Combined Evidence of Coverage and Disclosure Form

Shield Signature
San Bernardino County
Group Number: W0051658-M0042023
Effective Date: July 26, 2025
Provider Network: Shield Signature

blueshieldca.com

blue california

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blue of california

Summary of Benefits

San Bernardino County - Actives
Effective July 26, 2025
Shield Signature Benefit Plan

Custom Shield Signature Plan

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

Provider Network: Shield Signature Network

This benefit Plan uses a specific network of Health Care Providers, called the Shield Signature provider network. This Plan provides Benefits at two different levels:

- **Shield Signature Level I (HMO Participating Providers):** Services must be provided or prior authorized by your Primary Care Physician or Medical Group/IPA, except in an Emergency or as otherwise specified. Please review your EOC for details about how to access care under this level.
- **Shield Signature Level II (PPO Participating Providers):** Services are provided by Participating Providers for outpatient professional services provided in an office setting. Any Copayment or Coinsurance is calculated from the Allowable Amount.

You are responsible for any Copayment or Coinsurance and any charges over the Allowable Amount. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

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

		Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating Providers[3]
Calendar Year medical Deductible	*Individual coverage*	$0	$0
	Family Coverage	$0: individual $0: Family	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

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

	Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating Providers[3]
Individual coverage	$1,500	No maximum
Family Coverage	$1,500: individual $3,000: Family	

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Preventive Health Services[6]				
Preventive Health Services	$0		$30/visit	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$10/visit		$30/visit	
Specialist care office visit	$10/visit		$30/visit	
Physician home visit	$10/visit		Not covered	
Physician inpatient, outpatient, and surgery services	$0		Not covered	
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants therapists, and podiatrists.*	$10/visit		$30/visit	
Acupuncture services	Not covered		Not covered	
Chiropractic services *Up to 20 visits per Member, per Calendar Year.*	$10/visit		Not covered	
Teladoc consultation	$0		Not covered	
Family Planning				
• Counseling, consulting, and education	$0		Not covered	
• Diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Injectable contraceptive *Under Level II, services are only covered if received in a Physician's office.*	$0		$30/visit	
• Tubal ligation	$0		Not covered	
• Vasectomy	$10/surgery		Not covered	
• Infertility services	50%		Not covered	
Medical nutrition therapy, not related to diabetes	$0		Not covered	
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0		Not covered	
Abortion and abortion-related services	$0		Not covered	
Emergency Services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.*	$75/visit		$75/visit	
Emergency room Physician services	$0		$0	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Urgent care center services	$10/visit		$10/visit	
Ambulance services	$0		$0	
Outpatient facility services				
Ambulatory Surgery Center	$0		Not covered	
Outpatient department of a Hospital: surgery	$0		Not covered	
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		Not covered	
Inpatient facility services				
Hospital services and stay	$0		Not covered	
Transplant services				
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.				
• Special transplant facility inpatient services	$0		Not covered	
• Physician inpatient services	$0		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and Outpatient Physician services payments apply.				
Inpatient facility services	$0		Not covered	
Outpatient Facility services	$0		Not covered	
Physician services	$0		Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures,. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolau (Pap) test.				
• Laboratory center	$0		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient department of a Hospital	$0		Not covered	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	$0		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient Department of a Hospital	$0		Not covered	
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	$0		$0	
Under Level II, services are only covered if received in a Physician's office.				
• Outpatient Department of a Hospital	$0		Not covered	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0		Not covered	
• Outpatient Department of a Hospital	$0		Not covered	
Rehabilitative and habilitative services *Includes physical therapy, occupational therapy, and respiratory therapy services. Under Level II, up to 12 visits per Member, per Calendar Year.*				
Office location	$10/visit		$30/visit	
Outpatient Department of a Hospital	$0		Not covered	
Speech therapy services				
Office location	$10/visit		$30/visit	
Outpatient Department of a Hospital	$0		Not covered	
Durable medical equipment (DME)				
DME	$0		Not covered	
Breast pump	$0		Not covered	
Orthotic equipment and devices	$0		Not covered	
Prosthetic equipment and devices	$0		Not covered	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating Providers[3]**	**CYD[2] applies**
Home health services				
Home health agency services *Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.*	$0		Not covered	
Home visits by an infusion nurse	$0		Not covered	
Home health medical supplies	$0		Not covered	
Home infusion agency services	$0		Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$0		Not covered	
Skilled Nursing Facility (SNF) services				
Freestanding SNF	$0		Not covered	
Hospital-based SNF	$0		Not covered	
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	$0		Not covered	
• Self-management training	$0		$30/visit	
• Medical nutrition therapy	$0		$30/visit	
Dialysis services	$0		Not covered	
PKU product formulas and Special Food Products	$0		Not covered	
Allergy serum	$0		$0	
Travel immunizations and vaccinations	$10/injection		$30/injection	
Eye examination *One comprehensive eye examination in a consecutive 12-month period provided through the contracted VPA.*				
• Ophthalmologic exam	$10/visit		$0 up to $60/Calendar Year plus 100% of additional charges	
• Optometric exam	$10/visit		$0 up to $50/Calendar Year plus 100% of additional charges	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	**Shield Signature Level I MHSA Participating Providers[3]**	**CYD[2] applies**	**Shield Signature Level II MHSA Non-Participating Providers[3]**	**CYD[2] applies**
Outpatient services				
Office visit, including Physician office visit	$0 for the first 3 visits, then $10/visit		$0 for the first 3 visits, then $10/visit	
Teladoc consultation	$0		Not covered	
Intensive outpatient care	$0		Not covered	
Behavioral health treatment in an office setting	$0		$0	
Behavioral health treatment in home or other non-institutional facility setting	$0		$0	
Office-based opioid treatment	$0		$0	
Partial Hospitalization Program	$0		Not covered	
Psychological Testing	$0		Not covered	
Inpatient services				
Physician inpatient services	$0		Not covered	
Hospital services	$0		Not covered	
Residential Care	$0		Not covered	

Notes

1 Evidence of Coverage (EOC):
The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.
Defined terms are in the EOC. Refer to the EOC for an exPlanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):
Calendar Year Deductible explained. A deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.
If this benefit Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

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

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

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

Notes

Under Shield Signature Level I Participating Providers, Copayments not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached. *Under Shield Signature Level II Participating Providers,* there is neither a Calendar Year Deductible nor a Calendar Year Out-of-Pocket Maximum for Shield Signature Level II Covered Services. However, the Member will be responsible for applicable Copayments and non-covered charges, and for non-Shield Signature Providers all charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

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

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

6 Preventive Health Services:
If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit under the Shield Signature Level I provider network. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

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

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

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

- Provide personal service to you that is worthy of our family and friends; and
- Build deep, trusting relationships with providers to improve the quality of health care and lower the cost.

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

About this Evidence of Coverage

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

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

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

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

Tables and images

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

Phone numbers and addresses

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

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

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

"You" means the Member

In this Evidence of Coverage, "you" or "your" means any Member enrolled in the plan, including the Subscriber and all Dependents. "The County" means San Bernardino County.

Capitalized words have a special meaning

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

About this plan

Blue Shield of California's Shield Signature plan for the County of San Bernardino is a single product with two distinct levels of care to meet your health needs. These Shield Signature levels of care are fully described in this Evidence of Coverage and Disclosure Form booklet.

Shield Signature Level I: Health Maintenance Organization (HMO)

Shield Signature Level I is an established network of Primary Care Physicians and Specialist Physicians, Hospitals, Participating Hospice Agencies, and other Health Care Providers to provide Covered Services to Members. To receive Shield Signature Level I Benefits, you must obtain or receive approval for all Covered Services from your Primary Care Physician. Each Member must select a Primary Care Physician from the list of Primary Care Physicians in the HMO Physician and Hospital Directory. The Physician and Hospital Directory will be given to you at the time of enrollment. Your Primary Care Physician will be accessible on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements for coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Shield Signature Hospitals. The list of providers in the Physician and Hospital Directory includes the location and phone numbers of all Primary Care Physicians, Hospitals and Participating Hospice Agencies in the Medical Group Service Area. You should contact Member Services for information on Health Care Providers in your Medical Group Service Area.

For coverage at Level I all non-emergency mental health inpatient Hospital admissions including Residential Care, and Other Outpatient Mental Health Services must be arranged through and authorized by the Mental Health Service Administrator (MHSA) and provided by a MHSA Participating Provider. Members are not required to coordinate Mental Health Services through their Primary Care Physician. A list of MHSA Participating Providers is available in the online Blue Shield of California Provider Directory or you may contact the MHSA for information on and to select a MHSA Provider by calling (877) 263-9952. Additional information can be found under the *Shield Signature Level I (HMO) Mental Health and Substance Use Disorder Benefits* section.

Shield Signature Level I Benefits

For a complete description of services covered under Shield Signature Level I please read this booklet's Summary of Benefits, the *Shield Signature Level I Benefits* section and the *Exclusions and limitations* section. There is no medical Deductible for Shield Signature Level I and the Calendar Year Out-of-Pocket Maximum for Covered Services is $1,500 per individual or $3,000 per Family. There is no lifetime maximum.

- Allergy Testing and Treatment
- Ambulance Benefits
- Ambulatory Surgery Center Benefits*****
- Bariatric Surgery*****
- Clinical Trial for Cancer Benefits*****
- Chemical Dependency Services (Substance Use Disorder)*****
- Diabetic Care Benefits
- Diagnostic X-Ray, Pathology and Laboratory Benefits
- Dialysis Center Benefits*****
- Durable Medical Equipment*****
- Emergency Room Benefits
- Eye Examination Benefit
- Family Planning and Infertility Benefits
- Home Health Care Benefits*****
- Home Infusion/Home Injectable Therapy Benefits*****
- Hospice Program Benefits*****
- Hospital services*****
- Medical Treatment of Teeth, Gums, Jaw Joints and Jaw Bone Benefits
- Mental Health Benefits
- Orthotics Benefits*****
- Prescription Drug Benefits
- PKU Related Formulas and Special Food Products*****
- Pregnancy and Maternity Care Benefits*****
- Preventive Health Services
- Physician and other professional services Benefits
- Prosthetic Appliance Benefits *****
- Rehabilitative Benefits (Physical, Occupational and Respiratory Therapy)
- Skilled Nursing Facility Benefits*****
- Speech Therapy Benefits
- Transplants*****
- Urgent Care Benefits

*** This benefit is only covered under Shield Signature Level I**

Shield Signature Level II: Blue Shield PPO Network outpatient professional services provided in an office setting

The Shield Signature Level II Benefits are designed to supplement the full range of Benefits covered under your Shield Signature Level I. Under Shield Signature Level II you have the option of receiving outpatient professional services that are provided in an office setting from any Participating Provider in Blue Shield's PPO network without receiving prior authorization from your Shield Signature Level I Primary Care Physician.

Please note that while the additional PPO outpatient Benefits enhance your range of Covered Services, you will be responsible for applicable Copayments and non-covered charges. There is neither a calendar year medical Deductible nor a Calendar Year Out-of-Pocket Maximum for Shield Signature Level II Covered Services. There is no lifetime maximum. You are still required to receive all inpatient care from a Hospital or other inpatient facility, Participating Hospice Agencies, and other Inpatient provider services under your Shield Signature Level I HMO coverage.

Under Shield Signature Level II, you may choose to receive covered Mental Health Services for outpatient professional services provided in an office setting from a Shield Signature Level II PPO Network Participating Provider. For Covered Services from Shield Signature Level II PPO Network Participating Providers you are responsible for any amounts billed in excess of the Allowable Amount.

Shield Signature Level II Benefits

The following outpatient Benefits are covered under Shield Signature Level II by Participating Providers in the Blue Shield PPO Network. For a complete description of services covered under Shield Signature Level II please read this booklet's *Summary of Benefits*, *Shield Signature Level II Benefits,* and *Exclusions and limitations* sections.

- Allergy testing or treatment visits provided in an office setting
- Ambulance Benefits
- Diabetes self-management training provided by Physician or a registered dietician or registered nurse that are certified diabetic educators provided in an office setting
- Emergency room services resulting in Hospital admission only until you can be transferred to a covered HMO Hospital
- Laboratory and X-rays provided in an outpatient office setting are covered. Laboratory, X-ray and diagnosis tests performed elsewhere such as in an Outpatient Facility, hospital or other inpatient facility are not covered.
- Medical Treatment of Teeth, Gums, Jaw Joints and Jaw Bone Benefits provided in an outpatient office setting
- Mental Health outpatient visits provided in an office setting
- Physician and Specialist office visits*
- Preventive Health Services provided in an office setting
- Rehabilitative services by a physical, occupational, or speech therapist provided in an office setting

*** Note: If a Blue Shield PPO Network Shield Signature Level II Physician or Specialist believes you require hospitalization, you must contact your Shield Signature Level I Primary Care Physician for treatment including referral**

How to contact customer service

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

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

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

Contacting customer service

If you need information about	*You should contact*
Medical Benefits, including prior authorization and claims submission	Blue Shield Member Services: 1-855-599-2657 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Prior authorization of radiological services	National Imaging Associates: (888) 642-2583
Mental Health and Substance Use Disorder services, including prior authorization	Mental Health Customer Service: (877) 263-9952 Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002
Eye examination Benefits	Vision Plan Administrator (VPA) Customer Service (877) 601-9083

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

Your bill of rights

	As a Shield Signature Member, you have the right to:
1	Receive considerate and courteous care with respect for your right to personal privacy and dignity.
2	Receive information about all health services available to you, including a clear explanation of how to obtain them.
3	Receive information about your rights and responsibilities.
4	Receive information about your Blue Shield plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you.
5	Select a Primary Care Physician and expect his/her team of health workers to provide or arrange for all the care that you need.
6	Have reasonable access to appropriate medical and mental health services.
7	Participate actively with your Physician in decisions about your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8	A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your Physician, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
10	Receive Preventive Health Services.
11	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12	Have confidential health records, except when the state law (California) or federal law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your Primary Care Physician.
13	Communicate with, and receive information from, Member Services in a language you can understand.
14	Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

	As a Shield Signature Member, you have the right to:
15	Obtain a referral from your Primary Care Physician for a second opinion.
16	Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care.
17	Voice complaints or grievances about your Blue Shield plan or the care provided to you.
18	Make recommendations on Blue Shield's Member rights and responsibilities policies.

Your responsibilities

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

How to access care

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

Health care professionals and facilities

By choosing Shield Signature you have the opportunity to be an active participant in your own health care. We'll help you make a personal commitment to maintain and, where possible, improve your health. 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.

You will have two Benefit options called "Levels" for medical care. The choice you make at the time you need medical care will determine your out-of-pocket costs.

Shield Signature Level I provides a full service of coverage through our HMO network.

Shield Signature Level II offers you the option of receiving selected PPO Network Participating Provider outpatient professional services provided in an office setting.

Shield Signature Level I – HMO Covered Services

Shield Signature Level I is the "HMO" level of Benefits. Using it provides you with the highest level of Benefits — i.e., full Shield Signature Benefits at the lowest out-of-pocket cost to you. You will be covered under Shield Signature Level I only when care is provided by (1) your Primary Care Physician, (2) any provider authorized by your Primary Care Physician, (3) a Mental Health Service Administrator (MHSA) Participating Provider, or (4) any provider for Emergency Services as described in this booklet's *Shield Signature Level I Benefits* section. You will only be responsible for the Shield Signature Level I Calendar Year Out-of-Pocket Maximum and Copayments.

To determine whether a Shield Signature Level I provider is a Participating Provider, consult the Blue Shield HMO Physician and Hospital Directory. You may also verify this information by accessing Blue Shield's Internet site located at blueshieldca.com, or by calling Member Services at the telephone number provided at the bottom of every page. Note: A Shield Signature Level I Participating Provider's status may change. It is your obligation to verify whether the provider you choose is a Shield Signature Participating Provider; in case there have been any changes since your directory was published.

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

Shield Signature Level II – Selected PPO Network Participating Provider outpatient professional services provided in an office setting

Shield Signature Benefits under Shield Signature Level II provide coverage for selected Shield Signature Level II PPO Network Participating Provider outpatient professional services provided in an office setting which are detailed in this booklet's *Summary of Benefits*. Referral or authorization by your Primary Care Physician is not required and there are no Deductibles or Copayment maximums. For services received by a Shield Signature Level II PPO Network Participating Provider you are responsible for any amount over the Allowable Amount.

Note: Coverage under Shield Signature Level II is only for selected Shield Signature Level II PPO Network Participating Provider outpatient services. All inpatient care including Hospitalization, Skilled Nursing care and services which cannot be provided in an outpatient medical office are not covered. Such services must be obtained through your HMO Medical Group and Primary Care Physician or MHSA Participating Provider except for Emergency Services and Urgent Services as described in this booklet.

To determine whether a provider is a Shield Signature Level II PPO Network Participating Provider, consult the Blue Shield Physician Directory. You may also verify this information by accessing Blue Shield's Internet site located at blueshieldca.com, or by calling Member Services at the telephone number provided on the bottom of every page. Note: A Shield Signature Level II Participating Provider's status may change. It is your obligation to verify whether the provider you choose is a Participating Provider; in case there have been any changes since your directory was published.

Note: Benefits for Mental Health Services are provided under Level I for MHSA Participating Providers and Level II for Shield Signature Level II PPO Network Participating Providers.

Please review this booklet, which summarizes the general provisions and operation of your Shield Signature coverage. If you have any questions regarding the information, you may contact us through our Member Services Department at the number listed on the bottom of every page.

Non-Participating Providers at a Participating Provider facility

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

Common types of providers

Primary Care Physicians (PCPs)

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

Benefit Administrators

Blue Shield contracts with Benefit Administrators to manage the Benefits listed in the table below through their own network of providers. Benefit Administrators authorize services, process claims, and address complaints and grievances for those Benefits on behalf of Blue Shield. If you receive a Covered Service from a Benefit Administrator, you should interact with the Benefit Administrator in the same way you would otherwise interact with Blue Shield.

Blue Shield's Benefit Administrators	
Benefit Administrator	***Benefit***
Mental Health Service Administrator (MHSA)	Mental Health and Substance Use Disorder services
Vision Plan Administrator (VPA)	Eye examination Benefits

Shield Signature Level I: MHSA Participating Providers

For Shield Signature Level I, all Mental Health and Substance Use Disorder Services must be provided by an MHSA Participating Provider, apart from the exceptions noted in the next paragraph. Information regarding MHSA Participating Providers is available online at blueshieldca.com. You or your Primary Care Physician may also contact the MHSA directly at (877) 263-9952 to obtain this information.

Mental Health and Substance Use Disorder Services received from a Shield Signature Level II PPO Network Participating Provider will not be covered at Level I except as an Emergency or Urgent Service or when no MHSA Participating Provider is available

to perform the needed services and the MHSA refers you to a Shield Signature Level II PPO Network Participating Provider and authorizes the services. Mental Health and Substance Use Disorder Services received from a health professional that is a Shield Signature Level II PPO Network Participating Provider at a facility that is an MHSA Participating Provider will be covered at Level I.

For coverage at Level I, all non-emergency Mental Health and Substance Use Disorder inpatient Hospital admissions including Residential Care, and Other Outpatient Mental Health and Substance Use Disorder Services must be prior authorized by the MHSA. For prior authorization of Mental Health and Substance Use Disorder Services, the MHSA Participating Provider should contact the MHSA at (877) 263-9952 at least five business days prior to the admission. The MHSA will render a decision on all requests for prior authorization of services as follows:

- For Urgent Services, as soon as possible to accommodate your condition not to exceed 72 hours from receipt of the request;
- For other services, within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and you within two business days of the decision.

If prior authorization is not obtained for an inpatient Mental Health and Substance Use Disorder Hospital admission or for any Other Outpatient Mental Health and Substance Use Disorder Services and the services provided to you are determined not to be a Benefit of the plan, or were not Medically Necessary, coverage will be denied.

Prior authorization is not required for an emergency Mental Health and Substance Use Disorder Hospital admission.

Shield Signature Level I – HMO Covered Services

Your Primary Care Physician

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

- Prior authorization requests;
- Health education;
- Specialist referrals;
- Hospital admissions; and
- Hospice program admissions.

Selecting a PCP

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

PCPs may be:

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

Your PCP must be a Participating Provider. If your PCP leaves this plan's network, Blue Shield will choose a new PCP for you and notify you.

Your relationship with your PCP

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

Your Medical Group

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

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

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

Changing your Medical Group

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

Changes to your Medical Group are effective on the first day of the month after Blue Shield approves the change. At that time, authorizations for any services by your old Medical Group are no longer valid. If you still need these services, they must be reauthorized by your new Medical Group.

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

Self-referral for obstetrical/gynecological (OB/GYN) services

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

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

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

Specialist referrals

You have two options if you need to see a Specialist.

PCP referrals

This option requires a referral from your PCP to see most types of Specialist. Your PCP will refer you to a Specialist or other appropriate Participating Provider in your Medical Group.

Self-referral to a Shield Signature Specialist

With this option, you do not need a referral from your PCP to visit a Shield Signature Specialist in your Medical Group. You can self-refer to a Shield Signature Specialist for:

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

You cannot self-refer to a Shield Signature Specialist for:

- Allergy testing;
- Endoscopic procedures;
- Diagnostic and nuclear 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 PCP.

Inpatient, Home Health Care, Hospice Program and other services under Shield Signature Level I

The Primary Care Physician is responsible for obtaining prior authorization before you are admitted to the Hospital or a Skilled Nursing Facility or receive home health care and certain other services or before you can be admitted into a Hospice Program through a Participating Hospice Agency under Shield Signature Level I. If the Primary Care Physician determines that you should receive any of these services, he or she will request authorization. If Blue Shield determines that the requested service is Medically Necessary, then your Primary Care Physician will arrange for your admission to the Hospital or Skilled Nursing Facility, including Subacute Care admissions, or to a Hospice Program through a Participating Hospice Agency, as well as for the provision of home health care and other Services. Note: 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 Shield Signature Level I Pregnancy and maternity care section for information relative to the Newborns' and Mothers' Health Protection Act.

ID cards

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

Canceling appointments

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

Continuity of care

Continuity of care may be available if:

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

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

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

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

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

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

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

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

See the *Your payment information* section for more information about the Allowable Amount.

Second medical opinion

You can ask your PCP for a referral to another provider for a second medical opinion in situations including but not limited to:

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

Your Medical Group will work with you to arrange for a second medical opinion. When no Participating Provider is available to perform the needed services, the Primary Care Physician will refer you to a non-Participating Provider after obtaining authorization. This authorization procedure is handled for you by your Primary Care Physician.

Care outside of California

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

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

Emergency Services

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

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

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the Participating or Non-Participating Provider Cost Share for that non-emergency Covered Service.

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

If you cannot find a Participating Provider

Call Member Services if you need help finding a Participating Provider who can provide the care you need close to home. If a Participating Provider is not available, you can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be obtained from a Participating Provider, we will approve your request and you will only be responsible for the Participating Provider Cost Share.

Other ways to access care

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

Teladoc

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

How to access Teladoc

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

Telebehavioral health services

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

Urgent care centers

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

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

Ambulatory Surgery Centers (Level I only)

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

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 Participating or Non-Participating Provider.

Timely access to care

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

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

Call Customer Service if you need help finding a Participating Provider or if a Participating Provider is not available. Please see the *If you cannot find a Participating Provider* section for more information.

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

Health advice and education

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

NurseHelp 24/7SM

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

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

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

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

LifeReferrals 24/7SM

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

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

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

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

Health and wellness resources

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

- Prenatal and other health education programs;

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

Visit blueshieldca.com to explore these resources.

Medical Management Programs

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

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

Prior authorization and PCP referrals

Coverage for most Benefits requires pre-approval from the Medical Group. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. Your PCP will manage your prior authorization requests.

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

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

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization.

When a decision will be made about your prior authorization request

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

Once a decision is made for routine Mental Health and Substance Use Disorder requests, a written notice will be sent to you and your provider within five calendar days. For urgent Mental Health and Substance Use Disorder requests, a written notice will be sent to you and your provider within 72 hours.

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

While you are in the Hospital (inpatient utilization review)

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

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

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

After you leave the Hospital (discharge planning)

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

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and

repeated hospitalizations, and to help you with the transition from Hospital to home. A Blue Shield care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Member Services. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and
- Identify community resources to lend support as you learn to manage a chronic health condition.

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

Managing a serious illness (palliative care services)

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

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

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

Your payment information

Paying for coverage

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

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

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Blue Shield Allowable Amount.

Your Cost Share includes any:

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

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

Allowed Charges and capitation (Level I)

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

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

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

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

Allowable Amount (Level II)

The Allowable Amount is the maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Blue Shield's payment to the provider is the difference between the Allowable Amount and your Cost Share.

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

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

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

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

Calendar Year Deductible

There is no Deductible under this Shield Signature plan.

Copayment and Coinsurance

A Covered Service may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Service. A Coinsurance is a percentage of the Allowable Amount you pay for a Covered Service.

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

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

Calendar Year Out-of-Pocket Maximum (Level I)

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Your Cost Share includes Deductible, Copayment, and Coinsurance and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year. If you want information about your Out-of-Pocket Maximum, you can call Member Services.

Some plans may have a separate Out-of-Pocket Maximum for:

- An individual Member and an entire Family;
- Participating Providers and Non-Participating Providers; and
- Participating Providers and combined Participating and Non-Participating Providers.

If you have a Family plan, there is an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means an individual family member can meet

the individual Out-of-Pocket Maximum before the entire Family meets the Family Out-of-Pocket Maximum.

If you have an individual plan and you enroll a Dependent, your plan will become a Family plan. Any amount you have paid toward the Out-of-Pocket Maximum for your individual plan will be applied to both the individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum for your new plan.

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

- Charges for services that are not covered; and
- Charges over the Allowable Amount.

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

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

Accrual balance

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

Cost Share concepts in action

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

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works.

Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

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

Deductible: **$500**

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

Out-of-Pocket Maximum: **$1,000**

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

Participating Provider Copayment: **$30**

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

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

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

	Participating Provider	***Non-Participating Provider***
You pay	**$30** ($30 Copayment)	**$80** ($40 Copayment plus $40 for charges over Allowable Amount)
Blue Shield pays	$70 (Allowable Amount minus your Cost Share)	$60 (Allowable Amount minus your Cost Share)
Total payment to the doctor	$100 (Allowable Amount)	$140 (Billed charge)

In this example, because you have already met your Deductible, you are responsible for the Participating Provider Copayment.

Claims for Emergency or Urgent Services

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

Claim forms are available at blueshieldca.com.

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

Claim processing and payments

Blue Shield or the Benefit Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information.

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

If a claim is unpaid at the time of a Member's death or if the Member is not legally capable of accepting it, payment will be made to the Member's estate or any relative or person who may legally accept on the Member's behalf.

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

Your coverage

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

Eligibility for this plan

To be eligible for coverage as a Subscriber, you must meet all of the County's eligibility requirements established by the County.

Coverage is Non-transferable

No person other than a properly enrolled Member is entitled to receive Benefits under this plan and it is non-transferable to any other person or entity.

Dependent eligibility

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

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

Enrollment and effective dates of coverage

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

If you are an Employee that meets County eligibility rules and reside in the Plan Service Area, you are eligible for coverage as a Subscriber on the first day of the pay period following the pay period in which the Employee worked the required number of hours. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan are not available before the effective date of coverage. This Contract has a 12-month term that begins on the County's effective date of coverage.

Open enrollment period

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

Special enrollment period

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

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

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

For a complete list of Qualifying Events, see ***Special enrollment period*** on page 74 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special

enrollment period. Generally, if the Employee or Dependents qualify for a special enrollment period, coverage will begin no later than the first day of the first calendar month following the date Blue Shield receives the request for special enrollment from the County.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

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

For coverage to continue beyond 31 days for a newborn, adopted child, or child placed for adoption, the Subscriber must ***notify the County within 90 days*** of birth, adoption, or placement for adoption and request that the child be added as a Dependent.

If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, they are not eligible to be Dependents of each other. You may enroll a child as a Dependent of either parent but not both.

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

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

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

Plan changes

Subject to notification and according to the terms of the Group Health Service Contract, the County has the right to amend, terminate or to replace this plan with another plan with different terms. This may include, but is not limited to, changes or termination of specific Benefits, exclusions and eligibility provisions.

No agent or employee of Blue Shield is authorized to change the form or content of this Plan. Any changes made will only become effective through an endorsed amendment valid only when reduced to writing, reviewed and recommended by the County's Employee Benefits and Advisory Committee (EBAC), executed and attached to the

original Agreement and approved by the person(s) authorized to do so on behalf of Blue Shield and the County.

No change in Shield Signature Benefits nor waiver of any of its provisions shall be valid without the approval of Blue Shield.

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

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

Blue Shield will give the County written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. The County is responsible for letting you know of any changes. Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

Coordination of benefits

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

When coverage ends

Your coverage will end if:

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

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

If the County cancels coverage

The County may cancel coverage at any time. To cancel coverage, the County must provide written notice to Blue Shield and its Employees.

If the Subscriber cancels coverage

If the Subscriber decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by the County.

Reinstatement

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

If Blue Shield cancels coverage

Blue Shield can cancel coverage if:

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

Blue Shield will provide 30 days' advance written notice of cancellation of coverage to the County if the County fails to meet Blue Shield's eligibility, participation, and contribution requirements. It is the County's responsibility to provide a copy of the notice to its Employees.

Cancellation for County's nonpayment of Premiums

Blue Shield can cancel coverage if the County does not pay the required Premiums in full and on time. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send a notice of intent to terminate for nonpayment of Premiums 30 days before the date coverage ends. The County is responsible for all Premiums during the term of coverage, including the 60-day grace period and 30-day notice of intent period.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

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

Extension of Benefits

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

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

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

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

Continuation of group coverage

Please examine your options carefully before declining this coverage.

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

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

COBRA

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

Cal-COBRA

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

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

Cal-COBRA qualifying event

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

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

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

Notification of a qualifying event

You are responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a Dependent's loss of Dependent status under this plan. This notice must be given within 60 days of the date of the qualifying event. Failure to provide such notice within 60 days will disqualify you from receiving continuation coverage under Cal-COBRA.

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

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

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

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

Duration and extension of group continuation coverage

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

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

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

In no event will continuation of group coverage under COBRA, Cal-COBRA, or a combination of COBRA and Cal-COBRA be extended for more than 36 months

from the date of the qualifying event that originally entitled you to continue your group coverage under this plan.

Payment of Premiums

Premiums for continuing coverage will be 110 percent of the applicable group Premium rate, except if you are eligible to continue Cal-COBRA coverage beyond 18 months because of a Social Security disability determination. In that case, the Premiums for months 19 through 36 will be 150 percent of the applicable group Premium rate.

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

Effective date of the continuation of group coverage

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

Termination of group continuation coverage

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

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

Continuation of group coverage while on leave

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

Family leave

The California Family Rights Act of 1991 and the federal Family & Medical Leave Act of 1993 allow you to continue your coverage under this plan while you are

on family leave. The County is solely responsible for notifying their Employee of the availability and duration of family leaves.

Military leave

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

Shield Signature Level I Benefits

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

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

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the Medical Management Programs; and
- The terms, conditions, limitations, and exclusions of this Evidence of Coverage.

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

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

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

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

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

This Benefit does not include:

- Blood testing for allergies.

Ambulance services and Emergency Medical Services programs

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

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and
- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

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

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

Bariatric surgery Benefits

(Benefits are provided only under Shield Signature Level I)

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

Services for residents of designated California counties

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

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

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

(Benefits are provided only under Shield Signature Level I)

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition.

A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

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

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

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

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

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

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

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately-licensed Health Care Provider who is certified as a diabetes educator.

Devices, equipment, and supplies

(Benefits are provided only under Shield Signature Level I)

Covered diabetic devices, equipment, and supplies include:

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

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

Self-management training and medical nutrition therapy

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

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

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

Benefits include:

- Basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography;
- Advanced diagnostic radiological and nuclear imaging, including CT, PET, MRI, and MRA scans;
- COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing;
- Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month, subject to a maximum reimbursement of $12 per test. See the *Claims* section for information about how to submit a claim for repayment for this Benefit;

- 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;
- Clinical pathology services;
- Laboratory services;
- Other areas of non-invasive diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, cardiovascular, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

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

For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services.

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

Dialysis Benefits

(Benefits are provided only under Shield Signature Level I)

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

Benefits include:

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

Benefits do not include:

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

Durable medical equipment

(Benefits are provided only under Shield Signature Level I)

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

Benefits include:

- Mobility devices, such as wheelchairs;

- Peak flow meter for the self-management of asthma;
- Glucose monitor including continuous blood glucose monitor, and all related necessary supplies for the self-management of diabetes;
- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;
- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price;
- Pasteurized donor human milk; and
- Breast pumps.

Benefits do not include:

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

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

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

Orthotic equipment and devices

(Benefits are provided only under Shield Signature Level I)

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

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for postoperative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing

abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

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

Prosthetic equipment and devices

(Benefits are provided only under Shield Signature Level I)

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

Benefits include:

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

Benefits do not include:

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

Emergency Benefits

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

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

Benefits include:

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

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 reference *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.

Continuing or follow-up treatment

(Benefits are provided only under Shield Signature Level I)

If you receive Emergency Services from a Hospital which is a non-Shield Signature Hospital, follow-up care must be authorized by Blue Shield or it may not be covered. Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

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

If, once your Emergency Medical Condition is stabilized, and your treating health care provider at the non-Shield Signature Hospital believes that you require additional Medically Necessary Hospital Services, the non-Shield Signature Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital Services by the non-Shield Signature Hospital. If Blue Shield determines that you may be safely transferred to a Hospital that is contracted with Blue Shield and your refuse to consent to the transfer, the non-Shield Signature Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided following stabilization of the Emergency Medical Condition. Also, if the non-Shield Signature Hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Shield Signature Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-

Shield Signature Hospital, you should contact Blue Shield at the telephone number on your identification card. Blue Shield will provide Benefits for care in a Hospital only for as long as your medical condition prevents transfer to a Shield Signature Hospital in the your Medical Group Service Area, as approved by the Medical Group or by Blue Shield. Unauthorized continuing or follow-up care after the initial emergency has been treated in a Hospital, or by a provider, is not a Covered Service under the Shield Signature plan.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or unborn child, stabilize means delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

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

Eye Examination Benefits

Your Plan also provides coverage for a diagnostic eye examination Benefit described in this section.

Note: An annual self-referred eye examination will not be covered under this Plan if the County provides Benefits for vision care through the Blue Shield Vision Plan. Please refer to your Blue Shield Vision Plan for specific information about covered eye examinations.

The Plan provides payment for the following service:

One comprehensive eye examination in a consecutive 12-month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive service constitutes a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields, and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, a determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

Note: Visits involving actual or suspected pathology or injury may be covered under the medical Benefits of your health Plan.

Reimbursement Provision

Prior to service, you should consult your Benefit information for coverage details. You can locate a Participating Provider by calling the contracted Vision Plan Administrator (VPA) Customer Service at 1-877-601-9083, or online at http://www.blueshieldca.com. You should make an appointment with the Participating Provider identifying yourself as a Blue Shield Vision Member. The

Participating Provider will submit a claim for covered Services online or by claim form obtained by the provider from the contracted VPA.

Participating Providers will accept payment by the Plan for covered Services as payment in full, minus your Copayment as shown on the Summary of Benefits. Please determine whether your ophthalmologist or optometrist is a Participating Provider by calling the contracted VPA.

When Services are provided by a non-Participating Provider, you must submit a Vision Service Report Form (claim form C-4669-61) which can be obtained from the Blue Shield web site located at: http://www.blueshieldca.com. This form must be completed in full and submitted with all related receipts to:

Blue Shield
Vision Plan Administrator
P.O. Box 25208
Santa Ana, California 92799-5208.

Information regarding Member non-Participating Provider Benefits can be found by consulting your Benefit information or by calling Blue Shield/VPA Customer Service at: 1-877-601-9083. Payments will be made through the contracted VPA by means of a Blue Shield check.

Payments for Services of a non-Participating Provider will be made directly to you. Any difference between the allowance and the provider's charge, minus your Copayment as shown on the Summary of Benefits, is your responsibility.

All claims for reimbursements must be submitted to the contracted VPA within 1 year after the month of service.

This Benefit is administered by the contracted VPA for Blue Shield of California. If you have questions about this Benefit, call toll-free 1-877-601-9083 (or) 1-714-619-4660.

Limitations and Exclusions

This vision Benefit does not cover corrective lenses, frames for eye glasses, contact lenses or the fitting of contact lenses; eye exercises; any other routine eye refractions; subnormal vision aids; vision training; any eye examination required by the County as a condition of employment; medical or surgical treatment of the eyes; Services performed by a close relative or by a person who ordinarily resides in your home; Services incident to any injury 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, or similar legislation. However, if Blue Shield provides payment for such Services, it shall be entitled to establish a lien for such other Benefits up to the amount paid by Blue Shield for treatment of the injury or disease; Services required by any government agency or program, federal, state or subdivision thereof; or Services for which no charge is made.

Family planning and Infertility Benefits

(Benefits are provided only under Shield Signature Level I)

Family planning

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

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling;
- 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;
- Voluntary tubal ligation and other similar sterilization procedures; and
- Vasectomy services and procedures.

Benefits do not include family planning services from Non-Participating Providers.

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

Infertility Benefits

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

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Services that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, standard fertility preservation services are a Covered Service and do not fall under the scope of Infertility Benefits described in the *Family Planning and Infertility Benefits* section.

Home health services

(Benefits are provided only under Shield Signature Level I)

Benefits are available for home health services authorized through your Primary Care Physician. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

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

Benefits include:

- Intermittent home care for skilled services from:
    - Registered nurses;
    - Licensed vocational nurses;
    - Physical therapists;
    - Occupational therapists;

    - Speech and language pathologists;
    - Licensed clinical social workers; and
    - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

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

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).

For this Benefit, coverage includes:

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

Benefits do not include:

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

Home infusion and injectable medication services

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

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Administration of parenteral nutrition formulations and solutions;
- Administration of enteral nutrition formulas and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

See the *PKU formulas and special food products* section for more information.

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

This Benefit does not include:

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

Hemophilia home infusion services

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

Benefits include:

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

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

Benefits do not include:

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

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

Hospice program services

(Benefits are provided only under Shield Signature Level I)

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

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

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

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must

be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

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

Benefits do not include:

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

Hospital services

(Benefits are provided only under Shield Signature Level I)

(Other than bariatric surgery services which are described under the *Bariatric surgery Benefits* section.)

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
  - Semiprivate Hospital room, or private room if Medically Necessary;
  - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
  - General and specialized nursing care; and
  - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:

- Operating, recovery, labor and delivery, and other specialized treatment rooms;
- Anesthesia, oxygen, medicines, and IV solutions;
- Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
- Dialysis services and supplies;
- Blood and blood products;
- Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
- Radiation therapy, chemotherapy, and associated supplies;
- Therapy services, including physical, occupational, respiratory, and speech therapy;
- Acute detoxification;
- Acute inpatient rehabilitative services; and
- Emergency room services resulting in admission.

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

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

Benefits include:

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

Benefits do not include:

- 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 dental services such as cleanings, space maintainers, and habit control devices except as covered under the Preventive Health Services Benefit;
- Periodontal care such as hard and soft tissue biopsies and routine oral surgery including removal of teeth;
- Reconstructive or restorative dental services such as crowns, fillings, and root canals;

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

Shield Signature Level I (HMO) Mental Health and Substance Use Disorder Benefits

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

Mental Health and 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.

The MHSA Participating Provider must get prior authorization from the MHSA for all non-emergency Hospital admissions for Mental Health and Substance Use Disorder services, and for certain outpatient Mental Health and Substance Use Disorder services. See the *Medical Management Programs* section for more information about prior authorization.

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

If you are unable to schedule an appointment with a Participating Provider for Mental Health and Substance Use Disorder services, contact Mental Health Customer Service. The MHSA will help you either schedule an appointment with a Participating Provider, or select a Non-Participating Provider in your area within five calendar days and contact you regarding available appointment times. For any Covered Services, you will be responsible for no more than the Cost Share for seeing a Non-Participating Provider. The MHSA may work with you to transition to a Participating Provider when one becomes available.

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

Office visits

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

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

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health and Substance Use Disorders.

For Behavioral Health Crisis Services rendered by a Non-Participating Provider, you will pay the same Cost Share for Covered Services received from a Participating 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.

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

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

Benefits do not include:

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

Inpatient Services

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

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

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

Physician and other professional services

(Other than Bariatric Surgery Benefits and Mental Health Benefits which are described elsewhere in this booklet's Benefits section.)

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

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications that must be administered by a Health Care Provider;
- Administration of radiopharmaceutical medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person; and
- Teladoc general medical consultations.

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

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for conditions other than diabetes. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to receive medical nutrition therapy as long as your

treatment is Medically Necessary. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

(Benefits are provided only under Shield Signature Level I)

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

Benefits include:

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

Benefits do not include:

- Grocery store foods including shakes, snack bars, used by the general population;
- Additives such as thickeners, enzyme products; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

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

Pregnancy and maternity care

(Benefits are provided only under Shield Signature Level I)

Benefits are available for maternity care services.

Benefits include:

- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;
- Elective newborn circumcision within 18 months of birth; and
- Abortion and abortion-related services, including preabortion and followup services.

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

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your

Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage. Blue Shield only covers Preventive Health Services when you receive them from a Participating Provider.

Benefits include:

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

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

California has declared a public health emergency, a new recommendation will be covered within 15 business days.

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

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

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

Benefits do not include:

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

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

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

Rehabilitative and habilitative services

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

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

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

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

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

Physical therapy

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

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider.

Occupational therapy

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

Speech therapy

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

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

Skilled Nursing Facility (SNF) services

(Benefits are provided only under Shield Signature Level I)

Subject to all of the inpatient Hospital services provisions, Medically Necessary Skilled Nursing services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. Note: For information concerning Hospice Program Benefits see Shield Signature Level I Hospice Program Benefits in this booklet's Benefits section.

Transplant services

(Benefits are provided only under Shield Signature Level I)

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

Tissue and kidney transplants

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

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

Special transplants

Benefits are available for special transplants only if:

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

Special transplants are:

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

Donor services

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

Donor services include:

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

Urgent Service Benefits

To receive urgent care within your Medical Group Service Area, call your Primary Care Physician's office or follow instructions given by your assigned Medical Group in accordance with the *How to access care* section.

When outside the Medical Group Service Area, you may receive care for Urgent Services as follows:

Inside California

For Urgent Services within California but outside your Medical Group Service Area, if possible, you should contact Blue Shield Member Services at the number provided on the bottom of each page of this booklet in accordance with the *How to access care* section. Member Services will assist you in receiving Urgent Services through a Blue Shield of California Participating Provider. You may also locate a Participating Provider by visiting Blue Shield's internet site at blueshieldca.com. You are not required to use a Blue Shield of California Participating 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. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Outside California or the United States

When temporarily traveling outside California, you should call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. If Urgent Services are not available through a BlueCard Program participating provider, and you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. See Claims for Emergency and Out-of-Area Urgent Services in the *How to access care* section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

For Shield Signature Level I services, up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. When a BlueCard Program participating provider is available, you should obtain out of area Urgent or follow-up Services from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. (See preceding paragraph for what to do if a participating provider is not available.) Authorization by Blue Shield is required for more than two follow-up outpatient visits. To receive Shield Signature Level I services, Blue Shield may direct the member to receive the additional follow-up care from the Primary Care Physician.

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the Blue Cross Blue Shield Global™ (BCBS Global™) Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient hospital care, contact the BCBS Global™ Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in

the *Your payment information* section. See *BlueCard Program* in the *Out-of-area services* section for additional information.

Before traveling abroad, you may call your local Member Services office for the most current listing of providers and to obtain a copy of the Blue Cross Blue Shield Global™ Network brochure that provides helpful information on receiving Covered Services in a foreign country, or you can visit Blue Shield's internet site at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide". However, you are not required to receive Urgent Services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

Exclusions and limitations

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

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

General exclusions and limitations	
	provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
8	Unless selected as an optional Benefit by the County, hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.
9	Orthoptics or vision training except when Medically Necessary, eye exams and refractions (except as specifically provided under *Eye Examination Benefit*), lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
10	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section.
11	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections.
12	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.
13	Unless selected as an optional Benefit by the County, any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.
14	Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits,

General exclusions and limitations	
	or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
15	Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program.
16	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.
17	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
18	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.
19	Select physical and occupational therapies, such as: • Massage therapy, unless it is performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider. Massage is considered not Medically Necessary when performed as the solitary treatment or prescribed to an individual who presents with no complications; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
20	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.
21	Services or Drugs that are Experimental or Investigational in nature.

General exclusions and limitations	
22	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.
23	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
24	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, and food delivery services.
25	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.
26	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.
27	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
28	Drugs dispensed by a Physician or Physician's office for outpatient use.
29	Hospital care programs or services provided in a home setting (Hospital-at-home programs).

These limitations, exceptions, exclusions and reductions apply specifically to Shield Signature Level II coverage	
1	All services provided by a Shield Signature Non-Preferred or Non-Participating Provider except for Covered Urgent Care and Emergency Care
2	All hospitalization and skilled nursing services
3	Inpatient and home visits physician services.
4	All services performed in an Ambulatory Surgery Center
5	Bariatric surgery
6	Clinical Trials for Cancer Benefits
7	Diabetic care devices, equipment and supplies
8	Dialysis center services
9	Durable Medical Equipment
10	Family planning and Infertility services
11	Home health services
12	Home infusion/home injectable therapy Benefits
13	Hospice care
14	Laboratory, X-ray and diagnostic services performed outside of a Physician's and Specialist's office
15	Maternity care and delivery services
16	Inpatient, Partial Hospitalization, Psychological Testing, Intensive Outpatient Care and Outpatient ECT services, and Psychosocial Support through LifeReferrals 24/7 Mental Health services
17	Orthotics
18	Outpatient Hospital services including chemotherapy and renal dialysis
19	PKU related formulas and Special Food Products

These limitations, exceptions, exclusions and reductions apply specifically to Shield Signature Level II coverage	
20	Prosthetic appliances
21	Rehabilitative Services provided under home health care, Hospital, inpatient unit of a Hospital and a Skilled Nursing Facility
22	Speech Therapy Services provided under home health Care, Hospital, inpatient unit of a Hospital and a Skilled Nursing Facility
23	Transplant Benefits – cornea, kidney or skin
24	Transplants – special
25	MBL, MUGA, PET and SPECT diagnostic services

Grievance process

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

Submitting a grievance

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

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

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

Where to mail grievances

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

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

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

If the County selected the optional Prescription Drug Benefits Rider, and Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may request an external exception request review. Blue Shield will ensure a decision within 72 hours.

Expedited grievance request

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

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

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

California Department of Managed Health Care review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-599-2657** 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 **(www.dmhc.ca.gov)** has complaint forms, IMR application forms, and instructions online.

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

Independent medical review

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

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

You can apply to the Department of Managed Health Care (DMHC) for an independent medical review of the denial. For a Medical Necessity denial, you must first submit a grievance to Blue Shield and wait for at least 30 days before requesting an independent medical review. However, if the request qualifies for an expedited review as described above, or if it involves a determination that the requested service is Experimental or Investigational, you may request an independent medical review as soon as you receive a notice of denial from Blue Shield. The DMHC's application for independent medical review is included with your appeal outcome letter.

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

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

ERISA review

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

Other important information about your plan

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

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 36 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when an eligible Subscriber or Dependent can enroll in, or change enrollment in, a health plan. The special enrollment period is 30 days following the date of a Qualifying Event except as otherwise specified below. The following are examples of Qualifying Events. For complete details and a determination of eligibility for special enrollment, please consult the County.

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

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

Cancellation for County's nonpayment of Premiums

Premium grace period

After payment of the first Premium, the County has a 60-day grace period from the due date to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. The County shall also be afforded a 30-day notice of intent to terminate. Coverage will continue through the grace period and notice of intent. However, if the County does not pay all outstanding Premiums within the grace period, coverage will end the day following the 60-day grace period. The County will be liable for all Premiums owed, even if coverage is canceled (subject to the terms of the Letter of Agreement, Group Health Service Contract and any/all attachments and amendments). This includes Premiums for coverage during the 60-day grace period and 30-day notice of intent period. Blue Shield will send a Notice of End of Coverage to you and the County no later than five calendar days after the day coverage ends.

Out-of-area services

Overview

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

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee

in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. Blue Shield's payment practices for both kinds of providers are described below and in the *Introduction* section of this Evidence of Coverage.

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

Inter-Plan Arrangements

Shield Signature Level I Emergency Services and Urgent Services while Traveling

Members who experience an Emergency Medical Condition or need Urgent Services 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.

Urgent Services while in your Medical Group Service Area

If you require urgent care for a condition that could reasonably be treated in your Primary Care 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 may go directly to an urgent care clinic in your Medical Group Service Area.

Within California

If you are temporarily traveling within California, but are outside of your Medical Group Service Area, if possible you should call Blue Shield Member Services the telephone number listed on your identification card for assistance in receiving Urgent Services through a Blue Shield of California Provider. You may also locate a Blue Shield Provider by visiting our web site at http://www.blueshieldca.com. However, you are not required to use a Blue Shield of California Participating Provider to receive Urgent Services; you may use any provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Benefits will be determined in accordance with the requirements of Shield Signature coverage, subject to the applicable Copayments.

Follow-up care is also covered through a Blue Shield of California Participating Provider and may also be received from any provider. However, when outside your Medical Group Service Area 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 the Primary Care Physician.

If services are not received from a Blue Shield of California Participating 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 Medical Group Service Area within California will be reviewed retrospectively for coverage.

Outside of California

Shield Signature provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described herein, which 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. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Shield Signature Level I: follow-up services

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

When a BlueCard® Program provider is available, Shield Signature Level I services should be obtained from a Participating Provider, when possible.

BlueCard® Program

Under the BlueCard® Program, benefits will be provided for Out-of-Area Covered Health Care Services received from a participating provider outside of California, but within the BlueCard® Service Area. When you receive Covered Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

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

- The billed charges for your Out-of-Area Covered Health Care Services; or
- The negotiated price that the Host Blue makes available to Blue Shield.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive

payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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 Evidence of Coverage.

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

Blue Shield Global® Core

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

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

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

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

Submitting a Blue Shield Global® Core claim

When you pay directly for services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the

claim form will help ensure timely processing of your claim. The claim form is available from Blue Shield Member Services, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Blue Shield Value-Based Programs

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

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

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

Limitation for duplicate coverage

Medicare

Blue Shield will provide Benefits before Medicare when:

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

Blue Shield will provide Benefits after Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws);

- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

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

Medi-Cal

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

Qualified veterans

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

Coverage by another government agency

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

Exception for other coverage

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

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

Reductions – third-party liability

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

from another source, and if Blue Shield paid Benefits for that injury, you must agree to the following provisions.

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

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

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

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

Ensure that any recovery is kept separate from and not comingled with any other funds or your general assets;

- Agree in writing that the portion of any recovery required to satisfy the lien or other right of recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield; and

- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

Coordination of benefits, continued

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

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

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

General provisions

Independent contractors

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

Assignment

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

Plan interpretation

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

Public policy participation procedure

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

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

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

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

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

At least one third of the Board of Directors is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not

have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from the Sr. Manager, Regulatory Filings as listed above.

Access to information

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

Right of recovery

Whenever payment on a claim is made in error, Blue Shield has the right to recover such payment from the Subscriber or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber's coverage, or payments made on fraudulent claims.

Definitions

Adverse Childhood Experiences	An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.
Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Allowable Amount	The maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Evidence of Coverage, the Allowable Amount is: • For a Participating Provider: the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service rendered. • For a Non-Participating Provider who provides Emergency Services: o Physicians and Hospitals: the amount is the Reasonable and Customary amount; or o All other providers: (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under state and federal laws. • For a Non-Participating Provider in California, who provides services other than Emergency Services: o The amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area but not exceeding any stated Benefit maximum; • For a provider outside of California but inside the BlueCard® Service Area, the lower of: o The provider's billed charge, or o The local Blue Plan's Participating Provider payment or the pricing arrangement required by applicable state law.

	• For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core. • For a Non-Participating Provider outside of California (within the BlueCard® Service Area) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services other than Emergency Services: the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a Non-Participating Provider performing the same services. Or, if the local Blue Cross and/or Blue Shield plan has no Non-Participating Provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California. Or, if applicable, the amount determined under federal law. • For Blue Shield's contracted Benefit Administrators (MHSA, DPA, VPA), the Allowable Amount is based on the administrator's contracted rate for its participating providers. Where required under federal law, the Allowable Amount used to determine your Cost Share may be based on the plan's "qualifying payment amount," which may differ from the amount Blue Shield pays the Non-Participating Provider or facility for Covered Services.
Allowed Charges	The amount an HMO Participating Provider agrees to accept as payment from Blue Shield or the billed amount for non-HMO Participating Providers (except Physicians rendering Emergency Services, hospitals which are not Participating Providers rendering any services, and non-contracting dialysis centers rendering any services when authorized by Blue Shield will be paid based on the Reasonable & Customary Charge as defined).
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
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 (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Benefit Administrator	Administrator for specialized Benefits such as Mental Health and Substance Use Disorder Benefits.
Blue Shield of California	California Physicians' Service, d/b/a Blue Shield of California, is a California not-for-profit corporation, licensed as a health care service plan. It is referred to throughout this Evidence of Coverage as Blue Shield.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.

County	Shortened name for the San Bernadino County.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Deductible	The Calendar Year amount you must pay for specific Covered Services that are a Benefit of the Shield Signature plan before you become entitled to receive any Benefit payments from Blue Shield for those Covered Services.
Dependent	The spouse, Domestic Partner, or child of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber. • A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber. • A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Evidence of Coverage. A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
Domestic Partner	An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements: • Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code; • The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring; • The partners are: o not currently married to someone else or a member of another domestic partnership, and o not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; • Both partners are capable of consenting to the domestic partnership; and • The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some

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

	• Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.
Employee	An individual who meets the eligibility requirements set forth in the Contract between Blue Shield and the County.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies shall be considered experimental or investigational if, as determined by Blue Shield, at least one of the following elements is met: • Requires approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered; or • Is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use; or • Is not approved or recognized in accordance with accepted professional medical standards, but nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or • Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable, or where the consensus amongst experts in recognized published medical literature is that further studies or experience are necessary to determine effectiveness and net health benefit in treatment of the illness, injury, or condition at issue, but nevertheless are authorized by law or by a government agency for use.
Family	The Subscriber and all enrolled Dependents.

Former Participating Provider	A Former Participating Provider is a provider of services to the Member under any of the following conditions:
	• A provider who is no longer available to you as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
	• A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
	• A provider who is a Participating Provider with Blue Shield or the MHSA but no longer available to you as a Participating Provider or an MHSA Participating Provider because:
	  ○ The Employer has terminated its contract with Blue Shield; and
	  ○ The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider or the MHSA Participating Provider in its network; and
	At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care	Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include: • Peer-reviewed scientific studies and medical literature; • Clinical practice guidelines and recommendations of nonprofit health care provider professional associations; • Specialty societies and federal government agencies; and • Drug labeling approved by the United States Food and Drug Administration.

Group Health Service Contract (Contract)	The contract for health coverage binding both Blue Shield and the County (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.
Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law; • Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • Registered respiratory therapist; • Speech and language pathologist.

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

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

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

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

Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.
Participating Hospice or Participating Hospice Agency	An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits.
Participating (Participating Provider)	A provider who participates in this plan's network and contracts with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan Service Area	A geographical area designated by the plan within which a plan shall provide health care services.
Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician.
Provider Incentive	An additional amount of compensation paid to a Health Care Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
Psychological Testing	Testing to diagnose a mental health condition when referred by an MHSA Participating Provider.
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
Reasonable and Customary	In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider.

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

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

Notices about your plan

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

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

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

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

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

Notice about Mental Health and 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.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your plan and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or contact Member Services to ensure that you can obtain the health care services you need.

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

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 Physician, unless you object.

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

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

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

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

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

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

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

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

Notice about confidentiality of personal and health information: Blue Shield protects the privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. Blue Shield will not disclose this information without authorization, except as permitted or required by 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 "Notice of Privacy Practices" can be obtained either by calling Member Services or by visiting blueshieldca.com.

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

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

Non-Discrimination: It is Blue Shield of California's policy to treat all individuals in the spirit of and in full compliance with equal opportunity requirements without regard to race, color, religion, sex, national origin, age, ancestry, physical or mental disability, political belief or activity, medical condition, sexual orientation, gender identity, marital status, veteran status, and any other basis protected by applicable law. Our policy prohibits individuals, who are otherwise eligible for health coverage under this Group Agreement, from having coverage refused or cancelled based solely on any of the above statuses or conditions.

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

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

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

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

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

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

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

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

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

Fax: 1-800-201-9020

blue of california

Outpatient Prescription Drug Rider

San Bernardino County – Actives
Effective July 26, 2025
Shield Signature Rx Plan

Custom Summary of Benefits

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

Calendar Year Brand Drug Deductible (CYD)[1]

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

		When using a Participating[2] or Non-Participating[3] Pharmacy
Calendar Year Brand Drug Deductible	*Per Member*	$0

Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	**CYD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Formulary Generic Drugs (Level 1)	$5/prescription		Not covered	
Formulary Brand Drugs (Level 2)	$10/prescription		Not covered	
Non-Formulary Brand Drugs (Level 3)	$25/prescription		Not covered	
Lancets	$0		Not Covered	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Formulary Generic Drugs (Level 1)	$10/prescription		Not covered	
Formulary Brand Drugs (Level 2)	$20/prescription		Not covered	
Non-Formulary Brand Drugs (Level 3)	$50/prescription		Not covered	
Lancets	$0		Not Covered	
Network Specialty Pharmacy Drugs	$10/prescription		Not covered	
Per prescription, up to a 30-day supply.				
Specialty Drugs are covered only when dispensed by a Network Specialty Pharmacy. Specialty Drugs from Non-Participating Pharmacies are not covered except in emergency situations.				

Notes

Notes

1 Calendar Year Brand Drug Deductible (CYD):

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

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

Any applicable Copayment, Coinsurance and CYD you pay does not count towards the Calendar Year Out-of-Pocket Maximum. *Outpatient prescription Drugs not subject to the Calendar Year Brand Drug Deductible.* Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Brand Drug Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

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

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting https://www.blueshieldca.com/wellness/drugs/formulary#heading2.

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

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

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

5 Outpatient Prescription Drug Coverage:

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

Notes

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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

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

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

Benefit designs may be modified to ensure compliance with State and Federal requirements.
Pb040125_GF

Prescription Drug Benefits

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

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

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

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

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 Customer Service.

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 Participating 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

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

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

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

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

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

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

Obtaining outpatient prescription Drugs at a Participating Pharmacy

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

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

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

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 Specialty Drugs will be covered at the Specialty Drug Copayment or Coinsurance. For all other Drugs that are approved as an exception, the Non-Formulary Brand Drug Copayment or Coinsurance 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 you, your Physician, or your Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you must pay the difference in cost, plus the applicable tier Copayment or Coinsurance of the Brand Drug. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent or Biosimilar Drug, plus the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance of the Brand Drug. For example, you select Brand Drug A when there is an equivalent Generic Drug A or Biosimilar Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300, and the contracted rate for Generic Drug A or Biosimilar Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance of the Brand Drug. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility.

If you, your Physician, or your Health Care Provider believes the Brand Drug is Medically Necessary, you can request an exception to the difference in cost between the Brand Drug and Generic Drug equivalent or Biosimilar Drug through the Blue Shield prior authorization process. The request will be reviewed for Medical Necessity. If the request is approved, you pay only the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

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

Obtaining outpatient prescription Drugs at a Non-Participating Pharmacy

When you receive Drugs from a Non-Participating Pharmacy, you must pay for the prescription in full and then submit a claim for reimbursement to:

Blue Shield of California
1606 Ave. Ponce de Leon
San Juan, PR 00909-4830

Blue Shield will reimburse you as shown on the Summary of Benefits, based on the price you paid for the Drugs.

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

Obtaining outpatient prescription Drugs from the mail service pharmacy

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

You must pay the applicable Copayment or Coinsurance listed in the *Summary of Benefits* for each prescription Drug.

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

Obtaining Specialty Drugs from a Network Specialty Pharmacy

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

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

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

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

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

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

Prior authorization/exception request/step therapy process

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

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.

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

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

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield. You can submit an exception request by calling Customer Service. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. 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 your Physician or Health Care Provider believes that step therapy coverage requirements for a prescription need not be met and that the Drug is Medically Necessary, the step therapy exception process must be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

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

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

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

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

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

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

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

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

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

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

You may refill covered prescriptions at a Medically Necessary frequency.

Exclusions and limitations

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

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

Outpatient prescription Drug exclusions and limitations

11	Compounded medications unless all of the following requirements are met: • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially available, medically appropriate alternatives; and • The compounded medication is self-administered.
12	Replacement of lost, stolen or destroyed Drugs.
13	If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice program services* section of your Evidence of Coverage.
14	Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to antibiotics prescribed to treat infection, Drugs prescribed to treat pain, or Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
15	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list.
16	Immunizations and vaccinations solely for the purpose of travel.
17	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
18	Prescription Drugs that are repackaged by an entity other than the original manufacturer.
19	A manufacturer's product may be excluded when the same or similar Drug (one with the same active ingredient or same therapeutic effect) is available under this Prescription Drug Benefit. Any dosage or formulation of a Drug may be excluded when the same Drug is available under the *Prescription Drug Benefit* in a different dosage or formulation.

Definitions

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

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

Formulary	A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are

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

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

Assisted Reproductive Technology Rider

Group Rider
HMO/POS/PPO/EPO

Additional Assisted Reproductive Technology Benefits Rider 95% Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this assisted reproductive technology Benefit.

Benefits	Your Payment	
	When using a Level I Provider	**When using a Non-Participating Provider**
Assisted reproductive technology (ART) procedures and associated services	5% of the allowable amount	Not covered

Services are not subject to the Calendar Year Medical Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.

Assisted Reproductive Technology (ART) Procedures and Associated Services	Lifetime Benefit Maximums
Natural artificial inseminations *Without ovum [oocyte or ovarian tissue (egg)] stimulation*	6/lifetime
Stimulated artificial inseminations *With ovum [oocyte or ovarian tissue] stimulation*	3/lifetime
Gamete intrafallopian transfer (GIFT)	2/lifetime
Zygote intrafallopian transfer (ZIFT)	3/lifetime
In-vitro fertilization (IVF)	3/lifetime
Intracytoplasmic sperm injection (ICSI)	3/lifetime
Cryopreservation of embryos, oocytes, ovarian tissue, sperm *Retrieved from a Member. Includes one retrieval and three years of storage per person*	1/lifetime

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

Introduction

Only the Member is entitled to Benefits under this assisted reproductive technology Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician to a Member for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Benefits

Benefits are provided for a Member who meets the definition of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Member is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered by the provider to induce fertilization. If the County selected the Outpatient Prescription Drug Rider as an optional Benefit, self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

Benefits are only provided for services received from Level I Providers.

The Calendar Year Medical Deductible does not apply to these Covered Services, and Cost Share for these Covered Services does not apply towards the Out-of-Pocket Maximum responsibility.

Exclusions

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Outpatient Prescription Drugs prescribed for self-administration, if the County did not select the Outpatient Prescription Drug Rider;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Member had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; or

- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Member who has diagnosed Infertility as defined at the time services are provided.

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

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

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

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

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

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

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

Language access services

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

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

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

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

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

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

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

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

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

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

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 សូមហៅទូរស័ព្ទស្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/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 ໂທຫາບໍລິໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີບໍລິໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໂປຫາບໍ(866) 346-7198. (Laotian)

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