The SHCA Medical Plan

Participant Responsibilities

As a SHCA Medical Plan Participant, you have the responsibility to:

1. Carefully read all SHCA Medical Plan materials immediately after you are enrolled so you understand how to use your Benefits. Ask questions when necessary. You have the responsibility to follow the provisions of your SHCA Plan as explained in this booklet.

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

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

4. Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.

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

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

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

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

9. Offer suggestions to improve SHCA Plan.

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

11. Notify SHCA as soon as possible if you are billed inappropriately or if you have any complaints.

12. Select a Primary Care Physician for your newborn before birth, when possible, and notify SHCA as soon as you have made this selection.

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

14. Pay your Fees, Copayments and charges for non-covered services on time.

15. For all Mental Health and substance abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Inpatient Mental Health and substance abuse Services.

16. Follow the provisions of SHCA Benefits Management Program.
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This booklet contains important information that details how this health Plan will be administered. It also contains a summary of the eligibility rules used to determine the conditions of coverage for this health Plan. For full details that explain the exact terms and conditions for health Plan eligibility you may request a copy of the Plan Document which is on file with your Employer.

**NOTICE**

This Benefit Booklet describes the terms and conditions of coverage of your SHCA Plan. The SHCA Plan offers a specially-developed healthcare network that includes Stanford Hospitals and Clinics.

Please read this Benefit Booklet carefully to be sure you understand the Benefits, exclusions and general provisions prior to receiving services. It is your responsibility to keep informed about any changes in your health coverage.

Should you have any questions regarding your health Plan, see your Employer, contact SHCA, or contact any of the Blue Shield offices listed on the last page of this booklet.

**IMPORTANT**

No Participant has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Group Continuation Coverage provision in this booklet.

Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Plan.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the plan document or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

Stanford University is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
SHCA Summary of Benefits

What follows is a summary of your Benefits and the Copayments applicable to the Benefits of your Plan. A more complete description of your Benefits is contained in the Principal Benefits and Coverages (Covered Services) section. Please be sure to read that section and the exclusions and limitations in the Principal Limitations, Exceptions, Exclusions and Reductions section for a complete description of the Benefits of your Plan.

Benefits described in this summary and Benefit Booklet must be provided or authorized by your Primary Care Physician, except in an Emergency, for Urgent Services outside your Primary Care Physician’s Service Area, or as otherwise specified in this Benefit Booklet. The Participant is responsible for payment of Services that are not authorized, when authorization is required.

Should you have any questions about your Plan, please call SHCA Member Care Services at 1-855-345-7422.

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

Summary of Benefits

<table>
<thead>
<tr>
<th>SHCA Plan</th>
<th>Deductible Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0 per Participant / $0 per Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant Calendar Year Deductible (Medical Plan Deductible)</th>
<th>Calendar Year Medical Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Maximum Calendar Year Out-of-Pocket Responsibility²</td>
<td>Calendar Year Out-of-Pocket maximum</td>
</tr>
<tr>
<td>Participant Maximum Calendar Year Copayment²</td>
<td>$3,000 per Participant / $6,000 per Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant Maximum Lifetime Benefits</th>
<th>Maximum Blue Shield Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>No maximum</td>
</tr>
</tbody>
</table>

Failure to Use the Benefits Management Program

Failure to Use the Benefits Management Program
Refer to the Benefits Management Program section for any penalties which may apply.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Participant Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Acupuncture by a licensed acupuncturist</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Acupuncture by Doctors of Medicine</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Up to a maximum of 20 visits per Participant per Calendar Year for any combination of Covered Services by a Doctor of Medicine or licensed acupuncturist</td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy serum purchased separately for treatment</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Primary Care Physician office visits (includes visits for allergy serum injections)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist office visits (includes visits for allergy serum injections)</td>
<td>$50 per visit</td>
</tr>
<tr>
<td><strong>Ambulance Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency or authorized transport</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Ambulatory Surgery Center Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory surgery center Outpatient surgery facility Services</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td>Ambulatory surgery center Outpatient surgery Physician Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Bariatric Surgery Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Participants.</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Hospital Outpatient Services</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td>Physician bariatric surgery Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Chiropractic Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Covered Services rendered by a chiropractor. Up to a Benefit maximum of 20 visits per Participant per Calendar Year.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Clinical trial for Treatment of Cancer or Life-Threatening Conditions Covered Services for Members who have been accepted into an approved clinical trial when prior authorized by Blue Shield. Note: Services for routine patient care, will be paid on the same basis and at the same Benefit levels as other Covered Services.</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Diabetes Care Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Devices, equipment and supplies⁵</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Diabetes self-management training provided by a Primary Care Physician in an office setting</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Diabetes self-management training provided by a Specialist in an office setting</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Diabetes self-management training provided by a registered dietician or registered nurse who are certified diabetes educators</td>
<td>$50 per visit</td>
</tr>
<tr>
<td><strong>Dialysis Center Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid as specified under Hospital Benefits (Facility Services) of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Breast pump</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Other Durable Medical Equipment</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Emergency Room Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room Physician Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Note: After Services have been provided, SHCA may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid as specified under Professional (Physician) Benefits, “Outpatient Physician services, other than an office setting” in this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Emergency room Services not resulting in admission</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Note: After Services have been provided, SHCA may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid as specified under Hospital Benefits (Facility Services), Outpatient Services for treatment of illness or illness, or injury, radiation therapy, chemotherapy, infusion therapy, biofeedback and necessary supplies in this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Emergency room Services resulting in admission</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>(Billed as part of Inpatient Hospital Services)</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
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<td>---------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Family Planning Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Note: Copayments listed in this section are for Outpatient</td>
<td></td>
</tr>
<tr>
<td>Physician Services only. If Services are performed at a facility</td>
<td></td>
</tr>
<tr>
<td>(Hospital, Ambulatory Surgery Center, etc.), the facility</td>
<td></td>
</tr>
<tr>
<td>Copayment listed under the applicable facility Benefit in the</td>
<td></td>
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<tr>
<td>Summary of Benefits will also apply, except for insertion</td>
<td></td>
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<tr>
<td>and/or removal of intrauterine device (IUD), an intrauterine</td>
<td></td>
</tr>
<tr>
<td>device (IUD), and tubal ligation.</td>
<td></td>
</tr>
<tr>
<td>Counseling and consulting</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>(Including Physician office visits for diaphragm fitting or</td>
<td></td>
</tr>
<tr>
<td>injectable contraceptives or implantable contraceptives.)</td>
<td></td>
</tr>
<tr>
<td>Diaphragm fitting procedure</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Injectable contraceptives</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Insertion and/or removal of intrauterine device (IUD)</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Intrauterine device (IUD)</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Intrauterine device (IUD)</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>$50 per surgery</td>
</tr>
<tr>
<td><strong>Home Health Care Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Home health care agency Services (including home visits by a</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>nurse, home health aide, medical social worker, physical</td>
<td></td>
</tr>
<tr>
<td>therapist, speech therapist, or occupational therapist)</td>
<td></td>
</tr>
<tr>
<td>Medical supplies</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Home Infusion/Home Injectable Therapy Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Hemophilia home infusion Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Services provided by a hemophilia infusion provider and prior</td>
<td></td>
</tr>
<tr>
<td>authorized by the Plan. Includes blood factor product.</td>
<td></td>
</tr>
<tr>
<td>Home infusion/home intravenous injectable therapy provided</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>by a Home Infusion Agency*</td>
<td></td>
</tr>
<tr>
<td>Note: Non-intravenous self-administered injectable drugs are</td>
<td></td>
</tr>
<tr>
<td>covered under the Outpatient Prescription Drug Benefit, and</td>
<td></td>
</tr>
<tr>
<td>are described in a Supplement included with this booklet.</td>
<td></td>
</tr>
<tr>
<td>Home visits by an infusion nurse*</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
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<td>-----------------------</td>
</tr>
<tr>
<td><strong>Hospice Program Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Covered Services for Participants who have been accepted into an approved Hospice Program</td>
<td></td>
</tr>
<tr>
<td>The Hospice Program Benefit must be prior authorized by Blue Shield and must be received from a Participating Hospice Agency.</td>
<td></td>
</tr>
<tr>
<td>24-hour Continuous Home Care</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Short term inpatient care for pain and symptom management</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Pre-hospice consultation</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Routine home care</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Hospital Benefits (Facility Services)</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Semi-private room and board, services and supplies, including Subacute Care.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Medically Necessary skilled nursing Services includ-</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>ing Subacute Care</td>
<td></td>
</tr>
<tr>
<td>Up to a maximum of 100 days per Calendar Year per Participant except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Services to treat acute medical complications of de-</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>toxification</td>
<td></td>
</tr>
<tr>
<td>Outpatient diagnostic testing X-ray, diagnostic examination and clinical laboratory Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Outpatient dialysis Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td>Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy, infusion therapy, biofeedback and necessary supplies</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Infertility Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and treatment of cause of Infertility (GIFT, IVF and ZIFT are not covered). This Benefit includes artificial inseminations and is limited to 3 cycles per lifetime. Note: Infertility drugs are limited to a Plan payment maximum of $5,000 per lifetime</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (Be sure to read the Principal Benefits and Coverages (Covered Services) section for a complete description.)</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center Outpatient Surgery facility Services</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Primary Care Physician services in an office location</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist services in an office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse Benefits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Mental Health and Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Note: These Services must be prior authorized by the MHSA</td>
<td></td>
</tr>
<tr>
<td>Inpatient Professional (Physician) Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Residential Care for Mental Health Condition</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Residential Care for Substance Abuse Condition</td>
<td>$100 per admission</td>
</tr>
<tr>
<td><strong>Non-Routine Outpatient Mental Health and Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Treatment (Applied Behavior Analysis) – home or other setting (non-institutional)</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Note: These Services must be prior authorized by the MHSA</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Treatment (Applied Behavior Analysis) – office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Note: These Services must be prior authorized by the MHSA</td>
<td></td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Office-based opioid treatment: outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Psychological testing to determine mental health diagnosis</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Transcranial Magnetic Stimulation</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Routine Outpatient Mental Health and Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) office visits</td>
<td>$20 per visit for services received from a SHCA Provider. If services received from a Non-SHCA Provider, then 20% of allowed charges. (Claims Administrator payment not to exceed $240 per Member per day)</td>
</tr>
<tr>
<td>(See Non-Preferred payment example below)</td>
<td></td>
</tr>
<tr>
<td>Example: office visit, up to the $300 Allowable Amount times (x) 80% Claims Administrator contribution = Claims Administrator payment of up to $240.</td>
<td></td>
</tr>
<tr>
<td><strong>Orthotics Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician office visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Orthotic equipment and devices</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Outpatient Prescription Drug Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Prescription Drug Benefits are described in Supplement A – Outpatient Prescription Drugs on page 57.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient X-Ray, Pathology and Laboratory Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Mammography and Papanicolaou test</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Outpatient X-ray, pathology and laboratory</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>PKU Related Formulas and Special Food Products Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>PKU Related Formulas and Special Food Products</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Podiatric Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Podiatric Services – office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Pregnancy and Maternity Care Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Licensed or Certified Midwives Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prenatal and preconception Physician office visit: initial visit</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prenatal and preconception Physician office visit: subsequent visits, See Outpatient X-Ray, Pathology, Laboratory Benefits for prenatal genetic testing</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Postnatal Physician office visits</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Routine newborn circumcision Note: Routine circumcisions must be performed within 31 days</td>
<td></td>
</tr>
<tr>
<td>Abortion Services Copayment shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility copayment may apply</td>
<td>$125 per surgery</td>
</tr>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the Benefit Booklet, for more information.</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Travel immunizations</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Professional (Physician) Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician Services For bariatric surgery services see the “Bariatric Surgery” section in this Summary of Benefits.</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Internet based consultations</td>
<td>$10 per consultation</td>
</tr>
<tr>
<td>Outpatient Physician Services, other than an office setting</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Primary Care Physician home visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist home visits</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Primary Care Physician office visits including visits for surgery, chemotherapy, radiation therapy, infusion therapy, biofeedback, diabetic counseling, asthma self-management training, mammography and Papanicolaou test, audiology examinations and second opinion consultations with a referral from your Primary Care Physician.</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist office visits including visits for surgery, chemother- apy, radiation therapy, infusion therapy, biofeedback, diabetic counseling, asthma self-management training, mammography and Papanicolaou test, audiology examinations when performed at the request of a Physician, and second opinion consultations with a referral from your Primary Care Physician. Note: Physical Therapy benefits are not provided under this Benefit. See below under Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy).</td>
<td>$50 per visit</td>
</tr>
<tr>
<td><strong>Prosthetic Appliances Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician office visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Prosthetic equipment and devices</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Radiological and Nuclear Imaging Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Note: Benefits in this section are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. Outpatient non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Prior authorization required.</td>
<td></td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prior authorization required by the Plan</td>
<td></td>
</tr>
<tr>
<td>Radiology Center</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prior authorization required by the Plan</td>
<td></td>
</tr>
<tr>
<td><strong>Reconstructive Surgery Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>For Physician services for these Benefits, see the “Professional (Physician) Benefits” section of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center Outpatient Surgery facility Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Primary Care Physician services in an office location</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Specialist services in an office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$100 per surgery</td>
</tr>
<tr>
<td><strong>Rehabilitation and Habilitation Services Benefits Benefits (Physical, Occupational and Respiratory Therapy)</strong></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Services by a free-standing Skilled Nursing Facility</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Up to a maximum of 100 days per Calendar Year per Participant except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility.</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Speech Therapy Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits. Speech Therapy Services by a licensed speech pathologist or certified speech therapist in the following settings:</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Transplant Benefits – Tissue and Kidney</strong></td>
<td></td>
</tr>
<tr>
<td>Organ Transplant Benefits for transplant of tissue or kidney.</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Professional (Physician) Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Transplant Benefits – Special</strong></td>
<td></td>
</tr>
<tr>
<td>Note: SHCA requires prior authorization from SHCA’s appointed Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by SHCA. Please see the Transplant - Special portion of the Principal Benefits (Covered Services) section in the Benefit Booklet for important information on this benefit.</td>
<td></td>
</tr>
<tr>
<td>Facility Services in a Special Transplant Facility</td>
<td>$100 per admission</td>
</tr>
<tr>
<td>Professional (Physician) Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Vision Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Eye Refraction</td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Limited to 1 self-referred exam every 12 months</td>
<td></td>
</tr>
</tbody>
</table>
Summary of Benefits

Footnotes

1. The Participant must choose a Primary Care Physician (PCP). All Benefits must be provided by SHCA Providers, except in an emergency. If services are unavailable within the SHCA network, the Participant with a referral or authorization would be directed to a Blue Shield Preferred Provider.

2. Copayments for Covered Services accrue to the Participant Maximum Calendar Year Copayment, except Copayments for:
   - Charges in excess of specified Benefit maximums;
   - Eye refractions;
   - Infertility Benefits;
   Note: Copayments and charges for Services not accruing to the maximum Calendar Year Copayment responsibility continue to be the Participant’s responsibility after the Calendar Year Copayment maximum is reached.

3. Prior authorization from SHCA/Blue Shield is required for all non-Emergency or non-Urgent Services.

4. If billed by your provider, you will also be responsible for an office visit Copayment.

5. Home infusion injectable medications require prior authorization from SHCA and must be provided by a Home Infusion Agency. See the description of Home Infusion/Home Injectable Therapy Benefits in the Benefit Booklet for details. See the Outpatient Prescription Drugs Benefit Supplement for coverage of home self-administered injectable medication.

6. For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.
INTRODUCTION TO THE STANFORD HEALTH CARE ALLIANCE PLAN

Welcome to the Stanford Health Care Alliance (SHCA) Plan which offers a specially-developed healthcare network that includes Stanford Hospitals and Clinics.

You will be able to select your own Primary Care Physician from SHCA Physician and Hospital Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Each of your eligible Family members may select a different Primary Care Physician. There is no Calendar Year deductible requirement under this Plan.

Participants enrolled in this SHCA Plan may only select Primary Care Physicians designated as SHCA providers as listed in SHCA Physician and Hospital Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Note: A Plan Provider’s status may change. It is your obligation to verify whether the provider you choose is a SHCA Provider; in case there have been any changes since your directory was published. Each of your eligible Family members may select a different Primary Care Physician or not authorized by SHCA will result in non-payment by the Plan and the Participant will be responsible all charges.

SHCA has contracted with the following facilities:

- Stanford Hospitals and Clinics (SHC)
- Lucile Packard Children’s Hospital (LPCH)
- LPCH Faculty Practice Organization (including LPCH physicians and PCHA providers)
- University Healthcare Alliance (including Menlo Clinic).

Note: Washington Hospital and Santa Clara Valley Med are not included in the SHCA Network.

You will 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 status. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

STANFORD HOSPITALS AND CLINICS FACILITIES

SHCA has contracted with the following facilities:

- Stanford Hospitals and Clinics (SHC)
- Lucile Packard Children’s Hospital (LPCH)
- LPCH Faculty Practice Organization (including LPCH physicians and PCHA providers)
- University Healthcare Alliance (including Menlo Clinic).

Note: Washington Hospital and Santa Clara Valley Med are not included in the SHCA Network.

CHOICE OF PHYSICIANS AND PROVIDERS

SELECTING A PRIMARY CARE PHYSICIAN

A close Physician-patient relationship is an important ingredient that helps to ensure the best medical care. Each Participant is therefore required to select a Primary Care Physician at the time of enrollment. This decision is an important one because your Primary Care Physician will:

1. Help you decide on actions to maintain and improve your total health;

Note: A decision will be rendered on all requests for prior authorization of services as follows:

- for Urgent Services and in-area urgent care, as soon as possible to accommodate the Participant’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 Participant within 2 business days of the decision.

You will 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 status. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

As a Participant in SHCA Plan, you may only request to change your enrollment upon the occurrence of one of the following:

- you move out of SHCA Plan Service Area; or
- during the Employer’s Open Enrollment Period; or
- an event occurs when you are allowed to make plan changes outside of the Open Enrollment Period (see the Eligibility and Effective Date sections for information).

All Covered Services must be provided by or arranged by your SHCA Plan Primary Care Physician, except for the following:

- Services received during a SHCA Specialist visit,
- OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician designated as a SHCA provider,
- Urgent care provided in your Stanford University SHCA Plan Primary Care Physician Service Area by an urgent care clinic
- Emergency Services, or
- Mental Health and substance abuse Services. (See the Mental Health and Substance Abuse Services paragraphs in the How to Use Your Health Plan section for information.)

Note: A decision will be rendered on all requests for prior authorization of services as follows:

- for Urgent Services and in-area urgent care, as soon as possible to accommodate the Participant’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 Participant within 2 business days of the decision.

You will 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 status. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

As a Participant in SHCA Plan, you may only request to change your enrollment upon the occurrence of one of the following:

- you move out of SHCA Plan Service Area; or
- during the Employer’s Open Enrollment Period; or
- an event occurs when you are allowed to make plan changes outside of the Open Enrollment Period (see the Eligibility and Effective Date sections for information).

STANFORD HOSPITALS AND CLINICS FACILITIES

SHCA has contracted with the following facilities:

- Stanford Hospitals and Clinics (SHC)
- Lucile Packard Children’s Hospital (LPCH)
- LPCH Faculty Practice Organization (including LPCH physicians and PCHA providers)
- University Healthcare Alliance (including Menlo Clinic).

Note: Washington Hospital and Santa Clara Valley Med are not included in the SHCA Network.

Charges received at these facilities will be paid as shown in the Summary of Benefits. Blue Shield will reimburse the facility its standard contract rate less the applicable member copayment.

CHOICE OF PHYSICIANS AND PROVIDERS

SELECTING A PRIMARY CARE PHYSICIAN

A close Physician-patient relationship is an important ingredient that helps to ensure the best medical care. Each Participant is therefore required to select a Primary Care Physician at the time of enrollment. This decision is an important one because your Primary Care Physician will:

1. Help you decide on actions to maintain and improve your total health;
2. Coordinate and direct all of your medical care needs;
3. Arrange your referrals to Specialty Physicians, Hospitals and all other health Services, including requesting any prior authorization you will need;
4. Authorize Emergency Services when appropriate;
5. Prescribe those lab tests, X-rays and Services you require;
6. If you request it, assist you in obtaining prior approval for Mental Health and substance abuse Services*; and,
   *See the Mental Health and Substance Abuse Services paragraphs in the How to Use Your Health Plan section for information.
7. Assist you in applying for admission into a Hospice Program through a Participating Hospice Agency when necessary.

To ensure access to Services, each Participant must select a Primary Care Physician who is located sufficiently close to the Participant’s home address to ensure reasonable access to care, as determined by SHCA. Participants enrolled in this Plan may only select Primary Care Physicians designated as SHCA providers in SHCA Plan Physician and Hospital Directory. If you do not select a current Primary Care Physician at the time of enrollment, the Plan will designate a Primary Care Physician for you and you will be notified. This designation will remain in effect until you notify the Plan of your selection of a different Primary Care Physician.

A Primary Care Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption but always within 31 days from the date of birth or placement for adoption. You may designate a pediatrician as the Primary Care Physician for your child. The Primary Care Physician selected for the month of birth must be designated as a SHCA provider when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Participant or if the child has been placed with the Subscriber for adoption, the Primary Care Physician selected must be a SHCA provider. If you do not select a Primary Care Physician within 31 days following the birth or placement for adoption, the Plan will designate a Primary Care Physician from SHCA Plan Physician and Hospital Directory. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Primary Care Physician for the child after the month of birth or placement for adoption, see the paragraphs below on Changing Primary Care Physicians. If your child is ill during the first month of coverage, be sure to read the information about changing Primary Care Physicians during a course of treatment or hospitalization.

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you must submit a written application as explained in the Eligibility section of this Benefit Booklet.

**RELATIONSHIP WITH YOUR PRIMARY CARE PHYSICIAN**

The Physician-patient relationship you and your Primary Care Physician establish is very important. The best effort of your Primary Care Physician will be used to ensure that all medically necessary and appropriate professional Services are provided to you in a manner compatible with your wishes.

If your Primary Care Physician recommends procedures or treatments which you refuse, or you and your Primary Care Physician fail to establish a satisfactory relationship, you may select a different Primary Care Physician. SHCA Member Care Services can assist you with this selection.

Your Primary Care Physician will advise you if he believes that there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, SHCA Member Care Services can assist you in the selection of another Primary Care Physician.

Repeated failures to establish a satisfactory relationship with a Primary Care Physician may result in your no longer meeting the eligibility and enrollment requirements for the Plan. However, such an event will only occur after you have been given access to other available Primary Care Physicians and have been unsuccessful in establishing a satisfactory relationship. Any such change in your eligibility will take place in accordance with written procedures established by SHCA and only after written notice to the Participant which describes the unacceptable conduct provides the Participant with an opportunity to respond and warns the Participant of the possibility of no longer remaining eligible to be covered under the Plan.

**CHANGING PRIMARY CARE PHYSICIANS**

You or your Dependent may change Primary Care Physicians by calling SHCA Member Care Services at 1-855-345-7422 or submitting a Participant Change Request Form to the SHCA Member Care Services. The change will be effective the first day of the month following notice of approval by SHCA/Blue Shield.

Once your Primary Care Physician change is effective, all care must be provided or arranged by the new Primary Care Physician, except for OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within SHCA Plan Physician and Hospital Directory. SHCA Member Care Services will assist you with the timing and choice of a new Primary Care Physician.

Additionally, changing your Primary Care Physician during a course of treatment may interrupt your health care. For this reason, the effective date of your new Primary Care Physician, when requested during a course of treatment, will be the first of the month following the date it is medically appropriate to transfer your care to your new Primary Care Physician, as determined by the Plan.

Exceptions must be approved by SHCA Medical Director. For information about approval for an exception to the
above provision, please contact SHCA Member Care Services.

If your Primary Care Physician discontinues participation in the Plan, SHCA will notify you in writing and designate a new Primary Care Physician for you in case you need immediate medical care. You will also be given the opportunity to select a new Primary Care Physician of your own choice within 15 days of this notification. Your selection must be approved by SHCA prior to receiving any Services under the Plan.

**HOW TO USE YOUR HEALTH PLAN**

**USE OF PRIMARY CARE PHYSICIAN**

At the time of enrollment, you will choose a SHCA Plan Primary Care Physician who will coordinate all Covered Services. You must contact your Primary Care Physician for all health care needs including preventive Services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological (OB/GYN) Physician Services, Specialist, and Mental Health and substance abuse Services), admission into a Hospice Program through a Participating Hospice Agency, Emergency Services, Urgent Services and for hospitalization.

The Primary Care Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care Services and requesting any needed prior authorization. You should only schedule an appointment for other necessary health care Services not provided by your Primary Care Physician if confirmation of prior authorization is obtained. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Primary Care Physician and self-arranged appointments to a Specialist or for OB/GYN Services. Because your Physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the Physician. Some offices may advise you that a fee (not to exceed your Copayment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Primary Care Physician for any reason, you must contact SHCA Member Care Services at the number provided on the last page of this booklet, Monday through Friday, between 7 a.m. and 7 p.m. to select a Primary Care Physician to obtain Benefits.

**REFERRAL TO SPECIALTY SERVICES**

Stanford University encourages you to receive specialty Services through a referral from your Primary Care Physician. The Primary Care Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty Services. Your Primary Care Physician will generally refer you to a Plan Specialist or Plan Non-Physician Health Care Practitioner from SHCA Plan Physician and Hospital Directory. Your Primary Care Physician will request any necessary prior authorization. For Mental Health and substance abuse Services, see the Mental Health and Substance Abuse Services paragraphs in the How to Use Your Health Plan section for information regarding how to access care. The Plan Specialist or Plan Non-Physician Health Care Practitioner will provide a complete report to your Primary Care Physician so that your medical record is complete.

To obtain referral for specialty Services, including lab and X-ray, you must first contact your Primary Care Physician. If the Primary Care Physician determines that specialty Services are Medically Necessary, the Physician will complete a referral form and request necessary authorization. Your Primary Care Physician will designate the Plan Provider from whom you will receive Services.

When no Plan Provider is available to perform the needed Service, SHCA Plan Primary Care Physician will refer you to a Blue Shield Provider after obtaining authorization. This authorization procedure is handled for you by your Primary Care Physician. Specialty Services are subject to all of the benefit and eligibility provisions, exclusions and limitations described in this booklet. You are responsible for contacting SHCA Member Care Services to determine that services are Covered Services, before such services are received.

**OBSTETRICAL/GYNECOLOGICAL (OB/GYN) PHYSICIAN SERVICES**

A female Participant may arrange for obstetrical and/or gynecological (OB/GYN) Services by an obstetrician/gynecologist or family practice Physician who is not her designated Primary Care Physician. A referral from your Primary Care Physician is not needed. However, the obstetrician/gynecologist or family practice Physician must be a designated SHCA provider.

Obstetrical and gynecological Services are defined as:

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

It is important to note that services by an OB/GYN or family practice Physician that is not a designated SHCA provider without authorization will not be covered under this Plan. Before making the appointment, the Participant should call SHCA Member Care Services at the number provided on the last page of this booklet to confirm that the OB/GYN or family practice Physician is a designated SHCA provider.
The OB/GYN Physician Services are separate from the Specialist feature described below.

CONTINUITY OF CARE BY A TERMINATED PROVIDER

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

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

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

SERVICES FOR EMERGENCY CARE

The Benefits of this Plan will be provided for covered Services received anywhere in the world for the emergency care of an illness or injury.

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

Note: For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up Services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician’s office.

ELIGIBILITY

To enroll and continue enrollment, a Participant must meet all of the eligibility requirements of the Plan.

If you are an Employee, you are eligible for coverage as a Participant the day following the date you complete the waiting period established by your Employer. Your spouse or Domestic Partner and all your Dependent children are eligible at the same time.

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period, they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer’s next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under another employer’s health plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish Blue Shield written proof of the loss of coverage.

Newborn infants of the Participant, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Participant, spouse or Domestic Partner has the right to control the child’s health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Participant’s, spouse’s or Domestic Partner’s right to control the child’s health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by Blue Shield within 31 days from the date of birth or placement for adoption of such Dependent.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

a. to continue coverage of a newborn or child placed for adoption;

b. to add a spouse after marriage, or add a Domestic Partner after establishing a domestic partnership;

c. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;

d. to add yourself and spouse after marriage;

e. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

A completed health statement may be required with the application. Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are both eligible to be Participants, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician’s written certification of such disabling condition. Blue Shield or the Employer will
notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician’s written certification within 60 days of the request for such information by the Employer or by the Plan. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than 2 years after the initial certification and then annually thereafter.

Subject to the requirements described under the Continuation of Group Coverage provision in this booklet, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this Plan when coverage would otherwise terminate.

2. If a Participant commits any of the following acts, they will immediately lose eligibility to continue enrollment:
   a. Abusive or disruptive behavior which:
      (1) threatens the life or well-being of Plan personnel, or providers of services;
      (2) substantially impairs the ability of Blue Shield to arrange for services to the Participant; or
      (3) substantially impairs the ability of providers of Services to furnish Services to the Participant or to other patients.
   b. Failure or refusal to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer benefits under the Plan.

3. Employer eligibility – The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group Plan. See your Employer for further information.

Active Employees

Faculty and staff of Stanford University and the SLAC National Accelerator Laboratory as well as certain family members are eligible for benefits coverage if the criteria below are met:

When you add a family member to your coverage, you need to confirm they are eligible. You have 30 days from the date you add your family member to submit the documentation. You will receive a request for the documents that includes instructions on how to submit them. If you do not submit documentation by the deadline, your dependent’s enrollment is cancelled and you must wait until another life event, or annual Open Enrollment Period, to add them again. See the Educated Choices Plan Document for detailed information.

You are eligible for Stanford’s benefits program if you are scheduled to work in a benefits-eligible position for 6 months or more (4 months or more for bargaining unit employees) and you are a:

- Part-time employee working between 50% and 74% time (FTE), or
- Full-time employee working between 75% and 100% time (FTE)

Eligible family members include:
1. Spouse, unless legally separated
2. Domestic Partner registered with the state of California
3. Dependent children to age 26
4. Unmarried children over the age limit if:
   a. They are dependent on you for primary financial support and maintenance due to a physical or mental disability
   b. They are incapable of self-support, and
   c. The disability existed before reaching age 19.

Eligible children include:
1. Natural children
2. Stepchildren
3. Legally adopted children
4. Foster children
5. Children for whom you are the legal guardian
6. Children placed with you for adoption
7. Children of your Domestic Partner who depend on you for support and who live with you in a regular parent/child relationship
8. Child for whom the court has issued a Qualified Medical Child Support Order (QMCSO)

Official Retirees

Official retirees from Stanford University and the Stanford Linear Accelerator Center are eligible for Stanford retiree medical benefits. There are two ways to become an official retiree:

- If you were hired after January 1, 1992, you must complete at least 10 years of benefits-eligible service and your age plus years of benefits-eligible service must equal at least 75 (the "Rule of 75").
- If you were hired before January 1, 1992, you must complete at least 10 years of benefits-eligible service and be at least age 55. Or you can qualify under the "Rule of 75."

To find out if you qualify as an official retiree, contact Stanford Benefits and to talk to a representative. Plan well in advance: you should allow at least 8 weeks after your call for us to research your employment history and determine your eligibility. Family member eligibility is the same as noted above.

Returning Employees

As a returning employee, your prior service may count towards becoming an official retiree.

Domestic Partners

You can cover your Domestic Partner if your partnership is registered with the State of California. The State of California registers same-sex Domestic Partners, as well as opposite-sex partners when one is age 62 or older and qualified.
for Social Security benefits. You may register your partnership in California even if you're not a California resident. For more information visit the State of California Domestic Partners Registry Web page at http://www.ss.ca.gov/dpregistry.

Generally, you can register your Domestic Partner if you share a common residence and your Domestic Partner is:

1. Age 18 or older
2. A member of your household for the coverage period
3. Not related to you in any way that would prohibit legal marriage
4. Not legally married to anyone else or in a registered domestic partnership with anyone else

For detailed information on Eligibility, refer to Stanford’s Educated Choices Summary Plan Description, Stanford’s Retiree Health Care Summary Plan Description, or see the Benefits Overview section of the Stanford Benefits Web site located at http://benefits.stanford.edu.

**EFFECTIVE DATE OF COVERAGE**

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date you made a written request for coverage or at the Employer’s next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

If you declined coverage for yourself and your Dependents during the initial enrollment period because you or your Dependents were covered under another employer health plan, and you or your Dependents subsequently lost coverage under that plan, you will not be considered a Late Enrollee. Coverage for you and your Dependents under this Plan will become effective on the date of loss of coverage, provided you enroll in this Plan within 31 days from the date of loss of coverage. You will be required to furnish Blue Shield written evidence of loss of coverage.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of marriage, establishment of domestic partnership, birth, or placement for adoption, you may request enrollment for yourself and your Dependents within 31 days. The effective date of enrollment for both you and your Dependents will depend on how you acquire your Dependent(s):

1. For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment;
2. For birth, the effective date will be the date of birth;
3. For a child placed for adoption, the effective date will be the date the Participant, spouse, or Domestic Partner has the right to control the child’s health care.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another health plan sponsored by your Employer to SHCA Plan. A completed enrollment form must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the anniversary date of this Plan following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Participant, spouse or Domestic Partner has the right to control the child’s health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield within 31 days. An application may also be submitted electronically, if available. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer’s next Open Enrollment Period.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your Employer, you and all your Dependents who were validly covered under the previous group health plan on the date of discontinuance, will be eligible under this Plan.
RENEWAL OF PLAN DOCUMENT

SHCA will offer to renew the Plan Document except in the following instances:

1. non-payment of fees (see “Termination of Benefits”);
2. fraud, or intentional misrepresentation of a material fact;
3. failure to comply with SHCA's applicable eligibility, participation or contribution rules;
4. termination of plan type by SHCA;
5. Employer relocates outside of California;
6. association membership ceases.

All groups will renew subject to the above.

UTILIZATION REVIEW

Blue Shield has a documented utilization review process. To request a copy of this document, call the Customer Service Department at the number listed on the last page of this booklet.

SECOND MEDICAL OPINION POLICY

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

The second opinion visit is subject to the applicable Co-payment, Coinsurance, Calendar Year Deductible and all plan contract Benefit limitations and exclusions.

State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call Customer Service Department at the number provided on the back page of this booklet.

NurseHelpSM® 24/7

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

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

*NurseHelpSM® 24/7 is available to all members of the SHCA Plan.

SHCA ONLINE

SHCA’s website is located at http://www.stanfordhealthcarealliance.org. Participants with Internet access and a Web browser may view and download information about SHCA Plan.

BENEFITS MANAGEMENT PROGRAM

SHCA has established the Benefits Management Program to assist you, your Dependents, or provider in identifying the most appropriate and cost-effective course of treatment for which certain Benefits will be provided under this health Plan and for determining whether the services are Medically Necessary. However, you, your Dependents and provider make the final decision concerning treatment. The Benefits Management Program includes: prior authorization review for certain services; emergency admission notification; Hospital Inpatient review, discharge planning, and case management if determined to be applicable and appropriate by SHCA.

Failure to contact SHCA for authorization of services listed in the sections below or on page 62 or failure to follow the Plan’s recommendations may result in non-payment if not authorized by SHCA or if SHCA determines the service was not a covered Service. Services received from a non-SHCA Provider without a referral from your Primary Care Physician or not authorized by SHCA will result in non-payment by the Plan and the Participant will be responsible for all charges. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefits Management Program also apply to your Dependents.

SHCA requires prior authorization for selected Inpatient and Outpatient services, supplies and Durable Medical Equipment; admission into an approved Hospice Program; and certain radiology procedures. Preadmission review is required for all Inpatient Hospital and Skilled Nursing Facility services (except for Emergency Services*).

*See the paragraph entitled Emergency Admission Notification later in this section for notification requirements.
By obtaining prior authorization for certain services prior to receiving services, you and your provider can verify: (1) If SHCA considers the proposed treatment Medically Necessary, (2) if Plan Benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by SHCA. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

**FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM**

For non-Emergency Services, failure of the Participant or Dependent to follow the procedures described under the Prior Authorization and Hospital and Skilled Nursing Facility Admissions sections of the Benefits Management Program will result in non-payment if not authorized by SHCA or if SHCA determines that the service is not a covered Service.

**PRIOR AUTHORIZATION**

For services and supplies listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a Covered Service and may also receive a recommendation for an alternative Service. Failure to contact SHCA as described below or failure to follow the recommendations of SHCA for Covered Services will result in a reduced payment or non-payment per procedure as described in the section entitled Failure to Use the Benefits Management Program.

For Services other than those listed in the sections below, you, your Dependents or provider should consult the Principal Benefits and Coverages (Covered Services) section of this booklet to determine whether a service is covered.

**NOTE:** For an expanded list of services requiring prior authorization, see the Prior Authorization list on page 62.

Your Physician must contact SHCA for prior authorization for the services listed in this section.

SHCA requires prior authorization for the following services:

1. Admission into an approved Hospice Program as specified under Hospice Program Benefits in the Covered Services section.
2. Clinical Trial for Treatment of Cancer or Life Threatening Conditions Benefits.
   
   Participants who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition as defined under the Covered Services section must obtain prior authorization from SHCA in order for the routine patient care delivered in a clinical trial to be covered.
3. Select injectable drugs, except injectable contraceptives (prior authorization not required) administered in the Physician office setting.*

   *Prior authorization is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available.

4. Durable Medical Equipment Benefits, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Glucose Monitoring Systems (CGMS), except breast pumps (prior authorization not required).

5. Reconstructive Surgery.


8. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis:
   
   CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnostic procedure utilizing Nuclear Medicine.

9. Special Transplant Benefits as specified under Transplant Benefits - Special in the Covered Services section.

10. All bariatric surgery

11. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).

12. Medically Necessary dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

Other specific services and procedures may require prior authorization as determined by SHCA. A list of services and procedures requiring prior authorization can be obtained by your provider by going to http://www.stanfordhealthcarealliance.org or by calling SHCA Member Care Services at 1-855-345-7422. You can also find an expanded list of services requiring prior authorization on page 62.

**HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS**

Prior authorization must be obtained from SHCA for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care, transplants, bariatric surgery, and Inpatient Mental Health and substance abuse Services if this health plan provides these benefits.

**Prior Authorization for Other than Mental Health and Substance Abuse Admissions**

Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician
must contact SHCA Member Care Services at 1-855-345-7422 at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, SHCA should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. SHCA will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this Health Plan that the Services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact SHCA as described or failure to follow the recommendations of SHCA may result in non-payment by SHCA if it is determined that the admission is not authorized by SHCA or is not a covered Service.

Prior Authorization for Inpatient Mental Health and Substance Abuse Services

All Inpatient Mental Health and substance abuse Services except for Emergency Services, must be prior authorized by Blue Shield.

For an admission for Emergency Mental Health or substance abuse Services, Blue Shield should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or services will not be covered as described under the Failure to Use the Benefits Management Program section.

For prior authorization of Inpatient Mental Health or substance abuse Services, call the Blue Shield MHSA at 1-800-378-1109.

Failure to contact Blue Shield as described above or failure to follow the recommendations of Blue Shield will result in non-payment by Blue Shield if it is determined that the admission is not a covered Service.

Note: Blue Shield will render a decision on all requests for prior authorization 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 Participant within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Participant or when the Participant is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Participant’s condition not to exceed 72 hours from receipt of the request.

Emergency Admission Notification

If you are admitted for Emergency Services, SHCA should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or services will not be covered as described under the Failure to Use the Benefits Management Program section.

Hospital Inpatient Review

SHCA monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal vaginal delivery or 96 hours or less for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of Hospital stays will be determined solely by your Physician in consultation with you. When a determination is made that the Participant no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, SHCA may work with you, your Physician and the Hospital discharge planners to determine whether benefits are available under this Plan to cover such care.

Case Management

The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of Plan Benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate through SHCA review. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the Benefit to which you would otherwise have been entitled under this Plan. SHCA is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative benefits will be for a specific period of time and will not be construed as a waiver of SHCA’s right to thereafter administer this health Plan in strict accordance with its express terms.
PALLIATIVE CARE SERVICES

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

DEDUCTIBLE

There is no Calendar Year Deductible for covered Services.

NO PARTICIPANT MAXIMUM LIFETIME BENEFITS

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

NO ANNUAL DOLLAR LIMITS ON ESSENTIAL BENEFITS

This Plan contains no annual dollar limits on essential benefits as defined by federal law.

PAYMENT

The Participant Copayment amounts, applicable Deductibles, and Copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on Benefit and Copayment maximums and restrictions.

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

Out-of-Area Programs

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

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

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

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to Blue Shield for payment. Blue Shield will notify you of its determination within 30 days after receipt of the claim. You will be responsible for paying the entire difference between the amount paid by Blue Shield and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant’s responsibility and are not included in Copayment calculations.

To receive the maximum Benefits of your Plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

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

2. visit the Participating Physician or Hospital and present your membership card.

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

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

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from Blue Shield, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.
Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center either at the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, 7 days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call Blue Shield at the customer service number noted on the back of your identification card. For Inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a Physician, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

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

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant’s liability (e.g., Copayment and Plan Deductible amounts shown in this booklet). However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

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

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

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Blue Shield.

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

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

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

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

PARTICIPANT’S MAXIMUM CALENDAR YEAR OUT-OF-POCKET RESPONSIBILITY

The per Participant and per Family maximum Copayment responsibility each Calendar Year for covered Services is shown on the Summary of Benefits.

Once a Participant’s maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Participant’s covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for the Participant’s and all covered Dependents’ covered Services for the remainder of that Calendar Year, except as described below.

Charges for Services which are not covered or not authorized by the SHCA, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in the maximum Calendar Year Out-of-Pocket responsibility.

For the Outpatient Prescription Drugs Benefit, if the Participant requests a brand name drug when a generic drug equivalent is available, the difference in cost that the Participant must pay is not included in the Calendar Year maximum out-of-pocket responsibility calculations. See the Outpatient Prescription Drugs Benefits section for details.

*Note: Certain Services and amounts are not included in the calculation of the maximum Calendar Year Out-of-Pocket responsibility. These items are shown on the Summary of Benefits.

Charges for these items may cause a Participant’s payment responsibility to exceed the maximums.
Copayments and charges for Services not accruing to the Participant’s maximum Calendar Year Out-of-Pocket responsibility continue to be the Participant’s responsibility after the Calendar Year Out-of-Pocket maximum is reached.

**Principal Benefits and Coverages (Covered Services)**

Benefits are provided for the following Medically Necessary covered Services, subject to applicable Deductibles, Copayments and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, SHCA will provide Benefits based on the most cost-effective service.

The Copayments for covered Services, if applicable, are shown on the Summary of Benefits.

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

**Allergy Testing and Treatment Benefits**

Benefits are provided for allergy testing and treatment.

**Ambulance Benefits**

Benefits are provided for (1) emergency ambulance Services (surface and air) when used to transport a Participant from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) pre-authorized, non-emergency ambulance transportation from one medical facility to another.

**Ambulatory Surgery Center Benefits**

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

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant’s health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

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

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

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

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

**Bariatric Surgery Benefits**

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as shown in the Summary of Benefits when:

1. Services are consistent with Blue Shield’s medical policy; and,
2. prior authorization is obtained, in writing, from the SHCA’s Medical Director.

**Chiropractic Benefits**

Benefits are provided for Chiropractic Services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial and subsequent office visits, an initial examination, adjustments, conjunctive therapy, and X-ray services up to the benefit maximum.

Benefits are limited to a per Participant per Calendar Year visit maximum as shown on the Summary of Benefits.

Covered X-ray Services provided in conjunction with this Benefit have an additional Copayment as shown under the
Outpatient X-ray, Pathology and Laboratory Benefits section.

**CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS**

Benefits are provided for routine patient care for a Participant who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by SHCA, and:

1. the clinical trial has a therapeutic intent and Participating Provider determines that the Participant’s participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
2. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits.

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

1. The investigational item, device, or service, itself;
2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.
7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An “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 and other life-threatening condition, and is limited to a trial that is:

1. Federally funded and approved by one or more of the following:
   a) one of the National Institutes of Health;
   b) the Centers for Disease Control and Prevention;
   c) the Agency for Health Care Research and Quality;
   d) the Centers for Medicare & Medicaid Services;
   e) a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;
   f) qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
2. the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

“Life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Involves a drug that is exempt under federal regulations from a new drug application.

**DIABETES CARE BENEFITS**

**Diabetes Equipment**

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

1. blood glucose monitors, including those designed to assist the visually impaired;
2. Insulin pumps and all related necessary supplies;
3. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;
4. visual aids, excluding eyewear and/or video-assisting devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug Benefit section.

**Diabetes Outpatient Self-Management Training**

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition ther-
apy that is Medically Necessary to enable a Participant to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Participant’s Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by Physicians, registered dieticians or registered nurses who are certified diabetes educators.

**DIALYSIS CENTERS BENEFITS**

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

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

**DURABLE MEDICAL EQUIPMENT BENEFITS**

Medically necessary Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by SHCA. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

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

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item*
   
   *This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: For benefits for asthma inhalers and inhaler spacers, see the Outpatient Prescription Drug Benefit.);
3. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with the Blue Shield medical policy. For further information call Customer Service or go to http://www.blueshieldca.com.

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

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

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

**EMERGENCY ROOM BENEFITS**

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

Emergency Services are Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Participant’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition.

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

For Emergency Room Services directly resulting in an admission to a different Hospital, the Participant is responsible for the Emergency Room Participant Copayment plus the appropriate Admitting Hospital Services Participant Copayment as shown on the Summary of Benefits.
FAMILY PLANNING BENEFITS

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

Note: No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for office-administered covered contraceptives;
2. Intrauterine devices (IUDs), including insertion and/or removal;
3. Implantable contraceptives;
4. Injectable contraceptives when administered by a Physician;
5. Voluntary sterilization (tubal ligation and vasectomy) and elective abortions;
6. Diaphragm fitting procedure.

HOME HEALTH CARE BENEFITS

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

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

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2. or 3. above;
5. Medical social worker.

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

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

This Benefit does not include medications, drugs, Insulin, Insulin syringes, certain Home Self-Administered Injectables covered under the Outpatient Prescription Drug Benefits Supplement, and Services related to hemophilia which are described below.

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

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All Services must be prior authorized by SHCA (see the Benefits Management Program section for specific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling SHCA Member Care Services at 1-855-345-7422.

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

Following evaluation by your Physician, a prescription for a blood factor product must be submitted to and approved by SHCA. Once prior authorized by SHCA, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the Emergency Room Benefits section.)
Included in this Benefit is the blood factor product for in-home infusion use by the Participant, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for Services in infusion suites managed by a Preferred Hemophilia Infusion Provider, and Medically Necessary Services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other medical benefits described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

This Benefit does not include:

1. physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2. services from a hemophilia treatment center or any Non-Preferred Hemophilia Infusion Provider; or,
3. self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), Outpatient Prescription Drug Benefits, or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

**HOSPICE PROGRAM BENEFITS**

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Participant requests admission to and is formally admitted to an approved Hospice Program. The Participant must have a Terminal Illness as determined by their Physician’s certification and the admission must receive prior approval from SHCA. (Note: Participants with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Participants can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider.

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

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Participants do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.
5. Social Services/Counseling Services with medical social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Participant to the extent that these needs are not met by the Participant’s other providers.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Participant at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can’t be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

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

**DEFINITIONS**

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

**Continuous Home Care** - home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services...
may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

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

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

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

1. Considers the Participant and the Participant’s family in addition to the Participant, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Participant and their family.
3. Requires the interdisciplinary team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Participants who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Participant’s death to assist the family to cope with social and emotional needs associated with the death.
7. Provides Services in the Participant’s home or primary place of residence to the extent appropriate based on the medical needs of the Participant.
8. Is provided through a Participating Hospice.

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

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

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

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

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

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

**Skilled Nursing Services** - nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Participant’s provider to the Participant and his family that pertain to the palliative, supportive services required by the Participant with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Participant or Dependent assessment, evaluation, and case management of the medical nursing needs of the Participant, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Participant and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Participant and his family and are available on a 24-hour on-call basis.

**Social Service/Counseling Services** - those counseling and spiritual Services that assist the Participant and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.
Terminal Disease or Terminal Illness - a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

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

HOSPITAL BENEFITS (FACILITY SERVICES)
(Other than Mental Health and Substance Abuse Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, and Dialysis Center Benefits.)

Inpatient Services for Treatment of Illness or Injury

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

2. Use of operating room and specialized treatment rooms.

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

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

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

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

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

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

6. Rehabilitation when furnished by the Hospital and approved in advance by SHCA under its Benefits Management Program.

7. Drugs and oxygen.

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

9. X-ray examination and laboratory tests.

10. Dialysis and radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

11. Use of medical appliances and equipment.

12. Subacute Care.

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

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

Outpatient Services for Treatment of Illness or Injury

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

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

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

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

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

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

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

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

6. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth.

Covered Physical Therapy, and Speech Therapy Services provided in an Outpatient Hospital setting are described under the Rehabilitation (Physical, Occupational and Respiratory Therapy) Benefits and Speech Therapy Benefits sections.

INFERTILITY BENEFITS

Benefits are provided for a medically appropriate diagnostic work-up and the following procedures per lifetime for a Participant, spouse or Domestic Partner who is covered within and has a current diagnosis of Infertility with the intention of resulting in conception in that Participant, spouse or Domestic Partner:

1. Three stimulated artificial inseminations cycles per lifetime;

2. Cryopreservation of sperm/oocytes/embryos when retrieved from a Participant, spouse or Domestic Partner covered within. Benefits include cryopreservation Services for a condition which the treating Physician anticipates will cause Infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). Benefits are limited to one retrieval and 1 year of storage per Participant per lifetime.

The Participant is responsible for the Copayment 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 or prescribed by a Preferred Provider during a course of treatment to diagnose Infertility or induce fertilization. Procedures must be consistent with established medical practice in the treatment of Infertility and authorized by SHCA.

No benefits are provided for:

1. Services received from Non-Preferred Providers;

2. 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 your Benefit Booklet;

3. Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield health plan, covered Services for Pregnancy and Maternity Care for the surrogate mother will be covered under that health plan;

4. Services for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Participant or enrolled spouse or enrolled Domestic Partner as defined, if Domestic Partners are covered by this plan;

5. Intracytoplasmic sperm injection (ICSI);

6. Gamete intrafallopian transfer (GIFT), Zygote intrafallopian transfer (ZIFT), or in vitro fertilization (IVF);

7. Covered Services in excess of the lifetime benefit maximums per Participant;

8. Services for or incident to a condition which the Participant anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of sperm/oocytes/ovarian tissue/embryos;

9. Any services not specifically listed as a covered Service, above.

Benefits are limited to a Participant, spouse or Domestic Partner covered hereunder who has diagnosed Infertility as defined at the time services are provided.
MEDICAL TREATMENT OF THE TEETH, GUMS, JAW JOINTS OR JAW BONES BENEFITS

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

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Participant as determined by SHCA;

Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.

3. Medically Necessary non-surgical treatment (e.g., splint and Physical Therapy) of Temporomandibular Joint Syndrome (TMJ);
4. surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones);
6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or
7. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

1. services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair), including treatment to alleviate TMJ;
3. dental implants (endosteal, subperiosteal or transosteal);
4. any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
5. alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
6. fluoride treatments except when used with radiation therapy to the oral cavity.

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

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

See the Out-Of-Area Program, BlueCard Program section for an explanation of how payment is made for out of state services.

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

Routine Outpatient Mental Health and Substance Abuse Services

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

Non-Routine Outpatient Mental Health and Substance Abuse Services

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

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

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

Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

2. Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure; used in the treatment of severe mental health conditions.

3. Intensive Outpatient Program - an Outpatient mental health or substance abuse treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
4. Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment.

5. Partial Hospitalization Program – an Outpatient treatment program that may be freestanding or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

6. Psychological Testing - testing to diagnose a Mental Health Condition when referred by a Participating Provider.


**Inpatient Services**

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

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

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

**Orthotics Benefits**

Benefits are provided for orthotic appliances, including:

1. shoes only when permanently attached to such appliances;

2. special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;

3. Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;

4. Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;

5. initial fitting and replacement after the expected life of the orthoses is covered.

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

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

**Outpatient X-ray, Pathology and Laboratory Benefits**

1. Laboratory, X-ray, Major Diagnostic Services. All Outpatient diagnostic X-ray and clinical laboratory tests and Services, including diagnostic imaging, electrocardiograms, and diagnostic clinical isotope Services.

2. Genetic Testing and Diagnostic Procedures. Genetic testing for certain conditions when the Participant has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with the Blue Shield medical policy.

Note: See Pregnancy and Maternity Care Benefits in the Plan Benefits section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

See the section on Radiological and Nuclear Imaging Benefits and the Benefits Management Program section for radiological procedures which require prior authorization by SHCA.

**PKU Related Formulas and Special Food Products Benefits**

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

**Podiatric Benefits**

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

**Pregnancy and Maternity Care Benefits**

Benefits are provided for maternity services, including the following:
1) prenatal care; 
2) outpatient maternity services; 
3) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia); 
4) inpatient hospital maternity care including labor, delivery and post-delivery care; 
5) abortion services; and 
6) outpatient routine newborn circumcisions performed within 18 months of birth.

See the Outpatient X-ray, Pathology and Laboratory Benefits section for information on prenatal genetic screening and diagnosis of genetic disorders of the fetus for high risk pregnancy.

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 unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

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

**Preventive Health Benefits**

Preventive Health Services are covered. These services include primary preventive medical screening and laboratory testing for early detection of disease as specifically listed below:

1) evidence-based items, drugs or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; 
2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians; 
3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 
4) with respect to women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at www.blueshieldca.com/preventive or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1) through 4) above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation.

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

**Professional (Physician) Benefits**

(Other than Preventive Health Benefit, Mental Health and Substance Abuse Benefits, Hospice Program Benefits, and Dialysis Center Benefits.)

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

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician’s office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com.

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

1. Visits to the office, beginning with the first visit; 
2. Services of consultants, including those for second medical opinion consultations; 
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests. 
4. Asthma self-management training and education to enable a Participant to properly use asthma-related...
medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.

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

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

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

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

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

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

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

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

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

11. Necessary preoperative treatment;

12. Treatment of burns;

13. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth;


Medically Necessary consultations with Internet Ready Preferred Physicians via the Blue Shield approved Internet portal. Internet based consultations are available to Participants only through Preferred Physicians who have agreed to provide Internet based consultations via the Blue Shield approved Internet portal (“Internet Ready”). Internet based consultations for Mental Health Conditions and Substance Abuse Conditions are not covered. Participants must be current patients of the Preferred Physician. Refer to the Online Physician Directory to determine whether a Preferred Physician is Internet Ready and how to initiate an Internet based consultation. This information can be accessed at http://www.blueshieldca.com.

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

**PROSTHETIC APPLIANCES BENEFITS**

Benefits are provided for Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized Prosthetic appliances equally appropriate for a condition, Benefits will be based on the most cost-effective Prosthetic appliance. Benefits include:

1. Tracheoesophageal voice prosthesis (e.g. Blom-Singer device, artificial larynx or other prosthetic device) for speech following laryngectomy;

2. artificial limbs and eyes;

3. internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;

4. contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia following cataract surgery when no intraocular lens has been implanted. These contact lenses will not be covered under this plan if the Member has coverage for contact lenses through a Blue Shield vision plan;

5. supplies necessary for the operation of prostheses;

6. initial fitting and replacement after the expected life of the item; and

7. repairs, except for loss or misuse.

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

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

RADIOLOGICAL AND NUCLEAR IMAGING BENEFITS

The following radiological and nuclear imaging procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by SHCA under the Benefits Management Program. Failure to obtain this authorization will result in non-payment for procedures which are determined not to be covered Services.

See the Benefits Management Program section for complete information.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and
5. Cardiac diagnostic procedure utilizing nuclear medicine.

REHABILITATION AND HABILITATION BENEFITS (PHYSICAL, OCCUPATIONAL AND RESPIRATORY THERAPY)

Rehabilitation Services include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy pursuant to a written treatment plan, and when rendered in the Provider’s office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in Speech Therapy Benefits in the Plan Benefits section.

Note: See Home Health Care Benefits in the Plan Benefits section for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

SKILLED NURSING FACILITY BENEFITS
(Other than Hospice Program Benefits which are described elsewhere under Covered Services.)

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

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

SPEECH THERAPY BENEFITS

Benefits are provided for outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist, or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, (2) evaluate the effectiveness of treatment; or (3) provide Habilitation services for the Member.

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs, and to Participants diagnosed with Mental Health Conditions and Substance Abuse Conditions.

Continued Outpatient Benefits will be provided for as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider’s treatment plan and records will be reviewed periodically for Medical Necessity. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Participant will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

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

Note: See the Home Health Care Benefits section for information on coverage for Speech Therapy Services rendered in the home, including visit limits. See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits and the Hospice Program Benefits section.

TRANSPLANT BENEFITS

Tissue and Kidney Transplants

Benefits are provided for Hospital and professional Services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient.

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

–Special Transplants

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with SHCA to provide the procedure, or in the case of Participants accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by SHCA, (2) prior authorization is obtained, in writing, from SHCA’s Medical Director and (3) the recipient of the transplant is a Participant or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.
The following procedures are eligible for coverage under this provision:

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

**PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS**

**GENERAL EXCLUSIONS AND LIMITATIONS**

Unless exceptions to the following exclusions are specifically made elsewhere in this booklet, no benefits are provided for the following services or supplies which are:

1. 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 and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Participant's home;
6. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;
7. for hearing aids;
8. for or incident to Services by Non-Preferred Providers, except as may be provided for Medically Necessary Emergency Services;
9. for 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;
10. for 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, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;
11. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;
12. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;
13. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to Medically Necessary Services which SHCA is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
14. for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
15. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
16. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;
17. which are Experimental or Investigational in nature, except for Services for Participants who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;
18. for learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary Services which SHCA is re-
quired by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

19. hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;

20. 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 Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

21. for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation 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 Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

22. incident to organ transplant, except as explicitly listed under Transplant Benefits;

23. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by SHCA consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
   - Lower eyelid blepharoplasty;
   - Spider veins;
   - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
   - Hair removal by electrolysis or other means; and
   - Reimplantation of breast implants originally provided for cosmetic augmentation; and
   - Voice modification surgery.

24. for Reconstructive Surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:
   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body.

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

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

25. for penile implant devices and surgery, and any related services, except for any resulting complications and Medically Necessary Services;

26. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;

27. for which the Participant is not legally obligated to pay, or for services for which no charge is made;

28. 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 SHCA provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by SHCA for the treatment of such injury or disease;

29. 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;

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

31. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;

32. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;

33. 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 Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
34. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) procedure, Zygote intrafallopian transfer (ZIFT) procedure, 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 Benefits under the SHCA health plan, except as specifically provided under Infertility Benefits;

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

36. massage therapy that is not Physical Therapy or a component of a multimodality rehabilitation treatment plan;

37. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Participant is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drugs Supplement or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section;

38. for services not authorized by SHCA;

39. not specifically listed as a Benefit.

**MEDICAL NECESSITY EXCLUSION**

The Benefits of this Plan are intended 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. SHCA reserves the right to review all claims to determine if a service or supply is medically necessary. SHCA may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. SHCA may limit or exclude benefits for services which are not necessary.

**LIMITATIONS FOR DUPLICATE COVERAGE**

**When you are eligible for Medicare**

1. Your Blue Shield group plan will provide benefits before Medicare in the following situations:
   a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
   b. When you are eligible for Medicare due to disability, if the Participant is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
   c. When you are eligible for Medicare solely due to end-stage renal disease during the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.

2. Your Blue Shield group plan will provide benefits after Medicare in the following situations:
   a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
   b. When you are eligible for Medicare due to disability, if the Participant is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
   c. When you are eligible for Medicare solely due to end-stage renal disease after the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
   d. When you are retired and age 65 years or older.

When your Blue Shield group plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield group plan may be lower but will not exceed the Medicare allowed amount. Your Blue Shield group plan Deductible and Copayments will be waived.

**When you are eligible for Medi-Cal**

Medi-Cal always provides benefits last.

**When you are a qualified veteran**

If you are a qualified veteran your Blue Shield group plan will pay the reasonable value or SHCA’s Allowable Amount for covered Services provided to you 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, your Blue Shield group plan will pay the reasonable value or SHCA’s Allowable Amount for covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

**When you are covered by another government agency**

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group plan will equal, but not exceed, what SHCA would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or SHCA’s Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how SHCA coordinates your group plan benefits in the above situations.
EXCEPTION FOR OTHER COVERAGE

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

CLAIMS REVIEW

Claims for Services received from Non-Participating/Non-Preferred Providers must be received within 12 months of the date of service to be considered for payment. SHCA reserves the right to review all claims to determine if any exclusions or other limitations apply. SHCA may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

REDUCTIONS – THIRD PARTY LIABILITY

If a Participant’s injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable or paid under the Plan unless the Participant agrees in writing, in a form satisfactory to the Plan, to do all of the following:
1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;
2. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Participant’s own uninsured or underinsured motorist coverage;
3. Execute a lien in favor of the Plan for the full amount of Benefits paid by the Plan;
4. Ensure that any Recovery is kept separate from and not commingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the Plan;
5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any Recovery has been obtained;
6. Direct any legal counsel retained by the Participant or any other person acting on behalf of the Participant to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If a Participant fails to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the Plan, through deductions from future benefit payments to the Participant or others enrolled through the Participant in the Plan.

“Recovery” includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys’ fees paid or owed by the Participant or on the Participant’s behalf, and without regard to whether the Participant has been “made whole” by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in the name of the Participant, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on behalf of the Participant, such as an attorney-client trust account.

The Participant shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, the Participant shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

The Participant’s acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been “made whole” by the Recovery or that the individual’s attorneys fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys fees and costs incurred in connection with the claims against the third party.

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If the Participant receives Services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from the Participant the difference between the amount paid by the Plan and the Hospital’s reasonable and necessary charges for such Services when payment or reimbursement is received by the Participant for medical expenses. The Hospital’s right to collect shall be in accordance with California Civil Code Section 3045.1.

COORDINATION OF BENEFITS

When a Participant who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for Hospital or medical expenses, such
Participant will not be permitted to make a “profit” on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for “allowable expenses” (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the covered Participant is also entitled to benefits under any of the conditions as outlined under the “Limitations for Duplicate Coverage” provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of benefit payments:

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

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the Dependent child of a Participant whose date of birth, excluding year of birth, occurs earlier in a Calendar Year, will determine its benefits before a plan which covers the Dependent child of a Participant whose date of birth, excluding year of birth, occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the plan which does not have the provisions of this paragraph will determine the order of benefits.

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

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

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

   a. a plan covering a Participant as a laid-off or retired Employee, or as a Dependent of that Participant will determine its benefits after any other plan covering that Participant as an Employee, other than a laid-off or retired Employee, or such Dependent; and

   b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

If this Plan is the primary carrier in the case of a covered Participant, then this Plan will provide its Benefits without making any reduction because of benefits available from any other plan, except that Physician Members and other Participating Providers may collect any difference between their billed charges and this Plan’s payment, from the secondary carrier(s).

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

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, SHCA may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan to the extent of these payments.

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

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

**Termination of Benefits**

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this health Plan.
Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Plan is discontinued, (2) the last day of the month in which the Participant’s employment terminates, unless a different date has been agreed to between SHCA and your Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer; or (4) the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Participant, entry of a final decree of divorce, annulment or dissolution of marriage from the Participant. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of fees will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

SHCA may terminate your and your Dependent’s coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or SHCA or Blue Shield;

2. Permitting use of your Participant identification card by someone other than yourself or your Dependents to obtain Services; or

3. Obtaining or attempting to obtain Services under the group by means of false, materially misleading, or fraudulent information, acts or omissions.

If a written or electronic application for the addition of a newborn or a child placed for adoption is not submitted to and received by SHCA within the 31 days following that Dependent’s effective date of coverage, Benefits under this Plan will be terminated on the 31st day at 11:59 p.m. Pacific Time.

**EXTENSION OF BENEFITS**

If a Participant becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Plan terminates, SHCA will extend the Benefits of this Plan, subject to all limitations and restrictions, for covered Services and supplies directly related to the condition, illness, or injury causing such Total Disability until the first to occur of the following: (1) 12 months from the date coverage terminated; (2) the date the covered Participant is no longer Totally Disabled; (3) the date on which the covered Participant’s maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Participant. The time the Participant was covered under this Plan will apply toward the replacement plan’s pre-existing condition exclusion.

No extension will be granted unless SHCA receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by SHCA.

**GROUP CONTINUATION COVERAGE**

**CONTINUATION OF GROUP COVERAGE**

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

Applicable to Participants when the Participant’s Employer is subject to Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, a Participant will be entitled to elect to continue group coverage under this Plan if the Participant would otherwise lose coverage because of a Qualifying Event that occurs while the Employer is subject to the continuation of group coverage provisions of COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Participant if the Qualifying Event had not occurred (including any changes in such coverage).

Under COBRA, a Participant is entitled to benefits if at the time of the qualifying event such Participant is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

**Qualifying Event**

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the Participant:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.

2. With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Participant or Domestic Partner during a COBRA continuation period may be immediately added as Dependents, provided the Employer is properly notified of the birth or placement
for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

a. the death of the Participant; or

b. the termination of the Participant’s employment (other than by reason of such Participant’s gross misconduct); or

c. the reduction of the Participant’s hours of employment to less than the number of hours required for eligibility; or

d. the divorce or legal separation of the Participant from the Dependent spouse or termination of the domestic partnership; or

e. the Participant’s entitlement to benefits under Title XVIII of the Social Security Act (“Medicare”); or

f. a Dependent child’s loss of Dependent status under this Plan.

3. With respect to a Participant who is covered as a retiree, that retiree’s Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA.

**Notification of a Qualifying Event**

The Participant is responsible for notifying the Employer of divorce, legal separation, or a child’s loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Participant’s death, termination, or reduction of hours of employment, the Participant’s Medicare entitlement or the Employer’s filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Participant by first class mail of the Participant’s right to continue group coverage under this Plan. The Participant must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Participant’s right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Participant does not notify the COBRA administrator within 60 days, the Participant’s coverage will terminate on the date the Participant would have lost coverage because of the Qualifying Event.

**Duration and Extension of Continuation of Group Coverage**

In no event will continuation of group coverage under COBRA be extended for more than 18 or 36 months (depending on Qualifying Event) from the date the Qualifying Event has occurred which originally entitled the Participant to continue group coverage under this Plan. However, if you or a family member becomes disabled at any time either before becoming eligible for COBRA continuation coverage or within the first 60 days of being covered by COBRA continuation coverage, you may be able to extend the maximum period of COBRA continuation coverage of 18 months, by up to an additional 11 months.

**Payment of Dues**

Dues for the Participant continuing coverage shall be 102 percent of the applicable group dues rate, except for the Participant who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

If the Participant is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all dues contributions to SHCA in the manner and for the period established under this Plan.

**Effective Date of the Continuation of Coverage**

The continuation of coverage will begin on the date the Participant’s coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

**Termination of Continuation of Group 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:

1. discontinuance of this group health plan (if the Employer continues to provide any group benefit plan for employees, the Participant may be able to continue coverage with another plan);

2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to Blue Shield as applicable. Coverage will end as of the end of the period for which dues were paid;

3. the Participant becomes covered under another group health plan;

4. the Participant becomes entitled to Medicare;

5. the Participant commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA will not be terminated except as described in this provision.
CONTINUATION OF GROUP COVERAGE FOR PARTICIPANTS ON MILITARY LEAVE

Continuation of group coverage is available for Participants on military leave if the Participant’s Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Participants who are planning to enter the Armed Forces should contact their Employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

GENERAL PROVISIONS

LIABILITY OF PARTICIPANTS IN THE EVENT OF NON-PAYMENT BY SHCA

In accordance with SHCA and Blue Shield's established policies, and by statute, every contract between Blue Shield and its Participating Providers and Preferred Providers stipulates that the Participant shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Participant's Plan. Participating Providers and Preferred Providers have agreed to accept the Plan’s payment as payment-in-full for covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Participant is responsible for all amounts Blue Shield of California does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Participant is responsible for any charges above the Benefit maximums.

INDEPENDENT CONTRACTORS

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

NON-ASSIGNABILITY

Coverage or any Benefits of this Plan may not be assigned without the written consent of SHCA. Possession of an ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Participant must be a Participant or Dependent who has been accepted by the Employer and enrolled by SHCA and who has maintained enrollment under the terms of this Plan.

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

If the Participant receives Services from a Non-Preferred Provider, the Participant is responsible for payment to the Non-Preferred Provider, except for Medically Necessary Services for Emergency Services. The Participant or the provider of Service may not request that the payment be made directly to the provider of Service.

PLAN INTERPRETATION

SHCA shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan. SHCA shall exercise this authority for the benefit of all Participants entitled to receive Benefits under this Plan.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

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

Blue Shield’s policies and procedures regarding our confidentiality/privacy practices are contained in the “Notice of Privacy Practices”, which you may obtain either by calling the Customer Service Department at the number listed on the back of this booklet, or by accessing Blue Shield’s internet site located at http://www.blueshieldca.com and printing a copy.

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

Correspondence Address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540
Toll-Free Telephone:
1-888-266-8080
Email Address:
blueshieldca_privacy@blueshieldca.com
ACCESS TO INFORMATION

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

RIGHT OF RECOVERY

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

CUSTOMER SERVICE

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact SHCA Member Care Services at 1-855-345-7422.

The hearing impaired may contact the Customer Service Department through Blue Shield’s toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

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

SETTLEMENT OF DISPUTES

INTERNAL APPEALS

INITIAL INTERNAL APPEAL

If a claim has been denied in whole or in part by SHCA, you, a designated representative, a provider or an attorney on your behalf may request that SHCA give further consideration to the claim by contacting the Customer Service Department via telephone or in writing including any additional information that would affect the processing of the claim. SHCA will acknowledge receipt of an appeal within 5 calendar days. Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be filed within 180 days after you receive notice of an adverse benefit decision. Appeals are resolved in writing within 30 days from the date of receipt by SHCA.

FINAL INTERNAL APPEAL

If you are dissatisfied with the initial internal appeal determination by SHCA, the determination may be appealed in writing to SHCA within 60 days after the date of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish SHCA to consider. SHCA shall notify you in writing of the results of its review and the specific basis therefore. In the event SHCA finds all or part of the appeal to be valid, SHCA, on behalf of the Employer, shall reimburse you for those expenses which the Claim Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days from the date of receipt by SHCA. Written requests for final internal appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

EXPEDITED APPEAL (INITIAL AND FINAL)

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. SHCA will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon
as possible to accommodate your condition, not to exceed 72 hours. To request an expedited decision, you, a designat-
ed representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Final Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health.

**EXTERNAL REVIEW**

**STANDARD EXTERNAL REVIEW**

If you are dissatisfied with the final internal appeal determin-
ation, and the determination involves medical judgment or a rescission of coverage, you, a designated representative, a provider or an attorney on your behalf may request an external review within four months after notice of the final internal appeal determination. Instructions for filing a request for external review will be outlined in the final internal appeal response letter.

**EXPEDITED EXTERNAL REVIEW**

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the adverse benefit decision without participating in the initial or final internal appeal process. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may fax a request to (916) 350-7585, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California  
Attn: Expedited External Review  
P.O. Box 5588  
El Dorado Hills, CA 95762-0011

**OTHER RESOURCES TO HELP YOU**

For questions about your appeal rights, or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**ERISA INFORMATION**

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 plan may have other voluntary alternative dispute resolution options, such as mediation.

For ERISA information refer to the Educated Choices Summary Plan Description (SPD). You can find the SPD online at [http://benefits.stanford.edu](http://benefits.stanford.edu). You can download a copy or request one by phone at (650) 736-2985 or (650) 926-2356 for SLAC employees.

**DEFINITIONS**

**PLAN PROVIDER DEFINITIONS**

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

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

**Doctor of Medicine** — a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

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

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

**Hospital**

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

2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

**Non-Participating Home Health Care and Home Infusion Agency** — an agency which has not contracted with Blue Shield.

**Non-Participating/Non-Preferred Providers** — any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Deductible, Co-payment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services. Certain services of this Plan are not covered if the service is provided by a Non-Participating/Non-Preferred Provider.
Non-Preferred Hemophilia Infusion Provider — a provider that has not contracted with Blue Shield to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has not been designated as a contracted hemophilia infusion product provider by Blue Shield. Note: Non-Preferred Hemophilia Infusion Providers may include Participating Home Health Care and Home Infusion Agency Providers if that provider does not also have an agreement with Blue Shield to furnish blood factor replacement products and services.

Other Providers —

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

2. Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

Participating Ambulatory Surgery Center — an Outpatient surgery facility which:

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

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

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

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with Blue Shield to furnish services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion agency by Blue Shield. (See Non-Participating Home Health Care and Home Infusion agency definition above.)

Participating Hospice or Participating Hospice Agency — an entity which: 1) provides Hospice services to Terminally Ill Participants and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice Service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Participating Physician — a selected Physician or a Physician Member that has contracted with Blue Shield to furnish Services and to accept Blue Shield's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

Participating Provider — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted with Blue Shield to furnish Services and to accept Blue Shield's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services.

Note: This definition does not apply to Hospice Program Services. For Participating Providers for Hospice Program Services, see the Participating Hospice or Participating Hospice Agency definitions above.

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

Physician Member — a Doctor of Medicine who has enrolled with Blue Shield as a Physician Member.

Preferred Dialysis Center — a dialysis services facility which has contracted with Blue Shield to provide dialysis Services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Laboratory Facility (Laboratory Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with Blue Shield to provide laboratory services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Radiology Facility (Radiology Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with Blue Shield to provide radiology services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hemophilia Infusion Provider — a provider that has contracted with Blue Shield to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has been designated as a contracted Hemophilia Infusion Provider by Blue Shield.

Preferred Hospital — a Hospital under contract to Blue Shield which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by Blue Shield.
Preferred Provider — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider.

Primary Care Physician - a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with SHCA as a Primary Care Physician to provide primary care to Participants and to refer, authorize, supervise and coordinate the provision of all Benefits to Participants in accordance with the contract.

Primary Care Physician Service Area - that geographic area served by your SHCA Primary Care Physician.

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

Specialist — a Physician other than a Primary Care Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with SHCA to provide Covered Services to Participants either according to an authorized referral by a Primary Care Physician, or for OB/GYN Physician Services.

ALL OTHER DEFINITIONS

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

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

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

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

Allowable Amount — Blue Shield of California Allowance (as defined below) for the Service (or Services) rendered, or the provider’s billed charge, whichever is less. Blue Shield of California Allowance, unless otherwise specified for a particular service elsewhere in this booklet, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield of California have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a non-participating/non-preferred provider (excluding a Hospital/Outpatient Facility) in California who provides non-Emergency Services, the amount Blue Shield of California would have allowed for a Participating Provider performing the same service in the same geographical area.

3. For a non-participating/non-preferred provider (excluding a Hospital/Outpatient Facility) who provides Emergency Services, the Reasonable and Customary Charge.

4. For a Hospital/Outpatient Facility that is a Non-Participating/Non-Preferred Provider in California who provides Emergency or non-Emergency Services, the amount negotiated by Blue Shield of California.

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

6. For a non-participating provider (i.e., that does not contract with Blue Shield of California or a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides non-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. If the local plan has no non-participating provider allowance, Blue Shield of California will assign the Allowable Amount used for a Non-Participating/Non-Preferred Provider in California.

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

Benefits (Services) — those Services which a Participant is entitled to receive pursuant to the Plan Document.

Calendar Year — a period beginning on January 1 of any year and terminating on January 1 of the following year.

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

Claims Administrator — the claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

Close Relative — the spouse, Domestic Partner, children, brothers, sisters, or parents of a covered Participant.

Copayment — the amount that a Participant is required to pay for specific Covered Services after meeting any applicable Deductible.
Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those Services which a Participant is entitled to receive pursuant to the terms of the Plan Document.

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

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

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

Dependent —
1. a Participant’s legally married spouse who is:
   a. not covered for Benefits as a Participant; and
   b. not legally separated from the Participant; or,
2. a Participant’s Domestic Partner who is not covered for Benefits as a Participant; or,
3. a child of, adopted by, or in legal guardianship of the Participant, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Participant, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Participant who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by Blue Shield as a Dependent and has maintained participation in accordance with the Blue Shield Plan.

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

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:
   a. the child must be chiefly dependent upon the Participant, spouse, or Domestic Partner for support and maintenance;
   b. the disability existed before reaching age 19;
   c. the Participant, spouse, or Domestic Partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and
   d. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield on the following schedule:
      (1) within 24 months after the month when the Dependent would otherwise have been terminated; and
      (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner — A person who is of the same or opposite sex as that of the eligible Participant, who (1) is involved in a long-term committed relationship of indefinite duration, (2) meets the definition of Partner (as defined by the Stanford University Domestic Partner policy), and (3) together with the Participant has completed and signed a "Certification of Domestic Partnership" form available in the Stanford Office of Total Compensation.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, and other items that Blue Shield determines are Durable Medical Equipment.

Emergency Services — services provided for an emergency medical condition, including a psychiatric emergency medical condition, or active labor, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:
1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.
Employer — is Stanford University and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for benefits under the Plan.

Enrollment Date — the first day of coverage, or if there is a waiting period, the first day of the waiting period (typically, date of hire).

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Participant and all enrolled Dependents.

Habilitation Services — Medically Necessary services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health care condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Respite care, day care, recreational care, Residential Care, social services, Custodial Care, or education services of any kind are not considered Habilitative Services.

Incurred — a charge will be considered to be “Incurred” on the date the particular service or supply which gives rise to it is provided or obtained.

Infertility — the Participant must actively be trying to conceive and has:

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
4. failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (the initial six cycles are not a benefit of this Plan); or
5. three or more pregnancy losses.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent shall not be considered a Late Enrollee if any of the following paragraphs (1.), (2.), (3.), (4.), (5.), (6.) or (7.) is applicable:

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
   a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and
   b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan’s coverage, exhaustion of COBRA continuation coverage, cessation of an employer’s contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
   d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and the eligible Employee elects this Plan during an open enrollment period; or
3. 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 within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or

5. For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or

6. For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or

7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Medical Necessity (Medically Necessary) —

The Benefits of this Plan are provided only for Services which are medically necessary.

1. Services which 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:
   a. consistent with Blue Shield medical policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
   d. furnished at the most appropriate level which 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 which are medically necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the 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 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; and
   e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.

4. Blue Shield reserves the right to review all claims to determine whether services are medically necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Mental Health Condition — mental disorders listed in the most current edition of the “Diagnostic & Statistical Manual of Mental Disorders” (DSM), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Service Administrator (MHSA) — Blue Shield of California has contracted with the Plan’s MHSA to manage Blue Shield’s Mental Health Services as described under the Benefits Management Program section of this booklet.

Mental Health Services — Services provided to treat a Mental Health Condition and Substance Abuse Condition.

Non-Routine Outpatient Mental Health Services – Outpatient Facility and professional services for the diagnosis and treatment of Mental Health Conditions, including but not limited, to the following:
1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
5) Transcranial Magnetic Stimulation
6) Behavioral Health Treatment
7) Psychological Testing

These services may also be provided in the office, home, or other non-institutional setting.
Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist, or other appropriately licensed Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient’s ability to function.

Open Enrollment Period — that period of time set forth in the plan document during which eligible employees and their Dependents may transfer from another health benefit plan sponsored by the employer to SHCA Plan.

Orthosis (Orthotics) — an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable body parts.

Outpatient — an individual receiving services but not as an Inpatient.

Partial Hospitalization Program (Day) Treatment — an Outpatient treatment program that may be free-standing or Hospital-based and provides Services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following stabilization.

Participant — an employee who has been accepted by the Employer and enrolled by Blue Shield as a Participant and who has maintained enrollment in accordance with this Plan.

Physical Therapy — treatment provided by a registered physical therapist, certified occupational therapist or other appropriately licensed Health Care Provider. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient’s musculoskeletal, neuromuscular and respiratory systems.

Plan — the Stanford Hospitals and Clinics SHCA Benefit Plan which is a part of the Stanford University Educated Choices Flexible Benefits Program.

Plan Administrator — is Stanford Hospitals and Clinics.

Plan Document — the document issued by the Plan that establishes the services that Participants and Dependents are entitled to receive from the Plan.

Plan Sponsor — is the Board of Trustees of the Leland Stanford Junior University, responsible for funding the payment of benefits or claims for benefits under this plan.

Preventive Health Services — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically listed below:

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. With respect to women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at http://www.blueshieldca.com/preventive or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1. through 4. above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation.

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

Prosthesis (Prosthetics) — an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Reasonable and Customary Charge — in California: The lower of (1) the provider’s billed charge, or (2) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a non-Plan Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider’s training and experience, and the geographic area where the services are rendered; outside of California: The lower of (1) the provider’s billed charge, or, (2) the amount, if any, established by the laws of the state to be paid for Emergency Services, if applicable.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible; dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

Rehabilitation — Inpatient or Outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses, in order to develop or restore an individual’s ability to function to the maximum extent practical.
Rehabilitation Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

Residential Care — Mental Health Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Participants who do not require acute Inpatient care.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient’s pulmonary function.

Routine Outpatient Mental Health Services – professional office visits for the diagnosis and treatment of Mental Health Conditions including the individual, family, or group setting.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who
1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child’s age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
   (a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;
   (b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes medically necessary healthcare services and medically necessary supplies furnished incident to those services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:
1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;
2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Physician and provided by a licensed speech pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient’s vocal or swallowing skills which have been impaired by diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Substance Abuse Condition — for the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

Total Disability (or Totally Disabled) —
1. in the case of an Employee or Participant otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;
2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.
### Participant Calendar Year

<table>
<thead>
<tr>
<th>Brand Name Drug Deductible</th>
<th>Deductible Responsibility</th>
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<tbody>
<tr>
<td>Per Participant</td>
<td>Participating Pharmacy</td>
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<td>$0</td>
</tr>
<tr>
<td>There is no Brand Name Drug deductible requirement.</td>
<td>Non-Participating Pharmacy</td>
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### Participant Maximum Lifetime Benefits

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<th>Infertility Drugs</th>
<th>Lifetime Maximum Blue Shield Payment</th>
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<tr>
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<td>Participating Pharmacy</td>
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<tr>
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<td>$5,000 per Participant</td>
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<td>Non-Participating Pharmacy</td>
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### Benefit

<table>
<thead>
<tr>
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<th>Participant Copayment</th>
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<td>Participating Pharmacy</td>
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<td>Non-Participating Pharmacy¹</td>
</tr>
<tr>
<td></td>
<td>Participant pays copayment below plus 25% of billed charges:</td>
</tr>
</tbody>
</table>

#### Retail Prescriptions

- **Contraceptive Drugs and Devices²**
  - Participating Pharmacy: $0 per prescription
  - Non-Participating Pharmacy: Applicable Retail Drug Tier Copayment applies.

- **Formulary Generic Drugs**
  - Participating Pharmacy: $10 per prescription
  - Non-Participating Pharmacy: $10 per prescription

- **Formulary Brand Name Drugs**
  - Participating Pharmacy: $30 per prescription
  - Non-Participating Pharmacy: $30 per prescription

- **Non-Formulary Brand Name Drugs**
  - Participating Pharmacy: $75 per prescription
  - Non-Participating Pharmacy: $75 per prescription

- **Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs**
  - Participating Pharmacy: $30 per prescription
  - Non-Participating Pharmacy: Not covered

- **Smoking Cessation Drugs**
  - Participating Pharmacy: $10 per prescription
  - Non-Participating Pharmacy: $10 per prescription

#### Mail Service Prescriptions

- **Contraceptive Drugs and Devices²**
  - Participating Pharmacy: $0 per prescription
  - Non-Participating Pharmacy: Not covered

- **Formulary Generic Drugs**
  - Participating Pharmacy: $20 per prescription
  - Non-Participating Pharmacy: Not covered

- **Formulary Brand Name Drugs**
  - Participating Pharmacy: $60 per prescription
  - Non-Participating Pharmacy: Not covered

- **Non-Formulary Brand Name Drugs**
  - Participating Pharmacy: $150 per prescription
  - Non-Participating Pharmacy: Not covered

¹ To obtain prescription Drugs at a Non-Participating Pharmacy, the Participant must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. Participant Copayment not to exceed billed charges.

² If a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Participant will be responsible for paying the difference between the cost for the Brand Name contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization to be covered without a Copayment.

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan’s prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
Outpatient Prescription Drug Benefits

The following prescription drug benefit is separate from the health plan coverage. The Coordination of Benefits provision does not apply to this Outpatient Prescription Drug Benefit; however, the general provisions and exclusions of the plan document shall apply.

Benefits are provided for Outpatient prescription Drugs, which meet all of the requirements specified in this supplement, are prescribed by a Physician, except as noted below, and are obtained from a licensed Pharmacy.

Blue Shield’s Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Blue Shield Outpatient Prescription Drug Benefit. Non-Formulary Drugs may be covered subject to higher Copayments. Select Drugs and Drug dosages and most Home Self-Administered Injectable medications require prior authorization by Blue Shield for Medical Necessity, including appropriateness of therapy and efficacy of lower cost alternatives. You and your Physician may request prior authorization from Blue Shield.

Coverage for selected Drugs may be limited to a specific quantity as described in “Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill”.

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield’s Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield’s Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most Generic Drugs. The fact that a Drug is listed on the Blue Shield Formulary does not guarantee that a Participant’s Physician will prescribe it for a particular medical condition.

Benefits may be provided for Non-Formulary Drugs subject to higher Copayments.

Participants may access the Drug Formulary at http://www.blueshieldca.com. Participants may also call Customer Service at the number provided on the back of this Benefit Booklet to inquire if a specific drug is included in the Formulary or to obtain a printed copy.

Definitions

Anticancer Medications — Drugs used to kill or slow the growth of cancerous cells.

Brand Drugs — Drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which has the same brand as that of the manufacturer with the original FDA approval.

Diabetic Drugs and Supplies — Medications and supplies used in the treatment and monitoring of Diabetes. These medications may be administered orally or by injection and supplies may include lancets, lancet puncture devices, and blood and urine testing strips and test tablets.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips and test tablets), (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B, (6) contraceptive Drugs and devices, including female OTC contraceptive drugs and devices, including diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives and emergency contraceptives, including female OTC contraceptive products when ordered by a Physician, (7) inhalers and inhaler spacers for the management and treatment of asthma, and (8) infertility drugs.

Note: To be considered for coverage, all Drugs require a valid prescription by the Participant’s Physician.

Formulary — a comprehensive list of Drugs maintained by Blue Shield’s Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent or authorized generic to the Brand Drug, (2) contain the same active ingredient as the Brand Drug, and (3) typically cost less than the Brand Drug equivalent.

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

Network Specialty Pharmacy — select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs.
To select a Specialty Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Customer Services number on your Blue Shield Identification Card.

**Non-Formulary Drugs** — Drugs determined by Blue Shield’s Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary drug alternatives. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

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

**Participating Pharmacy** — a pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Participants. Note: The Mail Service Pharmacy is a Participating Pharmacy.

To select a Participating Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Customer Service number on your Identification Card.

**Obtaining Outpatient Prescription Drugs at a Participating Pharmacy**

To obtain Drugs at a Participating Pharmacy, the Participant must present his Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Identification Card will be denied.

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

The Participant is responsible for paying the applicable Copayment for each prescription Drug at the time the Drug is obtained.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Participant will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Participant’s Copayment, the Participant will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Drug Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Participating Pharmacy at the time the Drug is obtained, until the Brand Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

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

If the prescribing Physician requests a Brand Name Drug when a Generic Drug equivalent is available, the Participant is responsible for paying the applicable Brand Drug Copayment.

**Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy**

To obtain prescription Drugs at a Non-Participating Pharmacy, the Participant must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The Participant will be reimbursed as shown on the Summary of Benefits based on the price actually paid for the Drugs. Claims must be received within 1 year from the date of service to be considered for payment.

When Drugs are obtained at a Non-Participating Pharmacy for a covered emergency, the Participant must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting “emergency request” on the form to Pharmacy Services -Emergency Claims, P. O. Box 7168, San Francisco, CA  94120. The Participant will be reimbursed the purchase price of covered prescription Drug(s) minus the Brand Name Drug Deductible for Brand Name Drugs (when applicable) and any applicable Copayment(s). Claim forms may be obtained from the Blue Shield Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

**Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program**

When Drugs have been prescribed for a chronic condition, a Participant may obtain the Drug through Blue Shield’s Mail Service Prescription Drug Program by enrolling online or by phone or mail. Participants should allow up to 14 days to receive the Drugs. The Participant’s Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Home Self-Administered Injectables, are not available through the Mail Service Prescription Drug Program.

The Participant is responsible for the applicable Mail Service Prescription Drug Copayment for each prescription Drug.

For more information about the Mail Service Prescription Drug Program or to determine applicable cost share, Participants may visit www.blueshieldca.com/bsca/pharmacy/home.sp or call the Customer Service number on your ID card.
Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Participant will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate is less than or equal to the Participant's Copayment, the Participant will only be required to pay the Participating Pharmacy's contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Brand Name Drug to the Mail Service Pharmacy prior to your prescription being sent to you until the Brand Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

If the Participant requests a Mail Service Brand Drug when a Mail Service Generic Drug is available, the Participant is responsible for the difference between the contracted rate for the Mail Service Brand Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

If the prescribing Physician requests a Mail Service Brand Drug when a Mail Service Generic Drug is available, the Participant is responsible for the difference between the cost to Blue Shield for the Brand Name Drug to the Mail Service Pharmacy prior to your prescription being sent to you until the Brand Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

Prior Authorization Process for Select Formulary, Non-Formulary and Home Self-Administered Injectables

Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compounded drugs are covered only if the requirements listed under the Exclusion section of this Supplement are met. If a compounded medication is approved for coverage, the Non-Formulary Brand Drug Copayment applies. You or your 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. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment will be assessed for each 30-day supply. Some prescriptions are limited to a maximum allowed quantity based on Medical Necessity.

2. Designated Home Self-Administered Injectables 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 Home Self-Administered Injectable Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Home Self-Administered Injectable 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 Home Self-Administered Injectable 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.

3. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Participant’s Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.

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

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

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 your Benefit Booklet – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage 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 Participant is an Inpatient, or in a Physician’s office, Skilled Nursing Facility, or Outpatient Facility (see the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Benefit Booklet);

3. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facility (see the Hospital Benefits (Facility Services) and Skilled Nursing Facility Benefits sections of your Benefit Booklet);

4. Except as specifically listed as covered under this Outpatient Prescription Drug Benefit, drugs 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 Participant 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 herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections of your Benefit Booklet). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;

8. Blood or blood products (see the Hospital Benefits (Facility Services) section of your Benefit Booklet);

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 (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections of your Benefit Booklet);

11. Any drugs which are not self-administered. These medications may be covered under the Other Outpatient Services, Hospice Program Services Benefits, and the Family Planning and Infertility Services Benefits sections of the health plan;

12. 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;

13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a Physician, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: refer to your medical Benefits for coverage of other contraceptive methods;

14. 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) medical literature supports its use for requested diagnosis;

15. Replacement of lost, stolen or destroyed prescription Drugs;

16. For Members enrolled in a Hospice Program through a Participating Hospice Agency only pharmaceuticals that are medically necessary for the palliation and management of Terminal Illness and related conditions are excluded from coverage under the Outpatient Prescription Drug Benefits, and are covered under the Hospice Program Benefits;

17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection medications prescribed to treat pain, or drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;

18. Drugs obtained from a Pharmacy not licensed by the National Association of Boards of Pharmacists, unless Medically Necessary for a covered Emergency;

19. 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;

20. 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.

21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).
# PRIOR AUTHORIZATION LIST

The following services are subject to prior authorization requirements. When submitting a request, please send pertinent medical records, treatment plans, test results, and evidence of conservative treatment to support the medical appropriateness of the request. All services performed by Non-SHCA providers require prior authorization.

<table>
<thead>
<tr>
<th>CATEGORY DESCRIPTION</th>
<th>SPECIFIC SERVICE</th>
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<tbody>
<tr>
<td>Ambulance Service</td>
<td>Air Transportation</td>
</tr>
<tr>
<td>Inpatient Behavioral Health and/or Substance Abuse Services</td>
<td>Contact Blue Shield of California’s Mental Health Services Administrator for Behavioral Health and/or Substance Abuse Services at (800) 378-1109.</td>
</tr>
<tr>
<td>Autism Spectrum Disorders-ABA Therapy only</td>
<td>Contact Blue Shield/Magellan Health Services for Autism Spectrum Disorders at (877) 263-9952</td>
</tr>
<tr>
<td>Biofeedback Therapy</td>
<td>Biofeedback Therapy</td>
</tr>
<tr>
<td>Cancer Clinical Trials</td>
<td>All codes requested as part of a Cancer Clinical Trial</td>
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</table>
| Durable Medical Equipment / Orthotics & Prosthetics | Airway Clearance Devices in the Outpatient Setting  
Continuous Glucose Monitoring Systems  
Cranial Remodeling Orthoses  
Electrical Bone Growth Stimulation  
External Insulin infusion Pump  
Incontinence Treatment System  
Knee Braces  
Lower Limb Prostheses  
Myoelectric Upper Limb Prostheses  
Power and custom wheelchair  
Ultrasound bone growth stimulation  
Vacuum-assisted closure (VAC)/negative pressure wound therapy (NPWT) for wound care |
| Genetic Testing                       | BRCA for breast and ovarian cancer, colorectal cancer screening, Tier 1 and Tier 2 Molecular pathology procedures for gene specific and genomic testing |
| Injectables / Infusions               | Injectable Bulking Agent  
Factor for the treatment of Hemophilia (Must use BS Hemophilia Vendor CVS/Caremark at 800-237-2767 or Walgreens at 866-202-4014)  
Injectable Medications commonly requested include: Eylea, Lucentis, Prolia, Remicade, Humira, Cimzia, Simponi, Enbrel, Rituxan Orencia, Epogen-Aranesp, Botox, Xiaflex. Refer to the BSC Injectable Appendix for a complete listing of office and self-injectables requiring prior-authorization. Self-injectables are administered through Blue Shield’s outpatient pharmacy program. For office injectables, providers may use Blue Shield’s preferred vendors: CVS/Caremark &/or Walgreen’s or their in-office stock. |
| Intensity Modulated Radiation Therapy (IMRT) | IMRT Services  
Reproductive medicine procedures to include culture of oocytes, oocyte identification, oocyte fertilization, embryo hatching, cryopreservation and thawing of oocyte |
| Infertility Services/Reproductive Medicine | Acute rehabilitation facility  
Inpatient Hospice  
Inpatient hospital  
Skilled Nursing Facility (SNF) |
| Investigational/Experimental services | Investigational/Experimental Services |
| Out-of Network/Non-Par Providers       | Referrals to and services by Non-SHCA providers                                  |
| Outpatient Radiology                  | All computed tomography (CT) scans, including cerebral perfusion analysis CT, Ultrafast CT heart, heart scan, electron beam CT, coronary artery Ca score  
All Magnetic Resonance Angiography (MRA)  
All Magnetic Resonance Imaging (MRI)  
All Positron emission tomography (PET)  
MUGA scan  
MR Cholangiopancreatography |
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<tr>
<th>CATEGORY DESCRIPTION</th>
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<tr>
<td>Outpatient Services</td>
<td>Actigraphy</td>
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<td>Autologous Chondrocyte Implantation (ACI)</td>
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<td>Artificial Intervertebral Disc</td>
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<td>Bariatric Surgery</td>
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<td>Blepharoplasty: Eye Lid and Brow Surgeries</td>
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<td></td>
<td>Breast Duct Cytology and Endoscopy</td>
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<td>Breast reductions and/or augmentation</td>
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<td>Carotid Intima-Media Thickness Measurement</td>
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<td>Cochlear and Auditory Brainstem Implants</td>
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<td>Deep Brain Stimulation</td>
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<td></td>
<td>Endoscopic Injection</td>
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<td></td>
<td>Extracorporeal Shock Wave Therapy for Musculoskeletal Conditions and Plantar Fasciitis Treatment</td>
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<td>General anesthesia for routine dental procedures performed in an outpatient surgery center or facility</td>
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<td></td>
<td>Hyperbaric Oxygen Therapy (HBOT)</td>
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<td>Neuromuscular and Functional Electrical Stimulation</td>
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<td>Oral/Maxillofacial and Orthognathic Procedures</td>
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<td></td>
<td>Panniculectomy, Abdominoplasty and Surgical Management of Diastasis Recti</td>
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<td>Posterior Tibial Nerve Stimulation (PTNS)</td>
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<td>Radioembolization of Liver Tumors (SIRT)</td>
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<td>Rhinoplasty</td>
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<td>Transplant Evaluation</td>
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<td>Transplant Related Services (including cadaver prep)</td>
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<tr>
<td></td>
<td>UPPP/UVPP (uvulopalatopharyngoplasty, uvulopharyngoplasty)</td>
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<tr>
<td></td>
<td>Varicose Vein Treatments</td>
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<td>Wireless Capsule Endoscopy</td>
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<td>Pain Management Procedures</td>
<td>Epidural Injections</td>
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<td>Facet Joint Injections</td>
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<td>Spinal Cord Stimulator</td>
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<td>Radiation Therapy</td>
<td>Brachytherapy for Oncologic Indications</td>
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<tr>
<td>Reconstructive Surgery</td>
<td>Cleft Palate</td>
</tr>
</tbody>
</table>

**Services that do NOT require Prior Authorization when performed by an SHCA In-Network provider, but DO require Notification to SHCA:**

- Dialysis Services
- Maternity Care (at the time of the first prenatal visit)

Providers can submit notification to SHCA through the IKA web portal at https://affinity-portals.ikaenterprise.com or by fax to AMS at (510) 662-3492. For assistance, Providers may contact SHCA at 855-900-SHCA (7422).
The SHCA Service Area consists of the zip codes of cities listed on the chart below.

The following Zip Codes are included in the SHCA Plan Service Area

<table>
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<tr>
<th>ZIP</th>
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For claims submission and information contact Blue Shield of California.

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

Participants may call SHCA Member Care Services:

1-855-345-SHCA (7422)  

BSC Customer Service Department toll free:

1- 800-873-3605  

The hearing impaired may call Customer Service through the toll-free TTY number:

1-800-241-1823  

Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the SHCA Member Care Services telephone number listed above.