Blue Shield Disclosure Form: HMO Plans

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

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

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

To obtain a copy of the EOC or if you have questions about the benefits of the plan, please contact Blue Shield's Customer Service Department at 1-800-424-6521. The hearing impaired may contact Member Services by calling the TTY number 1-800-241-1823.

Please Note

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

Choice of Physicians and Providers

Please read the following information so you will know from whom or what group of providers health care may be obtained.

An HMO offers Members a choice of providers within a contracted network of Physicians, Hospitals, and Non-Physician Health Care Practitioners. Each Member will select a Personal Physician from the Blue Shield HMO Plan Directory of general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians. Members within the same family may select a different Personal Physician.

All Covered Services must be provided by or arranged through the Member’s Personal Physician, except for the following:

1. Services received during an Access+ Specialist visit,
2. OB/GYN Services provided by an obstetrician/gynecologist or a family practice Physician within the same Medical Group/IPA as the Personal Physician,
3. Emergency Services,
4. Urgent Services outside the Personal Physician’s Service Area,
5. Mental health and substance abuse services.*
* Mental health and substance abuse services must be arranged and provided through the Mental Health Services Administrator (MHSA). See the Mental Health and Substance Abuse Services paragraphs later in this section.

The Member’s Personal Physician will manage obtaining prior authorization for services, when needed. A decision will be made on requests for prior authorization of services as follows:

For Urgent Services, as soon as possible to accommodate the Member’s condition not to exceed 72 hours from receipt of the request;

For other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.

Full HMO Plans

The Full HMO Plans offer Members with the largest selection of Independent Practice Associations (IPAs) and Medical Groups in the Full HMO Plan Service Area. Members select a Personal Physician from the Full HMO Plan Physician and Hospital Directory.

Exclusive HMO Plans

The Exclusive HMO Plans offer a select network of Independent Practice Associations (IPAs) and Medical Groups in the Narrow HMO Plan Service Area. This provides a more affordable plan option while still meeting access and availability requirements. Members select a Personal Physician from the Exclusive HMO Plan Physician and Hospital Directory.

Members have to live and/or work in the Exclusive HMO Plan Service Area in order to enroll in an Exclusive HMO Plan.

HMO Plans with ACO Network

An Accountable Care Organization (ACO) serves as the provider network for an HMO Plan with an Accountable Care Organization (ACO). This is the most narrow network of providers offered among Blue Shield HMO plans, and therefore the most affordable plan option. Members select a Personal Physician only from within the ACO network.

It is important for Members to review the list of providers within the ACO Physician and Hospital Directory before enrolling in this health plan. In some areas, there may only be one IPA or Medical Group from which to select a Personal Physician or to receive Covered Services. There also may be one Hospital in the ACO within the Service Area.

Referral to Specialty Services

When the Personal Physician determines that specialty services are Medically Necessary, he or she will initiate a referral to a designated Plan Provider and request necessary authorization. The Personal Physician will generally refer the Member to a Specialist or other health care provider within the same Medical Group/IPA. The Specialist or other health care provider will send a report to the Personal Physician.

In the event no Plan Provider is available to perform the needed services, the Personal Physician will refer the Member to a non-Plan Provider after obtaining authorization.

A Member with a condition or disease that is life-threatening, degenerative, or disabling and which requires specialized medical care over a prolonged period of time may be eligible to receive a standing referral to a specialist. To receive more information regarding standing referrals, contact Customer Service.

Members who have questions about their diagnosis, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may request a referral from their Personal Physician to another Physician for a second medical opinion. The Member’s Personal Physician may also offer a referral to
another Physician for a second opinion. State law requires that health plans disclose to members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, please call the Customer Service Department.

If the second opinion involves care provided by the Member’s Personal Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA. If the second opinion involves care received from a Specialist, the second opinion may be provided by any Blue Shield Specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the Medical Group/IPA.

**Access+ Specialist**

Through Access+ Specialist, a Member may arrange an office visit with a Plan Specialist in the same Medical Group or IPA as the Personal Physician without a referral from the Personal Physician. This Benefit is subject to the limitations described in the EOC. The Applicable Copayment and Coinsurance amounts for Access+ Specialist visits are indicated in the Benefit Summary, which is included as part of this Disclosure Form.

**Mental Health and Substance Abuse Services**

Blue Shield has contracted with a Mental Health Service Administrator (MHSA) to underwrite and deliver covered mental health and substance abuse services through a unique network of MHSA Participating Providers. All non-emergency mental health and substance abuse hospital admissions, and non-routine outpatient mental health and substance abuse services, except for Access+ Specialist visits, must be arranged through the MHSA. Members are not required to coordinate mental health and substance abuse services through their Personal Physician.

MHSA Participating Providers are indicated in the Blue Shield Behavioral Health Provider Directory. Members or their Personal Physician may also contact the MHSA directly at 1-877-263-9952.

Mental health and substance abuse services received from an MHSA Non-Participating Provider will not be covered except for Emergency or Urgent Services, or when no MHSA Participating Provider is available to perform the needed service and the MHSA refers the Member to an MHSA Non-Participating Provider and authorizes the services. Except for these stated exceptions, all charges for mental health or substance abuse services not rendered by an MHSA Participating Provider will be the Member’s responsibility.

**Liability of Subscriber or Enrollee for Payment**

For most Covered Services, a Member pays a Copayment at the time of service. Some Covered Services are covered at no charge to the Member.

The Member’s Personal Physician will either provide or arrange for the provision of Covered Services, with the exception of Emergency Services or Urgent Care Services when the Member is out of the Service Area. The Member’s Personal Physician will also manage obtaining prior authorization for services, when needed.

The Member is responsible for payment for any services that are not covered, or not authorized or rendered by Plan Providers (except for Emergency Services or Urgent Care Services) when the Member is out of the Service Area.

**Reimbursement Provisions**

Except as identified below, Members do not need to submit claim forms. Members pay a Copayment or Coinsurance at the time services are received. Coinsurance is calculated based on the negotiated rate with the Plan Provider. Some services are covered at no charge to the Member.

If Emergency Services are received and expenses are incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record for payment to Blue Shield within one year after the first provision of Emergency Services for which payment is requested. In the event covered medical transportation services are obtained in such an emergency situation, Blue Shield shall pay the medical transportation provider directly.

If out-of-area Urgent Services were received from a provider who is not a Plan Provider or a BlueCard* provider, the Member must submit a complete claim with the Urgent Service record for payment to Blue Shield within one year after the first provision of Urgent Services for which payment is requested. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. If Blue Shield determines that the services are not covered, it will notify the Member of that determination. Blue Shield will notify the Member of its determination within 30 days from receipt of the claim.

*BlueCard is a network of Blue Shield Participating Providers available to a Member while temporarily traveling outside of the Service Area. If a Member utilizes a BlueCard provider, they are responsible for applicable Copayment and Coinsurance amounts, as indicated on the Benefit Summary, which is included as part of this Disclosure Form; no claim form is
required. Complete information on the BlueCard program is contained in the EOC.

**Ratio of Healthcare Services**

For Blue Shield small group health plans in 2012, the ratio of the value of health services provided to the amount Blue Shield and Blue Shield Life collected in premiums was 78.1% which means that for every dollar of premiums it collected, Blue Shield paid $0.781 for healthcare services. The ratio was calculated after provider discounts were applied.

**Payment of Providers**

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

Members who want to know more about this payment system may contact the Blue Shield Customer Service Department or talk to their Plan Provider.

**Facilities**

Each Blue Shield HMO plan has a network of Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners in the Member’s Personal Physician Service Area. The specific network associated with a specific HMO plan is identified in the health plan Summary of Benefits and EOC.

Contact Customer Service for information on Non-Physician Health Care Practitioners in your Personal Physician Service Area.

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

**Continuity of Care by a Terminated Provider**

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

**Continuity of Care for New Members by Non-Contracting Providers**

Newly covered Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member’s coverage became effective under this health plan. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

**Services for Emergency Care**

Benefits will be provided for Emergency Services received anywhere in the world.

1. A Member who reasonably believes that he or she has an emergency medical condition or mental health condition that requires an emergency response is encouraged to appropriately use the “911” emergency response system (where available) or seek immediate care from the nearest Hospital.

2. A Member should notify their Personal Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for a medical condition for which a reasonable person would have believed that she or he had an emergency medical condition.

3. For Medically Necessary emergency care, the member is only responsible for the applicable Deductible, Copayment or coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowed Charges Blue Shield is obligated to pay.

4. If Blue Shield determines that the Member did not have a medical condition for which a reasonable person would have believed that he or she had an emergency, services will not be covered.
5. For Urgent care within the Personal Physician Service Area, a Member should call his or her Personal Physician.

**Utilization Management**

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

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

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

**Principal Benefits and Coverages**

The Benefits of this health plan, including acute and subacute care, are provided only for services that are Medically Necessary, and are provided, prescribed, or authorized by the Personal Physician or the MHSA, except for Emergency Services, out-of-area Urgent Services, Access+ Specialist visits, or OB/GYN Services provided by an obstetrician, gynecologist, or a family practice physician in the same medical group or IPA as the Member's Personal Physician. Please refer to the Benefit Summary and/or EOC for more detailed information on the benefits and coverages included in the HMO plan.

**Principal Exclusions and Limitations on Benefits**

**General Exclusions**

The HMO plans do not provide Benefits for the following:

1) routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;

2) for hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;

3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;

4) services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;

5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under Hospice Program Benefits;

6) services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;

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

8) hearing aids;

9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video
magnification equipment for any purpose;

10) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratooplasty);

11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;

12) for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

13) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member’s jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

14) for Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:

a) Surgery to excise, enlarge, reduce, or change normal structures of any part of the body to improve appearance.

b) Surgery to reform or reshape skin or bone to improve appearance.

c) Lower eyelid blepharoplasty.

d) Upper eyelid blepharoplasty without documentation of significant visual impairment or symptomology.

e) To correct spider veins.

f) Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures).

g) Items and services for the promotion, prevention, or other treatment of hair loss, hair growth or hair removal, including hair transplantation.

h) Reimplantation of breast implants originally provided for cosmetic augmentation.

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

j) Voice modification surgery.

15) for Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member.

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

16) for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

17) any services related to assisted reproductive technology, including but
not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;

18) home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

19) genetic testing except as described in the sections on Outpatient X-ray, Imaging, Pathology and Laboratory Benefits and the Pregnancy and Maternity Care Benefits;

20) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Plan Providers;

21) services performed in a Hospital by house officers, residents, interns, and others in training;

22) services performed by a Close Relative or by a person who ordinarily resides in the Member’s home;

23) services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under Mental Health and Substance Abuse Benefits;

24) massage therapy that is not Physical Therapy or a component of a multiple-modality rehabilitation treatment;

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

26) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

27) services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;

28) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

29) for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive
Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

30) patient convenience items such as telephone, television, guest trays, and personal hygiene items;

31) for disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home Health Care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

32) services for which the Member is not legally obligated to pay, or for services for which no charge is made;

33) services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker’s compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease; and

34) for spinal manipulation and adjustment, except as specifically provided under Professional (Physician) Benefits (other than for Mental Health and Substance Abuse Benefits) in the Plan Benefits section;

35) for transportation services other than provided under Ambulance Benefits in the Plan Benefits section;

36) for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as the Personal Physician, Emergency Services or Urgent Services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section.

37) for inpatient and Non-Routine Outpatient Mental Health and Substance Abuse Services unless authorized by the MHSA.

38) Drugs dispensed by a physician or physician’s office for outpatient use; and

39) Not specifically listed as a benefit.

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

Medical Necessity Exclusion

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

Outpatient Prescription Drug Benefit

No Benefits are provided for outpatient prescription drugs from non-participating pharmacies, except for covered Emergency Services, including drugs for emergency contraception.

For Outpatient Prescription Drug Copayments and for Brand Drug Deductibles (when applicable), please refer to the Benefit Summary, which is included as part of this Disclosure Form.

Outpatient Prescription Drug Formulary

Drug coverage is based on the use of Blue Shield’s Prescription Drug Formulary. Formularies are lists of preferred, covered medications recommended to prescribing physicians. The inclusion of a drug in the
Blue Shield Formulary does not guarantee that a Member’s physician will prescribe it for a particular medical condition.

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

Members may review the Formulary through the Blue Shield website at http://www.blueshieldca.com. Members may also contact Blue Shield Customer Service at the number listed on their Blue Shield Identification Card to inquire if a specific drug is included in the Formulary.

Benefits may be provided for non-Formulary (non-preferred) drugs subject to higher Copayments.

**Prior Authorization Process for Outpatient Prescription Drug Benefit**

Select preferred, Non-preferred, Compound and most Specialty Drugs require prior authorization for Medical Necessity and to determine if first-line therapy has been tried. Select Brand contraceptives may require prior authorization in order to be covered without a Copayment. Compound drugs are covered only if the requirements listed under the Outpatient Prescription Drug Benefit Exclusions and Limitation section are met.

A Member or the Member’s Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within five business days or within 72 hours for an expedited review, unless state or federal law requires the prior authorization to be completed within a shorter timeframe.

**Limitation on Quantity of Drugs that may be Obtained per Prescription or Refill**

1. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply, except as stated below.

   Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by the Blue Shield Pharmacy and Therapeutics Committee.

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

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

3. Mail service prescription drugs are limited to a quantity not to exceed a 90-day supply.

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

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

**Outpatient Prescription Drug Exclusions**

No Benefits are provided under the Outpatient Prescription Drug benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of the EOC. Refer to the applicable section of the EOC to determine if Drugs are covered under that benefit):

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1. Drugs obtained from a non-participating pharmacy, except for covered Emergencies, drugs for emergency contraception and drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible;

2. Any drug provided or administered while the member is an inpatient, or in a physician's office, Skilled Nursing Facility or Outpatient Facility;

3. Take home drugs received from a hospital, Skilled Nursing Facility, or similar facilities;

4. Drugs, (except as specifically listed as covered under the Outpatient Prescription Drugs benefit of the EOC) which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;

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

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

7. Medical devices or supplies, except as specifically listed as covered in the EOC. This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;

8. Blood or blood products;

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

10. Dietary or nutritional products;

11. Any drugs which are not self-administered;

12. All Drugs for the treatment of infertility;

13. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;

14. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) require a Physician’s prescription, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered;

15. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and (4) it is being prescribed for an FDA-approved indication;

16. Replacement of lost or stolen prescription Drugs;

17. Pharmaceuticals that are reasonable and necessary for the palliation and management of terminal illness and related conditions if they are provided to a member enrolled in a Hospice Program through a participating Hospice Agency;

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

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

20. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy, or included on a government exclusion list, except for a covered emergency;

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

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

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

**Pediatric Vision Benefits for Children to Age 19**

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

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

Covered Services are limited to the following:

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

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

   A report from the provider and prior authorization from the contracted VPA is required.

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

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

**Pediatric Vision Plan Exclusions**

The Pediatric Vision Plan does not provide benefits for:

a. Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;

b. Replacement or repair of lost or broken lenses or frames, except as provided in the EOC;

c. Any eye examination required by the employer as a condition of employment;

d. Medical or surgical treatment of the eyes;
e. Services performed by a Close Relative or by an individual who ordinarily resides in the Subscriber or Dependent’s home;

f. Services performed incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers’ compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by Blue Shield for the treatment of the injury or disease;

g. Contact lenses, except as specifically provided in your plan’s Summary of Benefits;

h. Services required by any government agency or program, Federal, state or subdivision thereof;

i. Services and materials for which the Member is not legally obligated to pay, or services and materials for which no charge is made to the Member;

j. Services not specifically listed as a Benefit;

k. Services, procedures, or supplies which are not reasonably necessary for the Member’s condition according to broadly accepted standards of professional care or which are Experimental or Investigational in Nature or which do not have uniform professional endorsement;

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

Prepayment Fees

The monthly dues (premiums) for a Subscriber and any enrolled dependents are indicated in the Group Health Services Contract. Members should check with their employer regarding the share they may be required to pay. The initial dues are payable on the effective date of this health plan, and subsequent dues are payable on the same date of each succeeding month. All dues required for coverage for the Subscriber and Dependents will be handled through the Employer and must be paid to Blue Shield. Employers purchasing coverage through the SHOP will pay premiums directly to the SHOP and the SHOP will forward the premiums to Blue Shield.

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

Other Charges

Deductibles, Benefit Levels and Maximums

Any annual medical deductible or annual brand drug deductible is identified in the Benefit Summary for the HMO plan. The HMO plan may also have Copayments or Coinsurance for Covered Services, and charges in excess of benefit maximums for which the Member is responsible to pay. All HMO plans have a calendar year out-of-pocket maximum amount. Please refer to the Benefit Summary, which is a part of this Disclosure Form, to find information regarding any Member share-of-cost or maximums that are applicable to the health plan.

Renewal Provisions

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

1. Non-payment of dues (see the “Termination of Benefits” and “Reinstatement, Cancellation and Rescission Provisions” sections of the EOC);

2. Fraud, misrepresentations, or omissions;

3. Failure to comply with Blue Shield’s applicable eligibility, participation, or contribution rules;

4. Termination of plan type by Blue Shield;

5. Employer relocates outside of California;

6. Employer is an association and association membership ceases; or

7. Employer purchases coverage through the SHOP and the Employer is no longer eligible to purchase coverage through the SHOP.

All group contracts will renew subject to the above.

Plan Changes

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

Group Termination

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

If the Employer fails to pay the required premiums when due, coverage will terminate upon the expiration of a 30-day grace period following notice of termination for non-payment of premium. The Employer will be liable for all premium accrued while this coverage continues during the grace period. If the Contract is terminated, a Member enrolled through the Contract will no longer receive benefits – including COBRA (groups with 20 or more employees) or Cal-COBRA (groups with 2-19 employees). Exceptions due to a disability are specifically outlined in the Extension of Benefits provision in the EOC.

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

Individual Termination

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

1. The Member no longer meets the eligibility requirements in the Employer’s Contract;
2. The Member engages in fraud or deception in the use of health plan benefits; or
3. The Member no longer resides or works in the Service Area.

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

Continuation of Group Coverage

Each Member should refer to the EOC and examine their options carefully before declining this coverage.

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

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

Continuation of Group Coverage: COBRA

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

Grievance Process

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

External Independent Medical Review

State law requires Blue Shield to disclose to Members the availability of an external independent review process when the grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational. Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. For further information about this review process works, see the External Independent Medical Review section in the EOC.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-424-6521 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 (1-888-319-5999) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department’s Internet Web site (http://www.dmhc.ca.gov) has complaint forms, IMR application forms, and instructions online.

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

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

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

Blue Shield also participates in quality measurement activities that may require us to access a Member’s personal and health information. We have policies to protect this information from inappropriate disclosure and we release this information only if aggregated or encoded. We will not disclose, sell, or otherwise use a Member’s personal and health information unless permitted by law and to the extent necessary to administer the health plan. We will obtain written authorization from the Member to use his or her personal and health information for any other purpose. For any of our prospective or current Members unable to give consent, we have a policy in place to protect that Member’s rights and that permits the Member’s legally authorized representative to give consent on his or her behalf. Blue Shield also will not release the Member’s personal and health information to the employer without his or her specific authorization, unless such release is permitted by law.

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

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

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

Definitions

Allowed Charges – the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan providers (except that Physicians rendering Emergency Services, Hospitals which are not Plan Providers rendering any services, and non-contracting dialysis centers rendering any services when authorized by the Plan will be paid based on the Reasonable and Customary Charge, as defined.)

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

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

1. Placing the Member’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency Services means the following with respect to an emergency medical condition:

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

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

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

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

HMO Provider – a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the Full HMO Plan and, for Mental Health and Substance Abuse Services, an MHSA Participating Provider.

Independent Practice Association (IPA) – a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members.

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

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

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

3. Hospital inpatient Services that are Medically Necessary include only those Services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and that could not have been provided in 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 services that are not Medically Necessary include hospitalization:

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

b. For medical observation or evaluation;

c. For personal comfort;

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

e. For inpatient rehabilitation that can be provided on an outpatient basis.

4. 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.

Mental Health Service Administrator (MHSA) – The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver the Plan’s Mental Health and Substance Abuse Services through a separate network of MHSA Participating Providers.

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

Personal Physician – a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a Personal Physician to provide primary care to members and to refer, authorize, supervise, and coordinate the provision of all Benefits to Members in accordance with the Contract.

Personal Physician Service Area – that geographic area served by your Personal Physician’s medical group or IPA.

Plan Non-Physician Health Care Practitioner – a health care professional who is not a physician and has an agreement with one of the contracted Independent Practice Associations, medical groups, Plan hospitals, or Blue Shield to provide covered Services to members when referred by a Personal Physician. For all Mental Health and Substance Abuse Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.
Plan Service Area – that geographic area served by the health plan.

Plan Specialist – a Physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide Covered Services to Members either according to an authorized referral by a Personal Physician, or according to the Access+ Specialist program, or for OB/GYN Physician Services. For all Mental Health and Substance Abuse Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Reasonable & Customary Charge —

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

2. Outside of California: The lower of (a) the provider’s billed charge, or, (b) the amount, if any, established by the laws of the state to be paid for Emergency Services.

SHOP – the Small Business Health Option Program (“SHOP”) operated by Covered California through which an Eligible Employer can provide its employees and their Dependents with access to one or more health plans.

Urgent Services – those Covered Services rendered outside of the Personal Physician Service Area (other than Emergency Services) that are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury, or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Personal Physician Service Area.
**TRIO ACO HMO Service Area Chart**

The Trio ACO HMO Service Area consists of only the counties listed on the chart below. Note: the Trio ACO HMO Plan Service Area may change. To verify Service Area information, you can access Blue Shield’s Internet site located at http://www.blueshieldca.com, or call Customer Services at the telephone number provided at the back of this booklet.

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The Trio ACO HMO Service Area consists of only the counties listed on the chart below. Note: the Trio ACO HMO Service Area may change. To verify Service Area information, you can access Blue Shield’s Internet site located at http://www.blueshieldca.com, or call Customer Services at the telephone number provided at the back of this booklet.

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The Trio ACO HMO Service Area consists of only the counties listed on the chart below. Note: the Trio ACO HMO Service Area may change. To verify Service Area information, you can access Blue Shield’s Internet site located at http://www.blueshieldca.com, or call Customer Services at the telephone number provided at the back of this booklet.

<table>
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TRIO ACO HMO SERVICE AREA CHART continued

The Trio ACO HMO Service Area consists of only the counties listed on the chart below. Note: the Trio ACO HMO Service Area may change. To verify Service Area information, you can access Blue Shield’s Internet site located at http://www.blueshieldca.com, or call Customer Services at the telephone number provided at the back of this booklet.

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You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.