drugs. These types of programs can lower the Member's out-of-pocket costs. If the Member receives any discounts at a Network Specialty Pharmacy, only the amount the Member pays will

be applied to any applicable Deductible and Out-of-Pocket Maximum.

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

The Member may receive up to a 12-month supply of hormonal contraceptive Drugs. Contraceptive Drugs and devices obtained from a Participating Pharmacy are covered without a Copayment or Coinsurance, except for brands that have a generic equivalent. If your Physician or Health Care Provider determines that the covered Generic Drug is not appropriate for you, the brand name equivalent contraceptive will be covered without a Copayment or Coinsurance upon submission of an exception request.

Drugs not listed on the Formulary may be covered if Blue Shield approves an exception request. If an exception request is approved, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment. For all other Drugs that are approved as an exception, the Tier 3 Copayment applies. If an exception is denied, the Non-Formulary Drug is not covered and you are responsible for the entire cost of the Drug.

If the Member or physician requests a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, the Member is responsible for paying the difference in cost plus the applicable tier Copayment of the Brand Drug. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and Generic Drug equivalent or Biosimilar Drug, plus the applicable tier Copayment of the Brand Drug. For example, if you select a Brand Drug when there is an equivalent Generic Drug or Biosimilar Drug available, the Participating Pharmacy's contracted rate for the Brand Drug is $300, and the contracted rate for the Generic Drug or Biosimilar Drug is $100. You would be responsible for paying the $200 difference in cost, plus the applicable tier Copayment of the Brand Drug. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility. The Member or prescribing provider may provide information supporting the medical necessity for using a Brand Drug versus an available Generic Drug equivalent or Biosimilar Drug through the Blue Shield prior authorization process. See the section below on Prior Authorization/ Step Therapy/ Exception Request Process for information on the approval process. If the request is approved, the Member is responsible for paying the applicable formulary tier Copayment.

You or your provider may request a reduced copayment for Tier 3 Drugs through Blue Shield's prior authorization process by providing information supporting the medical necessity and faxing it to 1-888-697-8122. See the section below on Prior Authorization/ Step Therapy/ Exception Request Process for information on the approval process. If the request is approved, the reduced Tier 3 Copayment will be $40 per 30-day prescription at a retail pharmacy, and you will be charged the reduced Tier 3 Copayment for that specific Tier 3 Drug until the end of the calendar year. If you wish to continue to receive the reduced copayment at the end of the calendar year approval period, you will need to make a new request using the prior authorization process noted below. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the end of the calendar year. If your request is denied, your Tier 3 Copayment will apply. The reduced Tier 3 Copayment does not apply to Non-Formulary Drugs, Drugs for sexual dysfunction or Brand Drugs with an available Generic Drug equivalent or Biosimilar Drug.

When Maintenance drugs have been prescribed for a chronic condition and the Member's medication dosage has been stabilized, the Member may obtain a 90-day supply of the drug through the home delivery Participating Pharmacy or at SELECT retail pharmacies. See the section below on CalPERS Maintenance Drug Program for additional information. If the Member continues to obtain the drug from a participating pharmacy, the higher Maintenance drug copayment will apply for each subsequent 30-day supply. Note: This does not apply to Specialty Drugs, drugs which are not available through or cannot safely be obtained through the home delivery Participating Pharmacy, or drugs obtained at SELECT retail pharmacies. This also does not apply to

Maintenance drugs for which a lower copayment was approved pursuant to the paragraph above.

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

Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency. When drugs are obtained at a non-participating pharmacy for a covered emergency, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim form to Blue Shield of California, 1606 Ave. Ponce de Leon, San Juan, PR 00909-4830. The Member will be reimbursed the purchase price of covered prescription drug(s) minus any applicable copayment(s). Claim forms are available by contacting Member Services. Claims must be received within 1 year from the date of service to be considered for payment.

Special Programs

Blue Shield may offer programs to support the use of more cost-effective and clinically appropriate prescription Drugs. Such programs may lower your out-of-pocket cost for a limited time if you participate.

Extended Quantity of Maintenance Drugs at SELECT Retail Pharmacies

Members may obtain prescribed maintenance medications for up to a 90-day supply through the home delivery Participating Pharmacy, or SELECT retail pharmacies. A list of SELECT retail pharmacies can be obtained at blueshieldca.com/calpers or by calling the Shield Concierge number on your Blue Shield ID card.

> **Copayment: You pay nothing for contraceptive drugs and devices*, $10 Tier 1, $40 Tier 2, $100 Tier 3, $60 Tier 4 per prescription not to exceed a 90-day supply. Brand Drug when Generic Drug equivalent or Biosimilar Drug is available, Brand Drug Copayment plus difference in cost between Generic Drug equivalent or Biosimilar Drug and Brand Drug. (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum). If the Member's provider indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.**

* See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Obtaining Outpatient Prescription Drugs Through the Home Delivery Participating Pharmacy

When Drugs have been prescribed on a regular basis to treat an ongoing chronic condition, a Member may obtain the drug through the home delivery Participating Pharmacy by enrolling via phone or online. The Member may continue to obtain the drug from a participating pharmacy; however, after 3 months, the higher Maintenance drug copayment will apply for each subsequent

30-day supply. The Member's provider must indicate a prescription quantity which is equal to the amount to be dispensed. Note: This does not apply to Specialty Drugs, nor to any other Drugs which are not available through or cannot safely be obtained through the home delivery Participating Pharmacy.

The Member is responsible for paying the applicable copayment for each prescription Drug.

For more information about the home delivery Participating Pharmacy or to determine applicable cost share, Members may visit blueshieldca.com/calpers or call the Shield Concierge number on your Blue Shield member ID card.

Copayment: You pay nothing for contraceptive drugs and devices*, $10 Tier 1, $40 Tier 2, $100 Tier 3, $60 Tier 4 per prescription not to exceed a 90-day supply; $1,000 out-of-pocket annual home delivery maximum, then no charge for Tier 1, Tier 2, and Tier 4 drugs at home delivery (Copays for Non-Formulary drugs, Tier 3 Drugs, and drugs for sexual dysfunction do not accrue to the $1,000 out-of-pocket maximum at home delivery). Brand Drug when Generic Drug equivalent or Biosimilar Drug is available, Brand Drug Copayment plus difference in cost between Generic Drug equivalent or Biosimilar Drug and Brand Drug. (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum or the $1,000 home delivery out of pocket maximum). If the Member's provider indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.

* See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

If the participating pharmacy contracted rate is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate.

The Member or prescribing provider may provide information supporting the medical necessity for using a home delivery Brand Drug versus an available home delivery Generic Drug equivalent or Biosimilar Drug through the Blue Shield prior authorization process. See the section below on Prior Authorization/ Step Therapy/ Exception Request Process for information on the approval process. If the request is approved, the Member is responsible for paying the applicable formulary tier Copayment.

You or your provider may request a reduced copayment for the Tier 3 Drug through Blue Shield's prior authorization process by providing information supporting the medical necessity and faxing it to 1-888-697-8122. See the section below on Prior Authorization/ Step Therapy/ Exception Request Process for information on the approval process. If the request is approved, the reduced Tier 3 Drug Copayment will be $70 for up to a 90-day supply prescription at the home delivery Participating Pharmacy, and you will be charged the reduced Tier 3 Drug Copayment for that specific Tier 3 Drug until the end of the calendar year. If you wish to continue to receive the reduced copayment at the end of the calendar year approval period, you will need to make a new request using the prior authorization process noted below. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the end of the calendar year. If your request is denied, your Tier 3 Drug Copayment will apply. The reduced Tier 3 Drug Copayment does not apply to Non-Formulary Drugs, drugs for sexual dysfunction, or Brand Drugs with an available Generic Drug equivalent or Biosimilar Drug.

For information about the home delivery Participating Pharmacy, the Member may visit blueshieldca.com/calpers or call the Shield Concierge number on the Blue Shield member ID card

Prior Authorization/ Step Therapy/ Exception Request Process

Select Drugs and Drug quantities may require prior authorization for medical necessity. Select contraceptives may require prior authorization for medical necessity in order to be covered. Non-Formulary Drugs may be covered when approved by Blue Shield through the exception process for medical necessity and if lower cost alternatives are not available or as effective. The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs for the Medically Necessary treatment of Class III obesity when prior authorized. You are required to enroll in a comprehensive weight loss program that includes a reduced calorie diet, physical activity, and behavior therapy. You will need to be in this type of program for a reasonable period of time, prior to and while on the weight loss Drug;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;
- When a Brand Drug is Medically Necessary, prior authorization is required if you, your Physician, or your Health Care Provider is requesting an exception to the difference in cost between the Brand Drug and the Generic equivalent or Biosimilar Drug. See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Compounded drugs include at least two or more ingredients with at least one being a Drug, as defined under this Section Q. They are not covered unless the following requirements are met: (1) there are no FDA-approved, commercially available, medically appropriate alternative(s), (2) the compounded medication is self-administered, and (3) it does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound), and (4) a compounded medication includes at least one Drug. If a compounded medication is approved for coverage, the Tier 3 Copayment applies. You or your physician may request prior authorization 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 all required supporting information is received, prior authorization approval or denial, determined by Blue Shield and based upon Medical Necessity, is provided within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

To request coverage for a Non-Formulary Drug, the Member, representative, or the Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Approvals for prior authorizations can be granted for up to one year, however, the timeframe may be greater or less, depending on the medication. See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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 the Physician or Health Care Provider

believes that step therapy coverage requirements for a prescription need not be met and that the medication is Medically Necessary, the step therapy exception process must be utilized and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

If Blue Shield denies a request for prior authorization or an exception request, the Member, representative, or the Provider can file a grievance with Blue Shield, as described in the Grievance Process section.

Exclusions

The Plan does not cover the following Prescription Drugs, except as described in this EOC in the Prescription Drug Benefits section or as required by law:

1. When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

2. When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.

3. When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

4. When prescribed solely for the purpose of shortening the duration of the common cold.

5. Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
   - Insulin,
   - Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs),
   - Over-the-counter drugs for reversal of an opioid overdose, or
   - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
6. Replacement of lost or stolen drugs.

7. Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

8. Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

For more information, please call the Shield Concierge number on your Blue Shield member ID card.

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

R. Inpatient Mental Health or Substance Use Disorder Services

Blue Shield of California administers Mental Health Services and Substance Use Disorder services for Blue Shield Members within California. All non-emergency Mental Health or Substance Use Disorder services, including Residential Care, must be prior authorized. For prior authorization for Mental Health or Substance Use Disorder services, Members should contact Blue Shield at 1-800-334-5847.

All non-emergency Mental Health or Substance Use Disorder services must be obtained from Plan Providers. (See the How to Use the Plan section, the Mental Health or Substance Use Disorder Services paragraphs for more information.)

Mental Health or Substance Use Disorder Benefits include Medically Necessary basic health care services and intermediate services, at the full range of levels of care, including but not limited to residential treatment, Partial Hospitalization Program, and Intensive Outpatient Program, and prescription Drugs.

If you are unable to schedule an appointment with a Plan Provider for Mental Health or Substance Use Disorder services, contact Blue Shield. Blue Shield will help you schedule an appointment with a Plan Provider and, within five calendar days of your initial request, provide written notice that if we are unable to find a Plan Provider, we will help you schedule an appointment with a Non-Plan Provider. If there is no Plan Provider for any Covered Benefits, you will only be responsible for paying the Plan Provider Cost Share for these services. Blue Shield may work with you to transition to a Plan Provider when one becomes available.

Upon request to Member Services, and at no cost to you, Member Services will provide the clinical review criteria and any training material or resources used to conduct utilization reviews for Mental Health or Substance Use Disorder benefits and services.

Benefits are provided for the following medically necessary covered Mental Health or Substance Use Disorders, subject to applicable copayments and charges in excess of any benefit maximums. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the benefit description below, and to the Exclusions and Limitations set forth in this booklet.

Benefits are provided for inpatient hospital and professional services in connection with hospitalization for the treatment of Mental Health or Substance Use Disorders.

Benefits are provided for inpatient and professional services in connection with Residential care admission for the treatment of Mental Health or Substance Use Disorders. All non-emergency Mental Health or Substance Use Disorder services must be prior authorized and obtained from Plan Providers. In addition, when no Plan Provider is available to perform the needed service, Blue Shield will refer you to a non-Plan provider and authorize services to be received.

See Section A. for information on medically necessary inpatient substance use disorder detoxification.

This Plan does not cover domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Mental Health or Substance Use Disorder services.

Copayment: No charge.

S. Outpatient Mental Health or Substance Use Disorder Services

1. Benefits are available for professional services for the diagnosis and treatment of Mental Health or Substance Use Disorders. You can receive these services at an office visit,

including Physician office visit, or in an individual, Family, or group professional outpatient setting, or as a telebehavioral health service.

Benefits include therapy, counseling, and medication management.

Copayment: $15 per visit.

2. Benefits are provided for hospital and professional services in connection with partial hospitalization for the treatment of Mental Health or Substance Use Disorders.

Copayment: No charge.

3. Psychosocial Support through LifeReferrals 24/7

See the Mental Health or Substance Use Disorder Services paragraphs under the How to Use the Plan section for information on psychosocial support services.

Copayment: No charge.

4. 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

Behavioral health treatment is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by Blue Shield. Treatment must be obtained from Plan Providers. Behavioral health 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.

Copayment: $15 per office visit. No charge for therapy provided in the home or other non-institutional setting.

5. Telebehavioral health services

Online telebehavioral health services for Mental Health or Substance Use Disorder conditions are available through Plan Providers and are a Covered Benefit regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health or substance use disorder provider. If you are currently receiving telebehavorial health services for Mental Health or Substance Use Disorders, you can continue to receive those services with the Plan Provider rather than switching to a Third-Party Corporate Telehealth Provider.

Copayment: $15 per visit.

6. Transcranial Magnetic Stimulation

Benefits are provided for Transcranial Magnetic Stimulation, a non-invasive method of delivering magnetic stimulation to the brain for the treatment of severe depression.

7. Behavioral Health Crisis Services

Benefits are provided for Behavioral Health Crisis Services and other services provided by a 988 center, a Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, regardless of whether the service is rendered by a Plan Provider or non-Plan Provider.

For Behavioral Health Crisis Services rendered by a non-Plan Provider, you will pay the same Copayment or Coinsurance for Covered Benefits received from a Plan Provider. Prior authorization is not required for the Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by a 988 center, Mobile Crisis Team, or other Behavioral Health Crisis Services.

Benefits do not include treatment not supported by current Generally Accepted Standards of Mental Health and Substance Use Disorder Care, including:

1. Outdoor, youth, or wilderness programs and accommodations;

2. Equine assisted therapy;

3. Treatment for the purpose of providing respite or day care;

4. Educational services; or

5. Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.

In addition, Benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs.

T. Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones

Hospital, Ambulatory Surgery Center, and professional services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues are a benefit only to the extent that they are provided for:

1. The treatment of odontogenic and non-odontogenic oral tumors (benign or malignant);

2. The treatment of damage to natural teeth caused solely by an accidental injury is limited to medically necessary services until the services result in initial, palliative stabilization of the Member as determined by the Plan;

   Dental services provided after initial medical stabilization, prosthodontics, orthodontia and 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 skeletal deformity; or

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

   Copayment: See applicable copayments for Physician Services and Hospital Services.

This benefit does not include:

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 dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ, preventive or periodontic services, dental orthosis and prosthesis, 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. Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

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

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 or for Benefits covered under Preventive Health Services.

See the Exclusions and Limitations section for additional services that are not covered.

U. Special Transplant Benefits

Benefits are provided for certain procedures listed below only if: (1) performed at a Transplant Network Facility approved by Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from the Blue Shield Corporate Medical Director, and (3) the recipient of the transplant is a Member.

The Blue Shield Corporate Medical Director shall review all requests for prior authorization and shall approve or deny benefits, based on the medical circumstances of the patient, and in accordance with established Blue Shield medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Blue Shield approved Transplant Network Facility will result in denial of claims for this benefit.

Pre-transplant evaluation and diagnostic tests, transplantation and follow-ups will be allowed only at a Blue Shield approved Transplant Network Facility. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than a Blue Shield Transplant Network Facility will not be approved. Evaluation of potential candidates at a Blue Shield Transplant Network Facility is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or more than one Transplant Network Facility will not be authorized unless the medical necessity of repeating the service is documented and approved. For information on Blue Shield of California's approved Transplant Network, call 1-800-334-5847.

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 (kidney only transplants are covered under Section U.);

6. Human bone marrow transplants, including autologous bone marrow transplantation 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;

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

Reasonable charges for services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Copayment: Physician Services and Hospital Services copayments apply.

V. Organ Transplant Benefits

Hospital and professional services provided in connection with human organ transplants are a benefit to the extent that they are provided in connection with the transplant of a cornea, kidney, or skin, and the recipient of such transplant is a Member.

Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered.

Copayment: Physician Services and Hospital Services copayments apply.

W. Diabetes Care

1. Diabetic Equipment

   Benefits are provided for the following devices and equipment, including replacement after the expected life of the item and when medically necessary, for the management and treatment of diabetes when medically necessary and authorized:

   a. blood glucose monitors, including continuous blood glucose monitors and those designed to assist the visually impaired, and all related necessary supplies;

   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;

   e. for coverage of diabetic testing supplies including blood and urine testing strips and test tablets, generic glucose (blood) test strips, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, see Section Q.

   Copayment: No charge.

2. Diabetes Self-Management Training and Medical Nutrition Therapy

   Diabetes outpatient self-management training, education and medical nutrition therapy that is medically necessary to enable a Member to properly use the diabetes-related devices and equipment and any additional treatment for these services if directed or prescribed by the Member's Personal Physician and authorized. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

   Copayment: $15 per visit.

   Benefits do not include:

   1. Routine foot care items and services that are not Medically Necessary, including:
      a. Callus treatment;
      b. Corn paring or excision;
      c. Toenail trimming;
      d. Over-the-counter shoe inserts or arch supports; or
      e. Any type of massage procedure on the foot.

X. Reconstructive Surgery

Medically necessary services in connection with 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 (including congenital anomalies) are covered. In accordance with the Women's Health & Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and reconstructive surgery on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas, are covered. Surgery must be authorized as described herein. 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:

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

2. Surgery to reform or reshape skin or bone;

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

4. Hair transplantation; and

5. 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.

Copayment: Physician Services and Hospital Services copayments apply.

Y. Clinical Trials for Treatment of Cancer or Life-Threatening Diseases or Conditions

Benefits are provided for routine patient care for Members who have been accepted into an Approved Clinical Trial for treatment of cancer or a Life-Threatening disease or condition when prior authorized through the Member's Personal Physician, and:

1. The clinical trial has a therapeutic intent and the Personal Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and

2. The hospital and/or physician conducting the clinical trial is a Plan provider, unless the protocol for the trial is not available through a Plan provider.

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

"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. The investigational item, device, or service, itself;

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

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

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

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

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

7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Copayment: Physician Services and Hospital Services copayments apply.

Z. Additional Services

1. Personal Health Management Program

   Health education and health promotion services provided by Blue Shield's Center for Health and Wellness offer a variety of wellness resources including, but not limited to: a member newsletter and a prenatal health education program.

   Copayment: No charge.

2. Medications Administered by a Healthcare Professional

   Medications approved by the FDA and that require administration by a healthcare professional are covered for the medically necessary treatment of medical conditions when prescribed or authorized by the Personal Physician or as described herein. See Section Q. outpatient prescription drug coverage for self-administered drugs. Drugs dispensed by a Physician or Physician's office for outpatient use are not covered.

   Copayment: No charge.

3. Hearing Aid Services

   a. Audiological Evaluation. To measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

      Copayment: No charge. Evaluation is in addition to the $1,000 maximum allowed every 36 months for both ears for the hearing aid and ancillary equipment.

   b. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid.

      Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months. Also excludes surgically implanted hearing devices. Cochlear implants are not considered surgically implanted hearing devices and are covered as a prosthetic under Section E.

      Hearing aids are covered at 100% in both ears every 36 months when medically necessary to prevent or treat speech and language development delay due to hearing loss.

      Limitations: Maximum payment will not exceed $1,000 per Member for both ears for the hearing aid instrument, and ancillary equipment.

   To receive these services, you may either contact your Personal Physician to obtain a referral or self-refer to a Trio+ Specialist as described in the How to Use the Plan section.

4. Smoking Cessation

   Members who participate and complete a smoking cessation class or program will be reimbursed up to $100 per class or program per calendar year. Members may contact their medical group or IPA for information about these classes and programs. If you have a question about the smoking cessation benefit, you should call Blue Shield Member Services at 1-800-334-5847.

5. Teladoc Health

   Your Plan includes a service, Teladoc Health, a Third-Party Corporate Telehealth Provider, that provides you confidential general medical consultations by phone or over secure online video . Teladoc Health general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc Health is not meant to replace your Personal Physician but is meant to serve as a supplemental service. You do not need to contact your Personal Physician before using the Teladoc Health service.

   Before this service can be accessed, you must complete a Medical History Disclosure (MHD) form. The MHD form can be completed online on Teladoc Health's website at no charge or can be printed, completed and mailed or faxed to Teladoc Health.

   If your Personal Physician's office is closed or you need quick access to a physician, you can call Teladoc Health toll free at 1-800-Teladoc (800-835-2362) or visit blueshieldca.com/teladochealth. The Teladoc Health physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

Teladoc Health physicians do not issue prescriptions for substances controlled by the DEA, non-therapeutic, and/or certain other drugs which may be harmful because of potential for abuse.

How to Access Teladoc Health	
Teladoc Health Service	Availability
General medical	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment
Mental health	7 a.m. to 9 p.m., 7 days a week by scheduled appointment only Consultations must be scheduled online and cannot be requested by phone

Copayment: $0 per consultation. If medications are prescribed, the applicable prescription drug copayments apply.

6. Acupuncture Benefits

   Benefits are provided for routine acupuncture Services up to the maximum visits per Calendar Year as shown below for acupuncture care when received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. Services provided by Non-Participating Providers will not be covered except for Emergency Services.

   Copayment: $15 per visit. Covered up to a combined Benefit maximum of 20 visits with Chiropractic Care Covered Benefits.

7. Chiropractic Care

   Manipulation of the spine to correct a subluxation, when provided by an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. Benefits are provided up to the maximum visits per Calendar Year as shown below. Services provided by Non-Participating Providers will not be covered except for Emergency Services.

   Copayment: $15 per visit. Covered up to a combined Benefit maximum of 20 visits with Acupuncture Benefits Covered Benefits. Chiropractic appliances are limited to $50 per Calendar Year.

8. Biofeedback

   Biofeedback therapy is covered only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

   Copayment: $15 per visit in a medical office setting; $15 per mental health visit.

9. Blood and Blood Products

   Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood.

   Copayment: No charge

10. Travel expense reimbursement

You may be eligible for reimbursement of your travel expenses for the following Covered Benefits: bariatric surgery, abortion, transgender services, organ and tissue transplant, acute inpatient pediatrics (except direct admission to the NICU) or specialty inpatient pediatrics (except direct admission to the pediatric intensive care unit), and outpatient pediatric hematology and oncology, including preoperative and postoperative visits, if you live at least 50 miles away from the nearest Plan Provider of eligible Covered Benefits.

For travel expense reimbursement, you must submit receipts, claim forms, and any other documentation required by Blue Shield. You must also have a claim or proof of claim for the eligible Covered Benefit for which you traveled on file with Blue Shield prior to reimbursement. Please send claims documentation to: Blue Shield of California, P.O. Box 272530, Chico, CA 95927. When you see a Plan Provider for eligible Covered Benefits, your provider submits the claim for those services to Blue Shield.

Blue Shield's maximum travel expense reimbursement will not exceed $5,000 per Member, per occurrence.

Expenses must be reasonably necessary. Reimbursable expenses include, if appropriate:

- Transportation to and from the facility to receive eligible Covered Benefits;
- Hotel accommodations if one or more overnight stays are required to obtain eligible Covered Benefits. Limited to 1 double-occupancy room up to $200/day. Only the room is covered. All other hotel expenses are excluded;
- Meals. Limited to $100/day. Expenses for tobacco, alcohol, drugs, phone, television, delivery, and recreation are excluded;
- Companion expenses for reimbursable expenses as listed above; and
- Both parents or guardians expenses for reimbursable expenses as listed above if the Member is under age 18.

Certain travel expense reimbursements may be tax reportable. When required, Blue Shield will issue a Form 1099-MISC to you, reporting travel expense reimbursements. Blue Shield does not provide tax advice. If you have tax questions about travel expense reimbursements, you should consult with your tax advisor.

For transplant and transgender services, you will be assigned a case manager who can help coordinate your health care services and submit your travel expense reimbursement forms. For additional questions, contact Shield Concierge.

Reimbursement is not available if the reimbursements themselves or the underlying services would be unlawful under applicable law.

Member Calendar Year Out-of-Pocket Maximum

The Member calendar year out-of-pocket maximum responsibility for Covered Benefits excluding those specified, is listed in the Summary of Covered Benefits. (Also, see the Member Calendar Year Out-of-Pocket Maximum paragraphs under How to Use the Plan.)

Note that copayments and charges for services not accruing to the Member calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached.

Exclusions and Limitations

General Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance

Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

1. Acupuncture Services. This Plan does not cover acupuncture services, except as described in the Acupuncture Benefits section, or as required by law.

2. Chiropractic Services. This Plan does not cover chiropractic services, except as described in the Chiropractic Care section, or as required by law.

3. Clinical Trials.

   This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in the *Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits* section or as required by law.

   Coverage of Approved Clinical Trials does not include the following:

   a. The investigational drug, item, or service itself.
   b. Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
   c. Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
   d. Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.
   e. This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in the *Independent Medical Review* section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in the *California Department of Managed Health Care review* section.

4. Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law.

   This exclusion does not apply to the following:

   a. Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
   b. Reconstructive surgery as described in this EOC in the *Reconstructive Surgery Benefits* section.
   c. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the *Reconstructive Surgery Benefits* section.

5. Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.

   This exclusion does not apply to the following:

   a. Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.

   b. Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

   c. Custodial care provided in a healthcare facility.

6. Dental Services. This Plan does not cover dental services or supplies, except as described in this EOC in the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections or as required by law.

7. Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in this EOC in the *PKU formulas and special food products section* or as required by law.

8. Disposable Supplies for Home Use. This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in the *Durable Medical Equipment, Prostheses and Orthoses and Other Services, Home health services, Hospice Program Benefits,* and *Prescription Drug Benefits* sections, or as required by law.

9. Experimental or Investigational services.

This Plan does not cover Experimental Services or Investigational Services, except as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

- Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
- Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
- Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an opportunity for you to request an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.

2. Your Health Care Provider must certify to the Plan that you have a Life Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.

3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4. You have been denied coverage by the Plan for the recommended or requested service.

5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in the Independent Medical Review section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the California Department of Managed Health Care review section.

10. Vision Care. This Plan does not cover Vision Services, except as described in this EOC in the *Durable Medical Equipment, Prostheses and Orthoses and Other Services* section or as required by law.

11. Hearing Aids. This Plan does not cover hearing aids, except as described in the *Hearing Aid Services* section if selected by your Employer as an optional Benefit, or as required by law.

12. Immunizations. This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

13. Non-licensed or Non-certified Providers. This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in the *Mental Health or Substance Use Disorder Benefits* sections or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or

Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

14. Private Duty Nursing. This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in the *Hospice Program Benefits* section or as required by law.
15. Personal or Comfort Items. This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
16. Reversal of Voluntary Sterilization. This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
17. Surrogate Pregnancy. This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.
18. Therapies. This Plan does not cover the following physical and occupational therapies, except as described in this EOC in the *Physical and Occupational Therapy* section or as required by law:
    a. Massage therapy, unless it is a component of a treatment plan;
    b. Training or therapy for the treatment of learning disabilities or behavioral problems;
    c. Social skills training or therapy; and
    d. Vocational, educational, recreational, art, dance, music, or reading therapy.
19. Routine Physical Examination. The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.
20. Travel and Lodging. This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in the *Ambulance services* section, as otherwise described in this EOC in the *Bariatric surgery Benefits, Transplant services,* and *Travel expense reimbursement* sections, or as required by law.
21. Weight Control Programs and Exercise Programs. This Plan does not cover weight control programs and exercise programs, except as described in this EOC in the *Diabetes care services* section or as required by law.

Medical Necessity Exclusion

Benefits are only available for services and supplies that are Medically Necessary, as determined by Blue Shield and consistent with Blue Shield medical policies and medication policies. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary. If two or more services or sequence of services are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease, coverage is provided for the least costly service or sequence of services.

Limitations for Duplicate Coverage

In the event that you are covered under the Plan and are also entitled to benefits under any of the conditions listed below, Blue Shield's liability for services (including room and board) provided to the Member for the treatment of any one illness or injury shall be reduced by the amount of benefits paid, or the reasonable value or the amount

of Blue Shield's fee-for-service payment to the provider, whichever is less, of the services provided without any cost to you, because of your entitlement to such other benefits. This exclusion is applicable to benefits received from any of the following sources:

1. Benefits provided under Title 18 of the Social Security Act ("Medicare"). If a Member receives services to which the Member is entitled under Medicare and those services are also covered under this Plan, the Plan provider may recover the amount paid for the services under Medicare. This provision does not apply to Medicare Part D (outpatient prescription drug) benefits. This limitation for Medicare does not apply when the employer is subject to the Medicare Secondary Payor Laws and the employer maintains:

   a. an employer group health plan that covers

      1) persons entitled to Medicare solely because of end-stage renal disease, and

      2) active employees or spouses or domestic partners entitled to Medicare by reason of age, and/or

   b. a large group health plan as defined under the Medicare Secondary Payor laws that covers persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to a Member who becomes eligible for Medicare on the date that the Member received notice of his eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision, except that this exclusion does not apply to Medi-Cal; or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the reasonable costs of services provided to the person at a Veterans Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.

Exception for Other Coverage

A Plan provider may seek reimbursement from other third-party payors for the balance of its reasonable charges for services rendered under this Plan.

Claims and Services Review

Blue Shield reserves the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield may use the services of physician consultants, peer review committees of professional societies or hospitals and other consultants to evaluate claims.

Services Not Charged

Blue Shield will not cover services that you are not legally obligated to pay, or for which you are not charged.

General Provisions

Members Rights and Responsibilities

You, as a Blue Shield Trio HMO Plan Member, have the right to:

1. Receive information about your rights and responsibilities.

2. Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.

3. Make recommendations regarding the Plan's member rights and responsibilities policy.

4. Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.

5. Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.

6. Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.

7. Receive timely and geographically accessible health care.

8. Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.

9. Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.

10. Certain accommodations for your disability, including:

    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.

    - Full and equal access, as other members of the public, to medical facilities.

    - Extra time for visits if you need it.

    - Taking your service animal into exam rooms with you.

11. Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.

12. Receive considerate and courteous care and be treated with respect and dignity.

13. Receive culturally competent care, including but not limited to:

    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.

    - To be addressed by your preferred name and pronoun.

14. Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

15. Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.

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

17. Receive health care coverage even if you have a pre-existing condition.

18. Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.

19. Receive certain Preventive Health Services, including many without a co-pay, Coinsurance, or Deductible.

20. Have no annual or lifetime dollar limits on basic health care services.

21. Keep eligible Dependent(s) on your Plan.

22. Be notified of an unreasonable rate increase or change, as applicable.

23. Protection from illegal balance billing by a Health Care Provider.

24. Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.

25. Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.

26. Ask most Health Care Providers for information regarding who has received your personal health information.

27. Ask your Plan or your doctor to contact you only in certain ways or at certain locations.

28. Have your medical information related to sensitive services protected.

29. Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.

30. Have an interpreter who speaks your language at all points of contact when you receive health care services.

31. Have an interpreter provided at no cost to you.

32. Receive written materials in your preferred language where required by law.

33. Have health information provided in a usable format if you are blind, deaf, or have low vision.

34. Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.

35. Have an Advanced Health Care Directive.

36. Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.

37. File a complaint, grievance, or appeal in your preferred language about:

    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.

38. Know why your Plan denies a service or treatment.

39. Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.

40. Ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

You, as a Blue Shield Trio HMO Plan Member, have the responsibility to:

1. Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.

2. Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.

3. Participate in developing mutually agreed-upon treatment goals with your Health Care

Providers and follow the treatment plans and instructions to the degree possible.

4. To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.

5. Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.

6. Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.

7. Timely pay any premiums, copayments, and charges for non-covered services.

8. Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy for Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (Health & Safety Code Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

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

Please follow these procedures:

- Your recommendations, suggestions or comments should be submitted in writing to the Director, Consumer Affairs, at the above address, who will acknowledge receipt of your letter;
- Your name, address, phone number, subscriber number and group number should be included with each communication;
- The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter;
- Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

Confidentiality of Medical Records and Personal Health Information

Blue Shield of California protects the confidentiality/privacy of your personal 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 will not disclose this information without your authorization, except as permitted by state or federal law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either by calling the Member Services Department at the number listed on the back cover of this booklet, or by ac-

cessing Blue Shield of California's internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield 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 of California Privacy Official
P.O. Box 272530
Chico, CA 95927-2530

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

Email Address:
blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California 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 Agreement. You agree that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. You agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Non-Assignability

Benefits of this Plan are not assignable.

Facilities

The Plan has established a network of physicians, hospitals, participating hospice agencies and non-physician health care practitioners in your Service Area.

The Personal Physician(s) you and your dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of medically necessary care. The hospitals in the Plan network provide access to 24-hour emergency services. The list of the hospitals, physicians and participating hospice agencies in your Service Area indicates the location and phone numbers of these providers. Contact Member Services at the number listed on the back cover of this booklet for information on Plan non-physician health care practitioners in your Personal Physician Service Area.

For urgent services when you are within the United States, you simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, 7 days a week. For urgent services when you are outside the United States, you can call collect 1-804-673-1177 24 hours a day. We will identify the Inter-Plan Program participating provider closest to you. Urgent services when you are outside the United States are available through the Blue Shield Global Core™ Network. For urgent services when you are within California, but outside of your Personal Physician Service Area, you should contact Blue Shield Member Services in accordance with the How to Use the Plan section. For urgent care services when you are within your Personal Physician Service Area, contact your Personal Physician or follow instructions provided by your assigned medical group or IPA.

Independent Contractors

Plan providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield of California conducts a process of credentialing and certification of all physicians who participate in the Trio HMO network. However, 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.

Trio+ Satisfaction

You may provide Blue Shield with feedback regarding the service you receive from Plan physicians. If you are dissatisfied with the service provided during an office visit with a Plan physi-

cian, you may contact Member Services to request a refund of your office visit copayment, as shown in the Summary of Covered Benefits under Physician Services.

Web Site
Blue Shield's Web site is located at http://www.blueshieldca.com. Members with Internet access and a Web browser may view and download health care information.

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

Blue Shield has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health & Safety Code.

To request a copy of the document describing this Utilization Review, call the Member Services Department at 1-800-334-5847.

Grievance Process

You, an authorized representative (Member), or a provider on behalf of the Member, may request a grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD), and must be submitted in one of the following ways:

- Call Shield Concierge at 1-800-334-5847; or
- Fill out a Member Grievance Form on the website at http://www.blueshieldca.com; or
- In writing by sending information to:
  Blue Shield of California
  Appeals and Grievance Department
  P.O. Box 272520
  Chico, CA 95927-2520

The grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the Blue Shield of California Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the Service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale.

The Member may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

For all grievances except denial of coverage for a Non-Formulary Drug or step therapy:

Blue Shield will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Shield Concierge at 1-800-334-5847.

If Blue Shield upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to the Member:

1. For FABDs involving medical judgment, the member may pursue the Independent External Review process described below;
2. For FABDs involving benefit, the Member may pursue the CalPERS Administrative Review process as described in the CalPERS Administrative Review section.

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Blue Shield determines the grievance meets one of the following:

1. The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; OR
2. The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; OR
3. A physician with knowledge of your medical condition determines that your grievance is urgent.

If Blue Shield determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR, at 1-888-466-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

For grievances due to denial of coverage for a Non-Formulary Drug or step therapy:
If Blue Shield denies an exception request for coverage of a Non-Formulary Drug or step therapy, the Member, representative, or the Provider may request an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Shield Concierge.

Experimental or Investigational Denials

Blue Shield does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Blue Shield denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of Blue Shield's decision from the DMHC. **Note**: DMHC does not require you to exhaust Blue Shield's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by calling us at 1-800-334-5847 or write to us at Blue Shield of California, P.O. Box 272520, Chico, CA 95927-2520. To qualify for this review, all of the following conditions must be met:

You have a Life-Threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:

1. A Life-Threatening disease or condition is one where the likelihood of death is high unless the course of the disease is interrupted. A Life-Threatening disease or condition can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
2. A seriously debilitating condition or disease is one that causes major irreversible morbidity.

Your medical group/physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this plan that is more beneficial than the proposed treatment.

The proposed treatment must either be:

- Recommended by a/an Blue Shield provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
- Requested by you or by a licensed

board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
- Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
- Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your doctor. Any newly developed or discovered relevant medical records that we or an Blue Shield provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your doctor determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Independent Medical Review Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your

Blue Shield Plan have been improperly denied, modified or delayed, in whole or in part, by Blue Shield or one of its providers because the service is deemed not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.

You have the right to provide information in support of the request for an IMR. Blue Shield must provide you with an IMR application form and Blue Shield's FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Blue Shield regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have had urgent care or emergency services that a provider determined was medically necessary, or
   (c) You have been seen by an Blue Shield provider for the diagnosis or treatment of the medical condition for which you want an IMR;
2. The disputed health care service has been denied, changed, or delayed by us or your medical group, based in whole or in part on a decision that the health care service is deemed not medically necessary; and
3. You have filed a complaint with us or your medical group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of Blue Shield. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor Blue Shield will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds Blue Shield's FABD, you may have additional review rights under the CalPERS Administrative Review section.

For more information regarding the IMR process or to request an application form, please call Shield Concierge at 1-800-334-5847.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-334-5847** (TTY users call 711) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be

available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website, **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, Grievance Procedures, Experimental or Investigational Denials, Independent Medical Review Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. **Eligibility Issues**

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account Management Division
Attn: Enrollment Administration
P.O. Box 942715
Sacramento, CA 94229-2715

888 CalPERS (or **888**-225-7377) CalPERS Customer Service and Outreach Division toll free telephone number

1-916-795-1277 fax number

2. **Coverage Issues**

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care service.

If you are dissatisfied with the outcome of Blue Shield's internal appeal process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care, proceed to court or Small Claims Court, if your coverage dispute is within the jurisdictional limits of Small Claims Court, or request an Administrative Review by CalPERS. You may not request a CalPERS Administrative Review if you decide to proceed to court or Small Claims Court.

3. **Malpractice and Bad Faith**

You must proceed directly to court.

4. **Disputed Health Care Service Issue**

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or Experimental or Investigational.

If you are dissatisfied with the outcome of Blue Shield's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the Department of Managed Health Care.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you

choose to proceed to court, you may not request a CalPERS Administrative Review.

CalPERS Administrative Review

If you remain dissatisfied with Blue Shield's determination, the DMHC's determination or the IMR's determination, the Member may request an Administrative Review. The Member must exhaust Blue Shield's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC FABD or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed 30 days.

The request must be mailed to:

CalPERS Health Benefits Compliance & Appeals Unit
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

The Member is encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. If the Member would like to designate an Authorized Representative to represent him/her in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. The Member must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding a Member's request for Administrative Review. The ARHI form will be provided to the Member with the FABD letter from Blue Shield. If the Member has additional medical records from Providers or scientific studies that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send copies of documents, not originals, as CalPERS will retain the documents for its files. The Member is responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) calendar days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if the Member requests an IMR at the same time the Member submits a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

Administrative Hearing

The Member must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

The Member must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); the Member may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to the Member within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

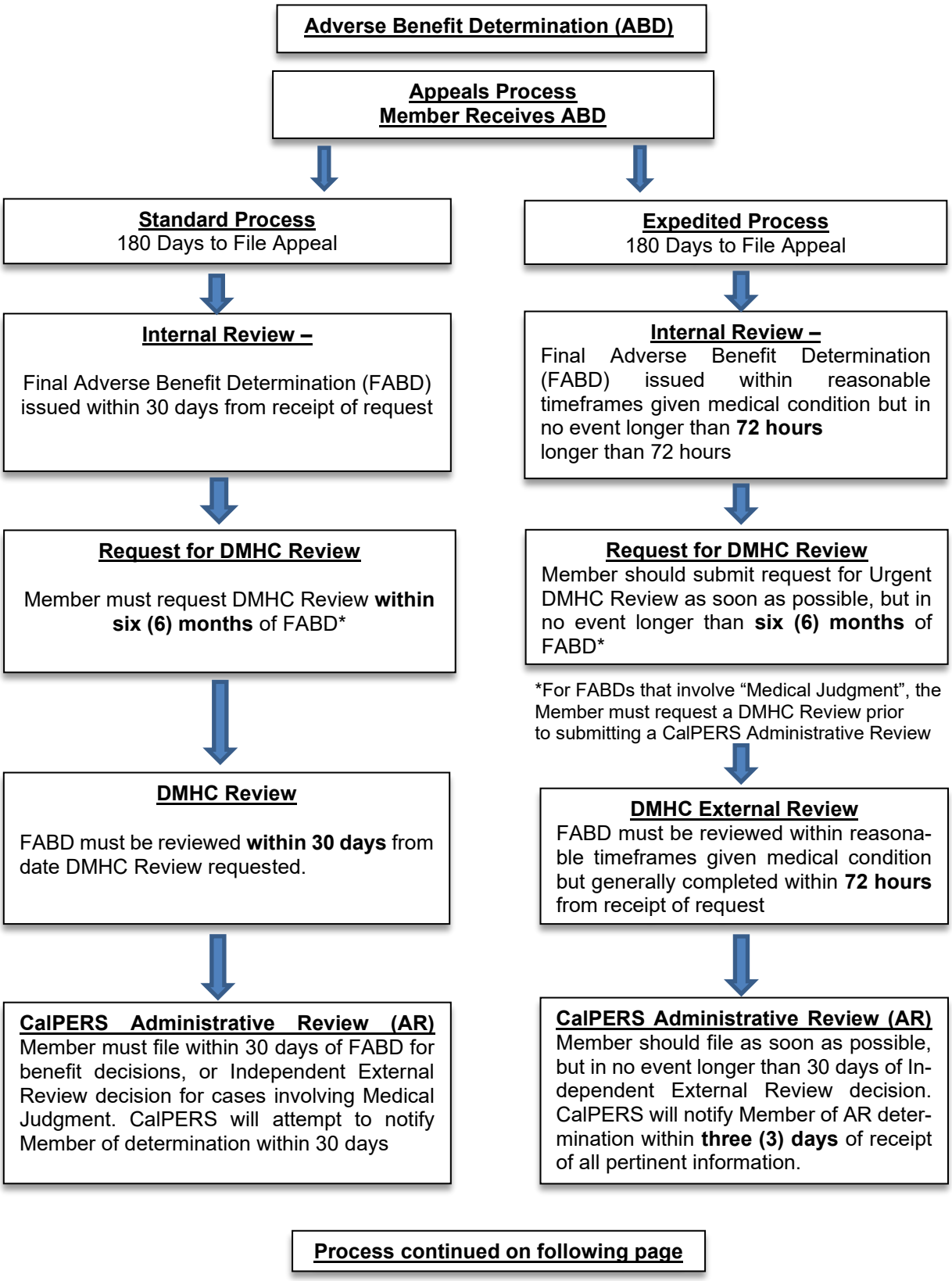
- **Right to records, generally.** The Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, the Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, the Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street, Sacramento, CA 95814

APPEALS CHART



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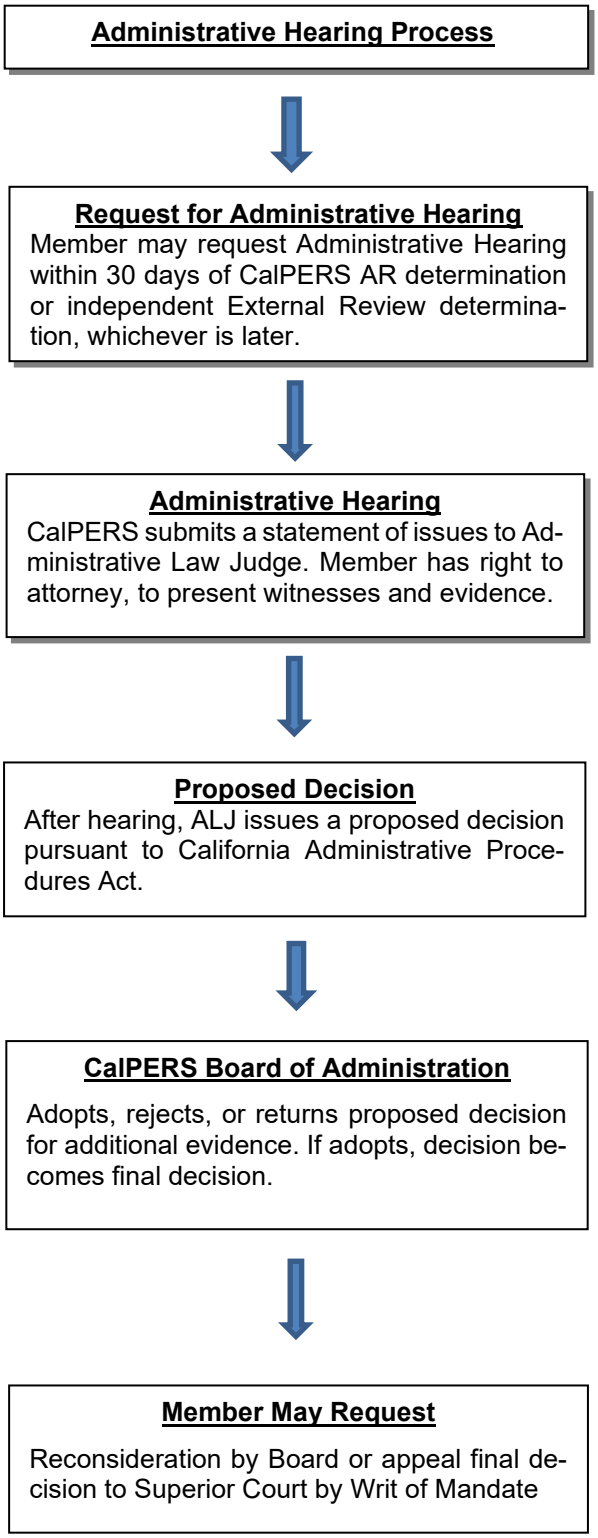
Administrative Hearing Process
Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination or independent External Review determination, whichever is later.
Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.
Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Alternate Arrangements

Blue Shield will make a reasonable effort to secure alternate arrangements for the provision of care by another Plan provider without additional expense to you in the event a Plan provider's contract is terminated, or a Plan provider is unable or unwilling to provide care to you.

If such alternate arrangements are not made available, or are not deemed satisfactory to the Board, then Blue Shield will provide all services and/or benefits of the Agreement to you on a fee-for-service basis (less any applicable copayments), and the limitation contained herein with respect to use of a Plan provider shall be of no force or effect.

Such fee-for-service arrangements shall continue until any affected treatment plan has been completed or until such time as you agree to obtain services from another Plan provider, your enrollment is terminated, or your enrollment is transferred to another plan administered by the Board, whichever occurs first. In no case, however, will such fee-for-service arrangements continue beyond the term of the Plan, unless the Continuity of Care or Extension of Benefits provisions apply to you.

Termination of Group Membership - Continuation of Coverage

Termination of Benefits

Coverage for you or your dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the group Agreement is discontinued, (2) the last day of the month in which the subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your employer, (3) the end of the period for which the premium is paid, or (4) the last day of the month in which you or your dependents become ineligible. A spouse also becomes ineligible following legal separation from the subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the subscriber. A domestic partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the Continuity of Care, Extension of Benefits, and COBRA provisions, there is no right to receive benefits for services provided following termination of this group Agreement.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see your employer about possibly continuing group coverage. Also, see the COBRA and/or Cal-COBRA provisions described in this booklet for information on continuation of coverage.

If the subscriber no longer lives or works in the Service Area, coverage will be terminated for him and all his dependents. If a dependent no longer lives or works in the Service Area, then that dependent's coverage will be terminated. (Special arrangements may be available for dependents who are full-time students, dependents of subscribers who are required by court order to provide coverage, and dependents and subscribers who are long-term travelers. Please contact the Member Services Department to request a brochure which explains these arrangements including how long coverage is available. This brochure is also available at http://www.blueshieldca.com for HMO Members.)

In the event any Member believes that his or her benefits under this Agreement have been terminated because of his or her health status or health requirements, the Member may seek from the Department of Managed Health Care, review of the termination as provided in California Health & Safety Code Section 1365(b).

Reinstatement

If you cancel or your coverage is terminated, refer to the CalPERS "Health Program Guide."

Cancellation

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Continuity of Care, Extension of Benefits, and COBRA provisions in this booklet.

The group Agreement also may be cancelled by CalPERS at any time provided written notice is

given to Blue Shield to become effective upon receipt, or on a later date as may be specified on the notice. Information pertaining to cancellation can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS.

Extension of Benefits

If a person becomes totally disabled while validly covered under this Plan and continues to be totally disabled on the date group coverage terminates, Blue Shield will extend the benefits of this Plan, subject to all limitations and restrictions, for Covered Benefits and supplies directly related to the condition, illness or injury causing such total disability until the first to occur of the following: (1) the date the covered person is no longer totally disabled, (2) 12 months from the date group coverage terminated, (3) the date on which the covered person's maximum benefits are reached, (4) the date on which a replacement carrier provides coverage to the person without limitation as to the totally disabling condition.

No extension will be granted unless Blue Shield receives written certification by a Plan physician of such total disability within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Blue Shield.

COBRA and/or Cal-COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

COBRA

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled family member who lose their regular group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her family member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months. The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

1. The covered employee's separation from employment for reasons other than gross misconduct.

2. Reduction in the covered employee's hours to less than half-time.

Four "qualifying events" allow an active or retired employee's enrolled family member(s) to elect the continuation coverage for up to 36 months. Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

1. The employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS).

2. Divorce or legal separation of the covered employee or retiree from the employee's or

retiree's spouse or termination of the domestic partnership.

3. A dependent child ceases to be a dependent child.

4. The primary COBRA subscriber becomes entitled to Medicare.

If elected, COBRA continuation coverage is effective on the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the specified time, or until one of the following events terminates the coverage:

1. The termination of all employer provided group health plans, or

2. The enrollee fails to pay the required premium(s) on a timely basis, or

3. The enrollee becomes covered by another health plan without limitations as to pre-existing conditions, or

4. The enrollee becomes eligible for Medicare benefits, or

5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.

You will receive notice from your employer of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact your (former) employing agency or CalPERS directly if you need more information about your eligibility for COBRA group continuation coverage.

Cal-COBRA

COBRA enrollees who became eligible for COBRA coverage on or after January 1, 2003, and who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the qualifying event has occurred which originally entitled the Member to continue group coverage under this Plan.

Monthly rates for Cal-COBRA coverage shall be 102% of the applicable group monthly rates.

Cal-COBRA enrollees must submit monthly rates directly to Blue Shield. The initial monthly rates must be paid within 45 days of the date the Member provided written notification to the Plan of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The monthly rate payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Member from continuation coverage.

Blue Shield of California is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their employer for information about their rights under the USERRA. Employers are responsible to ensure

compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for medical disability.

Payment by Third Parties

Third Party Recovery Process and the Member's Responsibility

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield, the Member's designated medical group, or the IPA shall, with respect to services required as a result of that injury, provide the benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage. Notwithstanding the foregoing, no coverage is provided under the Plan for services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.

This right to restitution, reimbursement or other available remedy is against any recovery the Member 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 or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "recovery"), without regard to whether the Member has been "made whole" by the recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total recovery that is due for the benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

The Member is required to:

1. Notify Blue Shield, the Member's designated medical group, or the IPA in writing of any actual or potential claim or legal action which such Member 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 and execute any forms or documents needed to enforce this 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 a lien calculated in accordance with California Civil Code section 3040. 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 and the Member's designated medical group or IPA, in writing, within 10 days after any recovery has been obtained.

A Member's failure to comply with 1. through 5. above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield, the Member's designated medical group, or the IPA.

Further, if the Member receives services from a Plan hospital for such injuries or illness, the hospital has the right to collect from the Member the difference between the amount paid by Blue

Shield and the hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

Workers' Compensation

No benefits are provided for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.

However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges.

Coordination of Benefits

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for hospital or medical expenses, such person will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any calendar year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit value or amount payable by each plan separately.

If the covered person is also entitled to benefits under any of the conditions as outlined under the Limitations for Duplicate Coverage provision, benefits received under any such condition will not be coordinated with the benefits of this Plan. The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision, it will always provide its benefits first. Otherwise, the plan covering the patient as an employee will provide its benefits before the plan covering the patient as a dependent.

Except for cases of claims for a dependent child whose parents are separated or divorced, the plan which covers the dependent child of a person whose date of birth (excluding year of birth) occurs earlier in a calendar year, shall determine its benefits before a plan which covers the dependent child of a person whose date of birth (excluding year of birth) occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding 1. above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

    a. A plan covering a patient as a laid-off or retired employee, or as a dependent of

such an employee, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such dependent; and,

b. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of a. above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its benefits without reduction because of benefits available from any other plan.

When this Plan is secondary in the order of payments, and Blue Shield is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the covered person: (1) assigns to Blue Shield the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Blue Shield actually provides and the value of the benefits that Blue Shield would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield in obtaining payment of benefits from the other plan, and (3) allows Blue Shield to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another Plan, Blue Shield may pay to the other Plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as benefits paid under this Plan. Blue Shield shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

Blue Shield may release to or obtain from any organization or person any information which Blue Shield considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other Plan. Any person claiming benefits under this Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.

Definitions

Trio Provider - a medical group or IPA, and all associated physicians and Plan Specialists, that participate in the Trio HMO Plan.

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

Advanced Health Care Directive – means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Adverse Benefit Determination (ABD) - a decision by Blue Shield to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

1. Determination of an individual's eligibility to participate in this Blue Shield plan; or
2. Determination that a benefit is not covered; or
3. Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Adverse Childhood Experiences - An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has

lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Agreement - see Group Health Service Agreement.

Allowed Charges – (1) the amount a Plan provider agrees to accept as payment from Blue Shield or (2) the billed amount for non-Plan Providers (except that physicians rendering emergency services and hospitals rendering any services who are not Plan providers will be paid based on the reasonable and customary charge, as defined) or, if applicable, the amount determined under state and federal law.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this Evidence of Coverage, including an adverse benefit determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Appropriately Qualified Health Care Provider – means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial – Means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veteran Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Authorized Representative - means an individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a

Grievance or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Blue Shield.

Behavioral Health Crisis Services – the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, Mobile Crisis Teams, and crisis receiving and stabilization services.

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.

Benefits (Covered Benefits) - means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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

Close Relative - the spouse, domestic partner, child, brother, sister or parent of a Member.

Continuous Nursing Services — Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

Copayment - the amount that a Member is required to pay for specific Covered Benefits.

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

Covered Benefits (Benefits) - means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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 or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician); or care furnished to a Member 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 patient 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.

Dental Care and Services - services or treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth or gums.

Disputed Health Care Service - any Health Care Service eligible for coverage and payment under your Blue Shield Plan that has been denied, modified or delayed by Blue Shield or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

Domestic Service Area – the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

Domiciliary Care - care provided in a hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Dues - the monthly prepayment that is made to the Plan on behalf of each Member by the contractholder.

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 patient's medical condition. Durable medical equipment includes wheelchairs, hospital beds, respirators, required dialysis equipment and medical supplies, and other items that the Plan determines are durable medical equipment.

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

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care (Emergency Services) – means:

- medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel 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, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or

- an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and 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.

Employer (Contractholder) - means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least 101 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for the purposes of buying health care coverage or insurance.

Evidence of Coverage - means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services (Experimental) - means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family - the subscriber and all enrolled dependents.

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

1. A provider who is no longer available to the Member as a Plan Provider, but at the time of the provider's contract termination with Blue Shield, the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Plan Provider" table in the Continuity of Care section.
2. A Non-Plan Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time the Member's coverage with Blue Shield became effective, the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Plan Provider" table in the Continuity of Care section.
3. A provider who is a Plan Provider with

Blue Shield but no longer available to the Member as a Plan Provider because:

a) The Employer has terminated its contract with Blue Shield; and
b) The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Plan Provider in its network; and
c) At the time of the Employer's contract termination the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Plan Provider table" in the Continuity of Care section.

Generally Accepted Standards of Mental Health or Substance Use Disorder Care - Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health or Substance Use Disorder care include:

- Peer-reviewed scientific studies and medical literature;
- Clinical practice guidelines and recommendations of nonprofit health care provider professional associations;
- Specialty societies and federal government agencies; and
- Drug labeling approved by the U.S. Food and Drug Administration.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Group Health Service Agreement (Agreement) - the Agreement issued by the Plan to the contractholder that establishes the services Members are entitled to from the Plan.

Health Care Provider - means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Hemophilia Infusion Provider - a provider who has an agreement with Blue Shield to provide hemophilia therapy products and necessary supplies and services for covered home infusion and home intravenous injections by Members.

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 - either 1., 2. or 3. below:

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

2. a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or,

3. a "psychiatric health facility" as defined in Section 1250.2 of the Health & Safety Code.

Host Blue — the local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the Domestic Service Area.

Independent Medical Review (IMR) - means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Independent Practice Association (IPA) - a group of physicians with individual offices who form an organization in order to contract, manage and share financial responsibilities for providing benefits to Members.

Infertility (effective 1/1/27- 6/30/27) –

1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or

2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Infertility (effective 7/1/27- 12/31/27) –

1. A licensed Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility in paragraph (3);
2. A person's inability to reproduce either as an individual or with their partner without medical intervention; or
3. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.

Inpatient - an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Intensive Outpatient Program - an outpatient mental health (or substance use disorder) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week.

Inter-Plan Programs – Blue Shield's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

Investigational Services (Investigational) - Means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

Life-Threatening–
means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medical Group - an organization of physicians who are generally located in the same facility and provide benefits to Members.

Medically Necessary (Medical Necessity) - means a service or product addressing the spe-

cific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medicare - refers to the program of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member - means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder(s) - means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Mobile Crisis Team - a multidisciplinary team of trained behavioral health professionals who provide Behavioral Health Crisis Services in the least restrictive setting 24 hours a day, 7 days a week, 365 days per year.

Occupational Therapy - treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period - a fixed time period designated by CalPERS to initiate enrollment or change enrollment from one plan to another.

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-Area Covered Health Care Services - Medically Necessary Emergency Services, Urgent Services, or Out-of-Area Follow-up Care provided outside the Service Area.

Out-of-Area Follow-up Care - non-emergent medically necessary services to evaluate the Member's progress after Emergency or Urgent Services provided outside the Service Area.

Outpatient - an individual receiving services under the direction of a Plan provider, but not as an inpatient.

Outpatient Department of a Hospital — any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Outpatient Facility - a licensed facility, not a physician's office, or a hospital that provides medical and/or surgical services on an outpatient basis.

Partial Hospitalization Program / Day Treatment – an outpatient treatment program that may be free-standing or hospital-based and provides services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

Participating Hospice or Participating Hospice Agency - an entity which: 1) provides hospice services to terminally ill Members 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 and 2) either has contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide hospice service benefits pursuant to the California Health and Safety Code Section 1368.2.

Personal Physician - a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with the Plan as a Personal Physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with the Agreement.

Personal Physician Service Area - that geographic area served by the Personal Physician's medical group or IPA.

Physical Therapy - treatment provided by a physician or under the direction of a physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. 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.

Physician - an individual licensed and authorized to engage in the practice of medicine or osteopathy.

Plan - the Blue Shield Trio HMO Health Plan and/or Blue Shield of California.

Plan Hospital - a hospital licensed under applicable state law contracting specifically with Blue Shield to provide benefits to Members under the Plan.

Plan Non-Physician Health Care Practitioner - a health care professional who is not a physician and has an agreement with one of the contracted IPAs, medical groups, Plan hospitals or Blue Shield to provide Covered Benefits to Members when referred by a Personal Physician.

Plan Provider- a provider who has an agreement with Blue Shield to provide Plan benefits to Members.

Plan Specialist - a physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide services to Members either according to an authorized referral by a Personal Physician, or according to the Trio+ Specialist program, or for OB/GYN physician services.

Preventive Health Services — mean those primary preventive medical Covered Benefits provided by a physician, including related laboratory services, for early detection of disease as specifically listed below:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Includes immunizations required for travel and immunizations, such as Hepatitis B, for individuals at occupational risk;

3. Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit (a Physician or other Health Care Provider's order must be provided for coverage);

4. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

5. Adverse Childhood Experiences screenings;

6. With respect to women, such additional preventive care and screenings not described in

paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive health services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered preventive health services is available in Blue Shield's Preventive Health Guidelines. The Guidelines are available at http://www.blueshieldca.com/preventive or by calling Member Services and requesting that a copy be mailed to you.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1. through 4. above, the new recommendation will be covered as a preventive health service no later than 12 months following the issuance of the recommendation. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

Prosthesis - an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Psychiatric Emergency Medical Condition - means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Reasonable and Customary Charge - in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Plan 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 geographic 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 state and federal laws to be paid for emergency services.

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 function, 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.

Rehabilitative Services – 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. Rehabilitative services may consist of physical therapy, occupational therapy, and/or respiratory therapy. Benefits for speech therapy are described in Speech Therapy in the Benefit Descriptions section.

Residential Care - mental health services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

Respiratory Therapy - treatment, under the direction of a physician and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Seriously Debilitating – means diseases or conditions that cause major irreversible morbidity.

Service Area - means the geographic area designated by the plan within which a plan shall provide health care services.

Services - includes medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Nursing Facility - a facility with a valid license issued 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.

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, PKU. It does not include grocery store foods or pre-packaged foods including shakes, snack bars, used by the general population, additives such as thickeners, enzyme products, or 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 physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by diagnosed illness or injury.

Standard Fertility Preservation Services - means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Subacute Care - skilled nursing or skilled rehabilitative services 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 - the person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

Third-Party Corporate Telehealth Provider - A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.

Total Disability -

1. In the case of an employee or Member otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

2. In the case of a dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life.

Trans-Inclusive Health Care - means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Urgent Services - those Covered Benefits rendered outside of the Service Area (other than emergency services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Service Area.

Vision Services - Services or materials related to orthoptics, vision training, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007

El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

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

Language Access Services

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

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

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

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

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

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

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

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

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

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

TRIO BASIC PLAN

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

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

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

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

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

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

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

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

TRIO BASIC PLAN

Service Area

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's Service Area. When you use your work ZIP Code, all enrolled dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's Service Area, even if they do not reside in that area.

Butte County[1] ***(Partial County Served)***	**Los Angeles County**[3] ***(Partial County Served)***	**Sacramento County**[1] ***(Partial County Served)***	**Shasta County**[1] ***(Partial County Served)***
Contra Costa County[1] ***(Entire County Served)***	**Nevada County**[1] ***(Partial County Served)***	**San Bernardino County**[3] ***(Partial County Served)***	**Stanislaus County**[1] ***(Partial County Served)***
El Dorado County[1] ***(Partial County Served)***	**Orange County**[2] ***(Entire County Served)***	**San Luis Obispo County**[2] ***(Partial County Served)***	**Tulare County**[2] ***(Partial County Served)***
Kern County[2] ***(Partial County Served)***	**Placer County**[1] ***(Partial County Served)***	**Santa Barbara County**[2] ***(Partial County Served)***	**Ventura County**[2] ***(Partial County Served)***
Kings County[2] ***(Partial County Served)***	**Riverside County**[3] ***(Partial County Served)***	**Santa Cruz County**[1] ***(Entire County Served)***	**Yolo County**[1] ***(Partial County Served)***

Pricing Regions for Contracting Agency Employees and Annuitants

1 Butte, Contra Costa, El Dorado, Nevada, Placer, Sacramento, Santa Cruz, Shasta, Stanislaus, and Yolo

2 Kern, Kings, Orange, San Luis Obispo, Santa Barbara, Tulare, and Ventura

3 Los Angeles, Riverside, and San Bernardino

Notes

Notes

Notes

This Combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of Blue Shield Trio HMO.

Should you have any questions, please call Member Services at 1-800-334-5847.

Blue Shield of California Trio HMO service areas by geographical cluster and county

Refer to the Service Area section in this booklet for an alphabetical list of all counties in the service areas. Contact the Plan for up-to-date confirmation of service areas and providers.

Blue Shield of California

Trio HMO

For inquiries, issues, or requests, please contact Shield Concierge:

(800) 334-5847

blueshieldca.com/calpers

P.O. Box 272530
Chico, CA 95927-2520

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601 12th Street, Oakland, CA 94607

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