Shield PPO℠
Needles

Combined Evidence of Coverage and Disclosure Form

County of San Bernardino

Group Number: 970661

Effective Date: July 26, 2014

An independent member of the Blue Shield Association

Grandfathered Health Plan Notice

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the Customer Service Department number on your identification card. If you obtain this plan/policy through the County and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NON-DISCRIMINATION

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

NOTICE

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

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

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Blue Shield Customer Service at the address or telephone number listed at the back of this booklet.

PLEASE NOTE

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

The Blue Shield PPO Health Plan

Subscriber Bill of Rights

As a Blue Shield PPO Plan Subscriber, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your PPO Health Plan, the Services we offer you, the Physicians and other practitioners available to care for you.
5. Have reasonable access to appropriate medical services.
6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive Preventive Health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
12. Communicate with and receive information from Customer Service in a language you can understand.
13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
14. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
15. Voice complaints or grievances about the PPO Health Plan or the care provided to you.
16. Participate in establishing Public Policy of the Blue Shield PPO, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.
17. Make recommendations regarding Blue Shield's Member rights responsibilities policy.

The Blue Shield PPO Health Plan

Subscriber Responsibilities

As a Blue Shield PPO Plan Subscriber, you have the responsibility to:

1. Carefully read all Blue Shield PPO materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield PPO membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement.
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 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 the Blue Shield PPO Plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
11. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
12. Treat all Plan personnel respectfully and courteously as partners in good health care.
13. Pay your Premiums, Copayments and charges for non-covered services on time.
14. For all Mental Health Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all non-Emergency Inpatient Mental Health Services.
15. Follow the provisions of the Blue Shield Benefits Management Program.

Table of Contents

PPO Summary of Benefits 7
Introduction to the Blue Shield of California PPO Plan 19
Blue Shield of California Preferred Providers 19
Continuity of Care by a Terminated Provider 20
Financial Responsibility for Continuity of Care Services 20
Submitting a Claim Form 20
Eligibility 21
Effective Date of Coverage 22
Renewal of Group Health Service Contract 22
Prepayment Fee 22
Plan Changes 23
Services for Emergency Care 23
Utilization Review 23
Second Medical Opinion Policy 23
Health Education and Health Promotion Services 23
Retail-Based Health Clinics 23
NurseHelp 24/7SM and LifeReferrals 24/7 24
Blue Shield Online 24
Benefits Management Program 24
Prior Authorization 24
Hospital and Skilled Nursing Facility Admissions 26
Emergency Admission Notification 26
Hospital Inpatient Review 26
Discharge Planning 27
Case Management 27
Additional and Reduced Payments for Failure to Use the Benefits Management Program 27
Deductible 28
Calendar Year Deductible (Medical Plan Deductible) 28
Services Not Subject to the Deductible 28
Prior Carrier Deductible Credit 28
No Member Maximum Lifetime Benefits 28
No Annual Dollar Limit on Essential Benefits 28
Payment 28
Subscriber's Maximum Calendar Year Copayment Responsibility 30
Principal Benefits and Coverages (Covered Services) 30
Acupuncture Benefits 30
Allergy Testing and Treatment Benefits 30
Ambulance Benefits 30
Ambulatory Surgery Center Benefits 30
Bariatric Surgery Benefits for Residents of Designated Counties in California 31
Chiropractic Benefits 32
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Benefits 32
Diabetes Care Benefits 33
Dialysis Center Benefits 33
Durable Medical Equipment Benefits 33
Emergency Room Benefits 34
Eye Examination Benefit 34
Family Planning Benefits 35
Home Health Care Benefits 35
Home Infusion/Home Injectable Therapy Benefits 35
Hospice Program Benefits 36
Hospital Benefits (Facility Services) 38
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits 39
Mental Health Benefits 40
Orthotics Benefits 41
Outpatient X-ray, Pathology and Laboratory Benefits 41
PKU Related Formulas and Special Food Products Benefits 41
Podiatric Benefits 41
Pregnancy and Maternity Care Benefits 42

Table of Contents

Preventive Health Benefits 42
Professional (Physician) Benefits 42
Prosthetic Appliances Benefits 43
Radiological and Nuclear Imaging Benefits 43
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) 43
Skilled Nursing Facility Benefits 44
Speech Therapy Benefits 44
Transplant Benefits – Cornea, Kidney or Skin 44
Transplant Benefits - Special 44
PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS 45
General Exclusions and Limitations 45
Medical Necessity Exclusion 48
Limitations for Duplicate Coverage 48
Exception for Other Coverage 49
Claims Review 49
Reductions – Third Party Liability 49
Coordination of Benefits 50
TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS 51
Termination of Benefits 51
Reinstatement, Cancellation and Rescission Provisions 52
Grace Period 53
Extension of Benefits 53
GROUP CONTINUATION COVERAGE AND INDIVIDUAL CONVERSION PLAN 53
Continuation of Group Coverage 53
Continuation of Group Coverage for Members on Military Leave 55
Availability of Blue Shield of California Individual Plans 55
Individual Conversion Plan 56
GENERAL PROVISIONS 56
Liability of Subscribers in the Event of Non-Payment by Blue Shield 56
Independent Contractors 57
Non-Assignability 57
Plan Interpretation 57
Public Policy Participation Procedure 57
Confidentiality of Personal and Health Information 57
Access to Information 58
Right of Recovery 58
CUSTOMER SERVICE 58
GRIEVANCE PROCESS 59
External Independent Medical Review 59
Department of Managed Health Care Review 60
DEFINITIONS 60
Plan Provider Definitions 60
All Other Definitions 62
NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES 69
SUPPLEMENT A — OUTPATIENT PRESCRIPTION DRUG BENEFITS 70
SUPPLEMENT B — SUBSTANCE ABUSE CONDITION BENEFITS 75

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

The group contract is on file with the County and a copy will be furnished upon request.

This is a Preferred Provider Plan. Benefits, particularly the payment provisions, differ from other Blue Shield of California plans. Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

Please read this Evidence of Coverage and Disclosure Form booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

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

IMPORTANT

No Member 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 group contract.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the group contract 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.

Note: The following Summary of Benefits contains the Benefits and applicable Co-payments of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, Benefits and exclusions of the Plan.

PPO Summary of Benefits

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

Summary of Benefits

Shield PPO

Member Calendar Year Deductible[1] (Medical Plan Deductible)	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Calendar Year Medical Deductible	None per Member / None per Family with two Family members / None per Family with three or more Family members	$250 per Member / $500 per Family with two Family members / $750 per Family with three or more Family members

Member Maximum Calendar Year Co-payment Responsibility[2]	Member Maximum Calendar Year Copayment[2, 3]	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers**
Calendar Year Copayment Maximum	$1,500 per Member / $3,000 per Family	$2,250 per Member / $4,750 per Family

Member Maximum Lifetime Benefits	Maximum Blue Shield Payment	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Additional Payment(s)
Additional Payment(s) for Failure to Utilize the Benefits Management Program
Refer to the Benefits Management Program section for any additional payments which may apply.

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Acupuncture Benefits		
Acupuncture by a licensed acupuncturist	You pay nothing[4]	You pay nothing[4]
Acupuncture by Doctors of Medicine	You pay nothing	30%
Up to a maximum of 20 visits per Member per Calendar Year for any combination of Covered Services by a Doctor of Medicine or licensed acupuncturist If your Plan has a Calendar Year medical Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Allergy Testing and Treatment Benefits		
Allergy Injection Services (serum not included)	$10 per visit	$10 per visit
Allergy serum purchased separately for treatment	$10 per visit	30%
Office visits (includes visits for allergy serum injections)	$10 per visit	30%
Ambulance Benefits		
Emergency or authorized transport	You pay nothing[6]	You pay nothing[6]
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. 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.		
Ambulatory Surgery Center Outpatient Surgery facility Services	You pay nothing	30%
Ambulatory Surgery Center Outpatient Surgery Physician Services	You pay nothing	30%
Bariatric Surgery All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.	**Services by Preferred and Participating Providers**	**Services by Non-Preferred and Non-Participating Providers[5]**
Bariatric Surgery Benefits for residents of designated counties in California All bariatric surgery Services for residents of designated counties in California must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See the Bariatric Surgery Benefits section, the paragraphs under Bariatric Surgery Benefits For Residents of Designated Counties in California, in Principal Benefits and Coverages (Covered Services) for a description.		
Hospital Inpatient Services	You pay nothing	Not covered
Hospital Outpatient Services	You pay nothing	Not covered
Physician bariatric surgery Services	You pay nothing	Not covered
Bariatric Surgery Benefits for residents of non-designated counties in California		
Hospital Inpatient Services	You pay nothing	30%
Hospital Outpatient Services	You pay nothing	30%
Physician bariatric surgery Services	You pay nothing	30%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Chiropractic Benefits		
Chiropractic Services Covered Services rendered by a chiropractor. Up to a Benefit maximum of 30 visits per Member per Calendar Year. If your Plan has a Calendar Year medical Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	$10 per visit	30%
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits		
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Services for routine patient care, not including research costs, will be paid on the same basis and at the same Benefit levels as other covered Services shown in this Summary of Benefits. The research costs may be covered by the clinical trial sponsor.	You pay nothing	You pay nothing
Diabetes Care Benefits		
Devices, equipment and supplies	You pay nothing[7]	30%
Diabetes self-management training provided by a Physician in an office setting	$10 per visit	30%
Diabetes self-management training provided by a registered dietician or registered nurse that are certified diabetes educators	$10 per visit	30%
Dialysis Center Benefits		
Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	You pay nothing	30%
Durable Medical Equipment Benefits		
Breast pump	You pay nothing	Not covered
Other Durable Medical Equipment	You pay nothing	30%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Emergency Room Benefits		
Emergency room Physician Services Note: After Services have been provided, Blue Shield 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 at the applicable Preferred and Non-Preferred Provider levels as specified under Outpatient Physician Services Benefit in the Professional (Physician) Benefits in this Summary of Benefits and will be subject to any Calendar Year medical Deductible.	You pay nothing	You pay nothing
Emergency room Services not resulting in admission Note: After Services have been provided, Blue Shield 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 at the applicable Preferred and Non-Preferred Provider levels as specified under Hospital Benefits (Facility Services), Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies in this Summary of Benefits and will be subject to any Calendar Year medical Deductible.	$50 per visit	$50 per visit
Emergency room Services resulting in admission (Billed as part of Inpatient Hospital Services)	You pay nothing	You pay nothing[8]
	Services by Vision Plan Administrator's Providers Only	**Services by Non-Preferred and Non-Participating Providers[5]**
Eye Examination Benefits		
One comprehensive eye examination in a consecutive 12-month period For visits to Non-Participating Providers, the maximum per Member per Calendar Year reimbursement is $60 for an ophthalmologic exam and $50 for an optometric exam.	$10 per visit	Maximum Benefit payment of $60 for an ophthalmologic exam and $50 for an optometric exam

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Family Planning Benefits Note: Copayments listed in this section are for Outpatient Physician Services only. If Services are performed at a facility (Hospital, Ambulatory Surgery Center, etc), the facility Copayment listed under the appropriate facility benefit in this Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), intrauterine device (IUD), and tubal ligation.		
Cervical Cap	You pay nothing	30%
Counseling and consulting (Including physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	You pay nothing	30%
Diaphragm fitting procedure	You pay nothing	30%
Elective abortion	$150 per surgery	30%
Implantable contraceptives	You pay nothing	30%
Injectable contraceptives	You pay nothing	$10 per injection
Insertion and/or removal of Intrauterine Device (IUD)	You pay nothing	30%
Intrauterine device (IUD)	You pay nothing	30%
Tubal ligation	You pay nothing	50%
Vasectomy	$75 per surgery	50%
Home Health Care Benefits		
Home health care agency Services (including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist) Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. If your Plan has a Calendar Year medical Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	You pay nothing	Not covered[9]
Medical supplies	You pay nothing	Not covered[9]
Home Infusion/Home Injectable Therapy Benefits		
Hemophilia home infusion Services provided by a hemophilia infusion provider and prior authorized by the Plan. Includes blood factor product.	You pay nothing	Not covered
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit if selected as an optional Benefit by your Employer, and are described in a Supplement included with this booklet.	You pay nothing	Not covered[9]
Home visits by an infusion nurse Home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation	You pay nothing	Not covered[9]

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program. All Hospice Program Benefits must be prior authorized by the Plan and must be received from a Participating Hospice Agency.		
24-hour Continuous Home Care	You pay nothing	Not covered[10]
General Inpatient care	You pay nothing	Not covered[10]
Inpatient Respite Care	You pay nothing	Not covered[10]
Pre-hospice consultation	You pay nothing	Not covered[10]
Routine home care	You pay nothing	Not covered[10]
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	You pay nothing	You pay nothing
Inpatient non-Emergency Facility Services Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section. Prior authorization required by the Plan.	You pay nothing	30%
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Calendar Year per Member 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. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	You pay nothing	30%
Inpatient Services to treat acute medical complications of detoxification	You pay nothing	30%
Outpatient diagnostic testing X-Ray, diagnostic examination and clinical laboratory services Note: These Benefits are for diagnostic, non-preventive health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits.	You pay nothing	30%
Outpatient dialysis Services	You pay nothing	30%
Outpatient Services for surgery and necessary supplies	You pay nothing	30%
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	You pay nothing	30%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits 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.)		
Ambulatory Surgery Center Outpatient Surgery facility Services	You pay nothing	30%
Inpatient Hospital Services	You pay nothing	30%
Office location	$10 per visit	30%
Outpatient department of a Hospital	You pay nothing	30%
Mental Health Benefits **All Services provided through the Plan's Mental Health Service Administrator (MHSA)**	**Services by MHSA Participating Providers**	**Services by MHSA Non-Participating Providers[11]**
Mental Health Benefits[12, 13]		
Behavioral Health Treatment - home or other setting (non-institutional)	You pay nothing	Not covered
Behavioral Health Treatment - office location	You pay nothing (first three visits); thereafter, $10 per visit	30%
Inpatient Hospital Services	You pay nothing	30%[14]
Inpatient Professional (Physician) Services	You pay nothing	30%
Outpatient Mental Health Services, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT)	You pay nothing (first three visits); thereafter, $10 per visit[15]	30%[15]
Outpatient Partial Hospitalization	You pay nothing[16]	30% per episode[16]
Psychological Testing	You pay nothing	30%
Psychosocial support through LifeReferrals 24/7	You pay nothing	You pay nothing
Transcranial Magnetic Stimulation	You pay nothing (first three visits); thereafter, $10 per visit	30%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Orthotics Benefits		
Office visits	$10 per visit	30%
Orthotic equipment and devices	You pay nothing	30%
Outpatient Prescription Drug Benefits Outpatient Prescription Drug coverage if selected as an optional Benefit by your Employer, is described in a Supplement included with this booklet.		
Outpatient X-Ray, Pathology, Laboratory Benefits 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. For Benefits for diagnostic radiological procedures such as CT scans, MRIs, MRAs, PET scans, etc. see the Radiological and Nuclear Imaging Benefits section of this Summary of Benefits. Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.		
Outpatient Laboratory Center or Outpatient Radiology Center Note: Preferred Laboratory Centers and Preferred Radiology Centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital. Laboratory and radiology Services obtained from a Hospital or Hospital affiliated laboratory and radiology center will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) of this Summary of Benefits.	You pay nothing[7, 17]	30%[7, 17]
PKU Related Formulas and Special Food Products Benefits		
PKU Related Formulas and Special Food Products	You pay nothing	You pay nothing
Podiatric Benefits		
Podiatric Services provided by a licensed doctor of podiatric medicine	$10 per visit	30%
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Covered Services section. When covered, Services will pay as any other surgery as noted in this Summary of Benefits.		
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	You pay nothing	30%
Prenatal and postnatal Physician office visits (including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy)	$10 per visit	30%
Preventive Health Benefits		
Preventive Health Services See the description of Preventive Health Services in the Definitions section for more information.	You pay nothing	30%

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Professional (Physician) Benefits		
Inpatient Physician Services For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section	You pay nothing	30%
Injections other than self injectables	$10 per visit	$10 per visit
Outpatient Physician Services, other than an office setting	You pay nothing	30%
Physician home visits	$10 per visit	30%
Physician office visits Note: For other Services with the office visit, you may incur an additional Benefit Copayment as listed for that Service within this Summary of Benefits. This additional Benefit Copayment may be subject to the Plan's medical Deductible. Additionally, certain Physician office visits may have a Copayment amount that is different from the one stated here. For those Physician office visits, the Copayment will be as stated elsewhere in this Summary of Benefits.	$10 per visit	30%
Prosthetic Appliances Benefits		
Office visits	$10 per visit	30%
Prosthetic equipment and devices	You pay nothing	30%
Radiological and Nuclear Imaging Benefits 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 by the Plan.		
Outpatient department of a Hospital Prior authorization required by the Plan.	You pay nothing	30%[17]
Radiology Center Note: Preferred Radiology Centers may not be available in all areas. Prior authorization required by the Plan.	You pay nothing[17]	30%[17]

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:		
Office location	$10 per visit[4, 7]	30%
Outpatient department of a Hospital	$10 per visit[4, 7]	30%
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services.	You pay nothing	30%
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days. Up to a maximum of 100 days per Calendar Year per Member 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. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	You pay nothing[4]	You pay nothing[4]
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Calendar Year per Member 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. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	You pay nothing[4]	You pay nothing[4]

Benefit	Member Copayment[3]	
	Services by Preferred, Participating, and Other Providers[4]	**Services by Non-Preferred and Non-Participating Providers[5]**
Speech Therapy Benefits Speech Therapy Services by a Doctor of Medicine or licensed speech pathologist or licensed speech therapist in the following settings:		
Office location – Services by a Doctor of Medicine	$10 per visit[7]	30%
Office visit – Services by a licensed speech pathologist or licensed speech therapist	$10 per visit[4, 7]	$10 per visit[4, 7]
Outpatient department of a Hospital	$10 per visit[4, 7]	30%
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	You pay nothing	30%
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days. Up to a maximum of 100 days per Calendar Year per Member 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. If your Plan has a Calendar Year medical Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	You pay nothing[4]	You pay nothing[4]
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin.		
Hospital Services	You pay nothing	30%
Professional (Physician) Services	You pay nothing	30%
Transplant Benefits - Special Note: Blue Shield requires prior authorization from Blue Shield's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield. Plese see the Transplant Benefits – Special portion of the Principal Benefits (Covered Services) section in the Evidence of Coverage for important information on this benefit.		
Facility Services in a Special Transplant Facility	You pay nothing	Not covered
Professional (Physician) Services	You pay nothing	Not covered

Summary of Benefits

Footnotes:

[1] There is no Calendar Year deductible for covered Services received from Preferred Providers and MHSA Participating Providers. The Calendar Year deductible only applies to covered Services received from Non-Preferred Providers and MHSA Non-Participating Providers. Copayments or Coinsurance paid for Covered Services will accrue to a Member Calendar Year Deductible (Medical Plan Deductible) except for the following Covered Services:

- Covered travel expenses for bariatric surgery;
- Injections other than self injectables;
- Services provided under the Outpatient Prescription Drug benefit Supplement if selected as an optional Benefit by your Employer.

[2] Copayment/Coinsurance for Covered Services accrue to the Member's maximum Calendar Year Copayment except Copayment/Coinsurance for:

- Additional and reduced payments under the Benefits Management Program;
- Charges by Non-Preferred Providers and MHSA Non-Participating Providers in excess of covered amounts;
- Charges in excess of specified benefit maximums;
- Covered travel expenses for bariatric surgery Services;
- Services provided under the Outpatient Prescription Drug benefit Supplement if selected as an optional Benefit by your Employer;
- Any optional Infertility Benefits;
- Any optional Hearing Aid Benefits.

Note: Copayments and charges for Services not accruing to the maximum Calendar Year Copayment responsibility continue to be the Member's responsibility after the Calendar Year Copayment maximum is reached.

[3] Copayments are calculated based on the Allowable Amount unless otherwise specified.

[4] "Other Providers" as defined in the Definitions section of this booklet, are not Participating or Preferred Providers. For Covered Services from Other Providers you are responsible for any Copayment and any charges above the Allowable Amount.

[5] For Covered Services from Non-Preferred and Non-Participating Providers you are responsible for a Copayment and all charges above the Allowable Amount.

[6] The Copayment will be calculated based upon the provider's billed charges or the amount the provider has otherwise agreed to accept as payment in full from the Plan, whichever is less.

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

[8] If you receive emergency room Services that are determined to not be Emergency Services and which result in admission as an Inpatient to a Non-Preferred Hospital, you will be responsible for a Non-Preferred Hospital Inpatient Services Copayment.

[9] Services from a Non-Participating Home Health Agency or Non-Participating Home Infusion Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[10] Services from a Non-Participating Hospice Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[11] For Covered Services from MHSA Non-Participating Providers you are responsible for a Copayment and all charges above the Allowable Amount.

[12] No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage is provided as an optional Benefit by your Employer. Inpatient Services to treat acute medical complications of detoxification are not considered the treatment of Substance Abuse Conditions and are covered.

[13] Prior authorization from the MHSA is required for all non-Emergency or non-Urgent Services except that no prior authorization is required for Professional (Physician) Office Visit.

[14] For Emergency Services received from a MHSA Non-Participating Hospital, your Copayment will be the MHSA Participating Provider level, based on the Allowable Amount.

[15] This Copayment includes both Outpatient facility and Professional (Physician) Services.

[16] For Outpatient Partial Hospitalization Services, an episode of care starts from the date the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates constitutes an episode of care. If the patient is readmitted at a later date, then this constitutes another episode of care.

[17] A Copayment will apply for each provider and date of service.

INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA PPO PLAN

If you have questions about your Benefits, contact Blue Shield of California before Hospital or medical Services are received.

This Plan is designed to reduce the cost of health care to you, the Subscriber. In order to reduce your costs, much greater responsibility is placed on you.

You should read your Summary of Benefits and Evidence of Coverage and Disclosure Form booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your Blue Shield of California ID card to your Physician, Hospital, or other licensed healthcare provider. Your ID card has your Subscriber and group numbers on it. Be sure to include these numbers on all claims you submit to Blue Shield of California.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Blue Shield of California Preferred Providers" section).

You are responsible for following the provisions shown in the "Benefits Management Program" section of this booklet, including:

1. You or your Physician must obtain Blue Shield of California approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services, or obtain prior approval from the Mental Health Service Administrator (MHSA) for all non-Emergency Inpatient Mental Health Services. (See the "Blue Shield of California Preferred Providers" section for information.)
2. You or your Physician must notify Blue Shield of California (or the MHSA in the case of Mental Health Services) within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Prior Authorization" in the "Benefits Management Program" section for a listing of Services requiring prior authorization.

Failure to meet these responsibilities may result in your incurring a substantial financial liability. Some Services may not be covered unless prior review and other requirements are met.

Note: Blue Shield or the MHSA 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 Subscriber 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 Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

BLUE SHIELD OF CALIFORNIA PREFERRED PROVIDERS

The Blue Shield of California Preferred Plan is specifically designed for you to use Blue Shield of California Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other Providers. Preferred Providers are listed in the Preferred Provider directories. All Blue Shield of California Physician Members are Blue Shield of California Preferred Providers. So are selected Hospitals in your community. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing Blue Shield's Internet site located at http://www.blueshieldca.com, or by calling Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by Blue Shield for services.

Blue Shield of California Preferred Providers agree to accept Blue Shield of California's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums as payment-in-full for covered Services, except as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability. This is not true of Non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision.

Blue Shield contracts with Hospitals and Physicians to provide Services to Members for specified rates. This contrac-

tual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

If you go to a Non-Preferred Provider, Blue Shield of California's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount Blue Shield of California pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying Blue Shield of California within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

For all Mental Health Services: Blue Shield of California has contracted with the Plan's MHSA. The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care, and will underwrite and deliver Blue Shield's Mental Health Services through a separate network of MHSA Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services to Blue Shield Subscribers. A Blue Shield Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of any applicable Deductible and Copayment, or amounts in excess of Benefit maximums specified, as payment-in-full for covered Mental Health Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Mental Health Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. Additionally, Subscribers may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-263-9952.

Directories of Blue Shield of California Preferred Providers located in your area have been provided to you. Extra copies are available from Blue Shield of California. If you do not have the directories, please contact Blue Shield of California immediately and request them at the telephone number listed on the last page of this booklet.

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate post-partum 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 the Blue Shield provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member 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.

Submitting a Claim Form

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by Blue Shield if Services are rendered by a Non-Preferred Provider. Payments to you for covered Services are in amounts identical to those made directly to providers. Requests for payment must be submitted to Blue Shield within 1 year after the month Services were provided. Special claim forms are not necessary, but each claim submission must contain your name, home address, group contract number, Subscriber's number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name. Blue Shield will notify you of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Blue Shield of California Subscriber's Statement of Claim form to the Blue Shield of California service center listed on the last page of this booklet.

Claim forms are available on Blue Shield's Internet site located at http://www.blueshieldca.com or you may call Blue Shield of California Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Blue Shield of California claim form.

Be sure to send in a claim for all covered Services even if you have not yet met your Calendar Year Deductible. Blue Shield of California will keep track of the Deductible for

you. Blue Shield of California uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

ELIGIBILITY

Coverage is Non-transferable

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

1. To enroll and continue enrollment, a Member must meet all of the eligibility requirements of the County of San Bernardino.

If you are an Employee that meets the County eligibility rules, you are eligible for coverage as a Subscriber the first day of the pay period following the pay period in which the Employee worked the required number of hours. 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 County's next Open Enrollment Period. Other than approved retroactive adjustments, 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 a previous employer's health plan and you apply for coverage under this Plan within 60 days of the date of loss of coverage. You will be required to furnish the County with written proof of the loss of coverage.

Newborn infants of the Subscriber, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 60 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, 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 Subscriber'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 60 days without lapse, an application must be submitted to and received by the County within 60 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 60 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 60 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.

Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of both parents.

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 County 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 County or by Blue Shield. 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 Member 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 Member; or

      (3) substantially impairs the ability of providers of Services to furnish Services to the Member 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.

EFFECTIVE DATE OF COVERAGE

Subject to the County's eligibility and enrollment rules, coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:00 a.m. Pacific Time on the eligibility date established by the County.

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 60 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 County's next Open Enrollment Period. Other than approved retroactive adjustments, 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 60 days from the date of loss of coverage. You will be required to furnish the County 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 60 days. The effective date of enrollment for both you and your Dependents will be the first day of the pay period following the pay period in which the qualifying event occurred.

Once each Calendar Year, the County will designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer to another health plan sponsored by the County.

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 60 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 Subscriber, 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 60 days without lapse, a written application must be submitted to and received by the County within 60 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 coverage must be provided by your County sponsored group health coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective within 60 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 County's next Open Enrollment Period.

RENEWAL OF GROUP HEALTH SERVICE CONTRACT

Blue Shield of California will offer to renew the Group Health Service Contract except in the following instances:

1. non-payment of Premiums (see "Termination of Benefits", and "Reinstatement, Cancellation and Rescission Provisions");
2. fraud, misrepresentations or omissions;
3. failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4. termination of plan type by Blue Shield;
5. association membership ceases.

All groups will renew subject to the above.

PREPAYMENT FEE

The monthly Premiums for you and your Dependents are indicated in your Employer's group Contract. The initial Premiums are payable on the effective date of the group Contract, and subsequent Premiums are payable on the same date (called the transmittal date) of each succeeding month. Premiums are payable in full on each transmittal date and must be made for all Subscribers and Dependents.

All Premiums required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield of California. Payment of Premiums will continue the Benefits of this group Contract up to the

date immediately preceding the next transmittal date, but not thereafter.

The Premiums payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. Your Employer will receive notice from the Plan of any changes in Premiums at least 60 days prior to the change. Your Employer will then notify you immediately. Note: This paragraph does not apply to a Subscriber who is enrolled under a contract where monthly Premiums automatically increase, without notice, the first day of the month following an age change that moves the Subscriber into the next higher age category.

PLAN CHANGES

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

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

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, and annual Copayment maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days' written notice of any such change.

Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

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.

Members 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.

UTILIZATION REVIEW

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

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

To request a copy of the document describing this Utilization Review process, 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.

Remember that the second opinion visit is subject to all Plan contract Benefit limitations and exclusions.

HEALTH EDUCATION AND HEALTH PROMOTION SERVICES

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

RETAIL-BASED HEALTH CLINICS

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com. See the Blue Shield of California Preferred Providers section for information on the advantages of choosing a Preferred Provider.

NURSEHELP 24/7SM AND LIFEREFERRALS 24/7

If you are unsure about what care you need, you should contact your Physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by 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.

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

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

These programs include:

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

Psychosocial support through LifeReferrals 24/7 - Members may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling. Note: See Principal Benefits and Coverages (Covered Services), the Mental Health Benefits section for important information concerning this feature.

BLUE SHIELD ONLINE

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

BENEFITS MANAGEMENT PROGRAM

Blue Shield 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 Blue Shield.

Certain portions of the Benefits Management Program also contain Additional and Reduced Payment requirements for either not contacting Blue Shield or not following Blue Shield's recommendations. Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in reduced payment or non-payment if Blue Shield determines the service was not a covered Service. 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.

Blue Shield requires prior authorization for selected Inpatient and Outpatient services, supplies and Durable Medical Equipment; admission into an approved Hospice Program; and certain radiology procedures. Prior authorization 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 Blue Shield 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 Blue Shield. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

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 Blue Shield as described below or failure to follow the recommendations of Blue Shield for Covered Services will result in a reduced payment per procedure as described in the section entitled Additional and Reduced Payments for 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.

You or your Physician must call the Customer Service telephone number indicated on the back of the Member's iden-

tification card for prior authorization for the services listed in this section except for the Outpatient radiological procedures described in item 10. below. For prior authorization for Outpatient radiological procedures, you or your Physician must call 1-888-642-2583.

Blue Shield 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.

   Members who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from Blue Shield in order for the routine patient care delivered in a clinical trial to be covered.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for Hospice Program Benefits and Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits above will result in non-payment of services by Blue Shield.

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.

   Note: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the Physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield for select injectable drugs may result in non-payment by Blue Shield if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.

4. Home Health Care Benefits from Non-Preferred Providers.

5. Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers.

6. 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).

7. Reconstructive Surgery.

8. Arthroscopic surgery of the temporomandibular joint (TMJ) Services.

9. Hemophilia home infusion products and Services.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for:

injectable drugs administered in the Physician office setting,
Home Health Care Benefits from Non-Preferred Providers,
Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers,
Durable Medical Equipment Benefits,
Reconstructive Surgery,
arthroscopic surgery of the TMJ services, and
hemophilia home infusion products and supplies

as described above may result in non-payment of services by Blue Shield.

10. 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.

    Prior authorization is not required for these radiological services when obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this booklet for an explanation of how payment is made for out of state services.

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

12. All bariatric surgery.

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

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

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for:

Outpatient radiological procedures as specified above,
Special Transplant Benefits,
all bariatric surgery,
Hospital and Skilled Nursing Facility admissions,
and
dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures

as described above will result in a reduced payment as described in the Additional and Reduced Payments for Failure to Use the Benefits Management Program section or may result in non-payment if Blue Shield determines that the service is not a covered Service.

Other specific services and procedures may require prior authorization as determined by Blue Shield. A list of ser-

vices and procedures requiring prior authorization can be obtained by your provider by going to http://www.blueshieldca.com or by calling the Customer Service telephone number indicated on the back of the Member's identification card.

Hospital and Skilled Nursing Facility Admissions

Prior authorization must be obtained from Blue Shield 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 Services described later in this section.

Prior Authorization for Other than Mental Health Admissions

Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician must contact Blue Shield at the Customer Service telephone number indicated on the back of the Member's identification card at least 5 business days prior to the admission. However, in case of an admission for Emergency 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. Blue Shield 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 Blue Shield as described or failure to follow the recommendations of Blue Shield will result in an additional payment per admission as described in the Additional and Reduced Payments for Failure to Use the Benefits Management Program section or may result in reduction or non-payment by Blue Shield if it is determined that the admission is not a covered Service.*

*Note: For admissions for special transplant Benefits and for bariatric Services for residents of designated counties, failure to receive prior authorization in writing and/or failure to have the procedure performed at a Blue Shield-designated facility will result in non-payment of services by Blue Shield. See Transplant Benefits and Bariatric Surgery Benefits for Residents of Designated Counties in California under the Covered Services section for details.

Prior Authorization for Inpatient Mental Health Services

All Inpatient Mental Health Services except for Emergency Services, must be prior authorized by the MHSA.

For an admission for Emergency Mental Health Services, the MHSA 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 the Subscriber may be responsible for the additional payment as described below.

For prior authorization of Inpatient Mental Health Service, call the MHSA at 1-877-263-9952.

Failure to contact Blue Shield or the MHSA as described above or failure to follow the recommendations of Blue Shield will result in an additional payment per admission as described in the Additional and Reduced Payments for Failure to Use the Benefits Management Program section or may result in reduction or non-payment by Blue Shield or the MHSA if it is determined that the admission is not a covered Service. Note: Blue Shield or the MHSA 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 Subscriber 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 Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

Emergency Admission Notification

If you are admitted for Emergency 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 you may be responsible for the additional payment as described under the Additional and Reduced Payments for Failure to Use the Benefits Management Program section.

Hospital Inpatient Review

Blue Shield 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 Member 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, Blue Shield 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 a Blue Shield 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. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other Member 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 Blue Shield's right to thereafter administer this health Plan in strict accordance with its express terms.

ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM

For non-emergency services, additional payments may be required, or payments may be reduced, as described below, when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization and Hospital and Skilled Nursing Facility Admissions sections of the Benefits Management Program. These additional payments will be required in addition to any applicable Calendar Year Deductible, Copayment and amounts in excess of Benefit dollar maximums specified and will not be included in the calculation of the Subscriber's maximum Calendar Year Copayment responsibility.

1. Failure to contact Blue Shield as described under the Prior Authorization for Other than Mental Health Admissions section of the Benefits Management Program or failure to follow the recommendations of Blue Shield will result in an additional payment per Hospital or Skilled Nursing Facility admission as described below or may result in reduction or non-payment by Blue Shield if it is determined that the admission is not a covered Service.

   - *$250 per Hospital or Skilled Nursing Facility admission.

Only one $250 additional payment will apply to each Hospital admission for failure to follow the Benefits Management Program notification requirements or recommendations.

2. Failure to contact the MHSA for Inpatient Services as described under the Prior Authorization for Inpatient Mental Health Services section or for Substance Abuse Conditions as specified below, or failure to follow the recommendations of the MHSA will result in an additional payment per admission as described below or may result in reduction or non-payment by the MHSA if it is determined that the admission is not a covered Service.

   - *$250 per Hospital admission for Inpatient Care for diagnosis or treatment of Mental Health conditions;
   - *$250 per Hospital admission for the diagnosis or treatment of Substance Abuse Conditions if substance abuse coverage is selected as an optional Benefit by the County. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

   *Only one $250 additional payment will apply per Hospital admission for failure to notify or to follow a recommendation of the MHSA.

3. Failure to obtain prior authorization for the radiological procedures listed in the Benefits Management Program section under Prior Authorization or to follow the recommendations of Blue Shield will result in reduced payment amounts described below per procedure and may result in non-payment for procedures which are determined not to be covered Services.

4. For other covered Services requiring prior authorization that are not authorized in advance, the amount payable will be reduced by 50% after the calculation of the Deductible and any applicable Copayments required by this Plan. You will be responsible for the remaining 50% and applicable Deductible and/or Copayments;

For Services provided by a Non-Preferred Provider, the Subscriber will also be responsible for all charges in excess of the Allowable Amount.

DEDUCTIBLE

CALENDAR YEAR DEDUCTIBLE (MEDICAL PLAN DEDUCTIBLE)

The Calendar Year per Member and per Family Deductible amounts are shown on the Summary of Benefits. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductible. The Deductible must be satisfied once during each Calendar Year by or on behalf of each Member separately, except that the Deductible shall be deemed satisfied with respect to the Subscriber and all of his covered Dependents collectively after the Family Deductible amount has been satisfied. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 60 days even if application is not made to add the child as a Dependent on the Plan.

SERVICES NOT SUBJECT TO THE DEDUCTIBLE

The Calendar Year Deductible applies to all covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

PRIOR CARRIER DEDUCTIBLE CREDIT

If you satisfied all or part of a medical Deductible under a health plan sponsored by the County or under an Individual and Family Health Plan (IFP) issued by Blue Shield during the same Calendar Year this Plan becomes effective, that amount will be applied to the medical Deductible required under this Plan.

Note: This Prior Carrier Deductible Credit provision applies only to new Employees who are enrolling on the original effective date of this Plan, if this health Plan allows credit of the medical Deductible from the County's previous health plan.

NO MEMBER 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 LIMIT ON ESSENTIAL BENEFITS

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

PAYMENT

The Subscriber 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 of California calculates the Subscriber'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 Subscriber'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.

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 to the local Blue Cross and/or Blue Shield plan, or to Blue Shield of California for payment. Blue Shield will notify you of its determination within 30 days after receipt of the claim. Blue Shield will pay you at the Non-Preferred Provider benefit level. Remember, your copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield of California 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 Subscriber'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 of California, the out-of-area provider should call the Customer Service telephone number indicated on the back of the Member's 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 Services received outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free BlueCard Program Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven 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 of California at the Customer Service telephone number indicated on the back of the Member's 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.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

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

Inter-Plan Programs

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.

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.

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, Blue Shield will remain responsible for fulfilling our contractual obligations. 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 healthcare 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 healthcare services according to applicable law.

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

Subscriber's Maximum Calendar Year Copayment Responsibility

1. The per Member and per Family maximum Copayment responsibility each Calendar Year for covered Services rendered by Preferred Providers, MHSA Participating Providers and Other Providers is shown on the Summary of Benefits.
2. The per Member and per Family maximum Copayment responsibility each Calendar Year for covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers, MHSA Participating and Non-Participating Providers and Other Providers is shown on the Summary of Benefits.

Once a Member's maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Member'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 Subscriber'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, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and reduced payments Incurred under the Benefits Management Program are the Subscriber's responsibility and are not included in the maximum Calendar Year Copayment responsibility.

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

Charges for these items may cause a Subscriber's payment responsibility to exceed the maximums.

Copayments and charges for Services not accruing to the Subscriber's maximum Calendar Year Copayment responsibility continue to be the Subscriber's responsibility after the Calendar Year Copayment 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 Contract, 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, Blue Shield will provide Benefits based on the most cost-effective service.

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

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Subscribers will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Subscriber Copayment.

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.

Acupuncture Benefits

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.) or a licensed acupuncturist up to a per Member per Calendar Year Benefit maximum as shown on the Summary of Benefits.

Allergy Testing and Treatment Benefits

Benefits are provided for allergy testing and treatment.

Ambulance Benefits

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary 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 18 months 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 Member is under the age of seven or developmentally disabled regardless of age or when the Member'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 of California 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 for Residents of Designated Counties in California

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric Services*, Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1. performed at a Preferred bariatric surgery Services Hospital or Ambulatory Surgery Center and by a Preferred bariatric surgery Services Physician that have contracted with Blue Shield to provide the procedure; and,
2. they are consistent with Blue Shield's medical policy; and,
3. prior authorization is obtained, in writing, from Blue Shield's Medical Director.

*See the list of designated counties below.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric Benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and Blue Shield medical policy.

For Members who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred bariatric surgery Services Hospital by a Preferred bariatric surgery Services Physician will result in denial of claims for this benefit.

Note: Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must be provided by a Preferred Bariatric Surgery Services Physician, whether performed in a Preferred Bariatric Surgery Services Hospital, a qualified Ambulatory Surgery Center, or the Preferred Bariatric Surgery Services Physician's office.

The following are designated counties in which Blue Shield has contracted with facilities and physicians to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement for Residents of Designated Counties in California

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric Services at a Preferred bariatric surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Preferred bariatric surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. for the Member for a maximum of 3 trips:
      1 trip for a pre-surgical visit,
      1 trip for the surgery, and
      1 trip for a follow-up visit.
   b. for one companion for a maximum of 2 trips:
      1 trip for the surgery, and
      1 trip for a follow-up visit.
2. Hotel accommodations not to exceed $100 per day:
   a. for the Member and one companion for a maximum of 2 days per trip:

1 trip for a pre-surgical visit, and

1 trip for a follow-up visit.

b. for one companion for a maximum of 4 days for the duration of the surgery admission.

All hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3. Related expenses judged reasonable by Blue Shield not to exceed $25 per day per Member up to a maximum of 4 days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Calendar Year Deductible and do not accrue to the Subscriber's maximum Calendar Year Copayment responsibility.

Note: Bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described 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 Blue Shield's Medical Director.

For Members who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

CHIROPRACTIC BENEFITS

Benefits are provided for Medically Necessary Chiropractic Services rendered by a chiropractor. 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 Member 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 Member who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by Blue Shield, and:

1. the clinical trial has a therapeutic intent and a Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
2. the Hospital and/or Physician conducting the clinical trial is a 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.

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 when Medically Necessary:

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-assisted 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 if selected as an optional Benefit by your Employer.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Subscriber 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 Member'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 CENTER BENEFITS

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

Included in this Benefit are Medically Necessary 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 Blue Shield. 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.

Medically necessary 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 if selected as an optional Benefit by your Employer.);
3. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with 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 Members 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 Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which Blue Shield determines is not an emergency will be paid as part of the Inpatient Hospital Services. The Subscriber 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 Subscriber is responsible for the Emergency Room Subscriber Copayment plus the appropriate Admitting Hospital Services Subscriber Copayment as shown on the Summary of Benefits.

EYE EXAMINATION BENEFIT

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

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

The Plan provides payment for the following service:

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

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

REIMBURSEMENT PROVISION

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

This vision Benefit does not cover corrective lenses, frames for eye glasses, contact lenses or the fitting of contact

lenses; eye exercises; any other routine eye refractions; subnormal vision aids; vision training; any eye examination required by the County as a condition of employment; medical or surgical treatment of the eyes; Services performed by a close relative or by a person who ordinarily resides in your home; Services incident to any injury arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, or similar legislation. However, if Blue Shield provides payment for such Services, it shall be entitled to establish a lien for such other Benefits up to the amount paid by Blue Shield for treatment of the injury or disease; Services required by any government agency or program, federal, state or subdivision thereof; or Services for which no charge is made.

FAMILY PLANNING BENEFITS

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

For Family Planning Services, for Plans with a Calendar Year Deductible for Services by Preferred Providers, the Calendar Year Deductible only applies to male sterilizations and to abortions.

Note: No benefits are provided for Family Planning Services from Non-Preferred Providers. 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 diaphragm fitting or injectable 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.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by Blue Shield.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Person per Calendar Year visit maximum as shown on the Summary of Benefits.

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 Member remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the supplemental Benefit for Outpatient Prescription Drugs if selected as an optional Benefit by your Employer.

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: See the Hospice Program Services section for information about when a Member is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutritional Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing must be prior authorized by Blue Shield.

This Benefit does not include medications, drugs, Insulin, Insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefits Supplement if selected as an optional Benefit by your Employer, 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.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion Agencies must be prior authorized by Blue Shield.

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 Blue Shield (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 Customer Service at the telephone number shown on the last page of this booklet.

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

Following evaluation by your Physician, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once prior authorized by Blue Shield, 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 Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for Services in infusion suites managed by a 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 if selected as an optional Benefit by your Employer, 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 Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from Blue Shield. (Note: Members with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered 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. Members can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.

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

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Member to the extent that these needs are not met by the Member's other providers.
7. Volunteer Services.

8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. 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 Member 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.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Member 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 Member. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

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

Home Health Aide Services - services providing for the personal care of the Terminally Ill Member and the performance of related tasks in the Member's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the 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 Member to carry out the treatment plan.

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

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and 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 Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Member's death to assist the family to cope with social and emotional needs associated with the death.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.
8. Is provided through a Participating Hospice.

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

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

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

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

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

Social Service/Counseling Services - those counseling and spiritual Services that assist the Member and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

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

HOSPITAL BENEFITS (FACILITY SERVICES)

(Other than Mental Health Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, Dialysis Center Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services)

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 Subscriber, 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 Blue Shield of California 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 Blue Shield 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. 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 Member is under the age of seven or developmentally disabled regardless of age or when the Member'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 Member 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 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 of California 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 Member is under the age of seven or developmentally disabled regardless of age or when the Member'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 18 months of birth.

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

Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits

Benefits are provided for Hospital, Ambulatory Surgery Center 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 Member as determined by the Plan;

   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 BENEFITS

Blue Shield of California's MHSA administers and delivers the Plan's Mental Health Services.

All non-Emergency Inpatient Mental Health Services must be prior authorized by the MHSA including those obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this booklet for an explanation of how payment is made for out of state Services. For prior authorization, Subscribers should contact the MHSA at 1-877-263-9952. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following Medically Necessary covered Mental Health Conditions, subject to applicable Deductibles and Copayments, MHSA Participating Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit description below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet.

Benefits are provided, as described below, for the diagnosis and treatment of Mental Health Conditions. All non-Emergency Inpatient Mental Health Services must be prior authorized by the MHSA.

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

Note: For all Inpatient Hospital care, except for Emergency Services, failure to contact the MHSA prior to obtaining Services will result in the Subscriber being responsible for an Additional Payment, as outlined in the "Hospital and Skilled Nursing Facility Admissions" paragraphs of the Benefits Management Program section. No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage has been selected as an optional Benefit by the County, in which case an accompanying supplement provides the Benefit description, limitations and Copayments. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

1. Inpatient Mental Health Services

Benefits are provided for Inpatient Services in connection with hospitalization for the treatment of Mental Health Conditions. Residential care is not covered.

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

2. Outpatient Facility and Office Care

Benefits are provided for Outpatient facility and office visits for Mental Health Conditions.

3. Outpatient Hospital Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

Benefits are provided for Hospital and professional Services in connection with Partial Hospitalization, Intensive Outpatient Care and ECT for the treatment of Mental Health Conditions.

4. Psychological testing

Psychological testing is a covered Benefit when provided to diagnose a Mental Health Condition.

5. Psychosocial Support through Life Referrals 24/7

Notwithstanding the Benefits provided elsewhere in this section, the Member also may call 1-800-985-2405 on a 24-

hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

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

In the event that the Services required of a Member are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Member will be referred to the MHSA intake line to access their Mental Health Services which are described elsewhere in this section.

6. Behavioral Health Treatment

Behavioral Health Treatment is covered when prescribed by a Physician or licensed psychologist and treatment is provided under a treatment plan approved by the MHSA. Behavioral Health Treatment delivered in the home or other non-institutional setting must be obtained from MHSA Participating Providers.

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

7. Transcranial Magnetic Stimulation

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

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 orthosis is covered.

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. No benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet. 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

Benefits are provided for diagnostic X-ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Routine laboratory Services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Blue Shield of California medical policy. (Note: See the section on Pregnancy and Maternity Care Benefits 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 Blue Shield.

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 customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures provided in conjunction with this Benefit are described under the Professional (Physician) Benefits section. 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, which include prenatal care, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy, Outpatient maternity Services, involuntary complications of pregnancy, and Inpatient Hospital maternity care including labor, delivery and post-delivery care. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia. (Note: See the section on Outpatient X-ray, Pathology and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Member qualifies for an extension of Benefits as described elsewhere in this booklet.

For Outpatient routine newborn circumcisions, for the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

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

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

PREVENTIVE HEALTH BENEFITS

Preventive Health Services, as defined, are covered.

PROFESSIONAL (PHYSICIAN) BENEFITS

(Other than Preventive Health Benefits, Mental Health Benefits, Hospice Program Benefits, Dialysis Center Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services)

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 Member 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 Blue Shield of California 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 in 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 Blue Shield of California 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 Member 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 18 months of birth;

14. Diagnostic audiometry examination.

Medically Necessary Internet based consultations, available only to Members through Preferred Physicians who have agreed to provide Internet based consultations. Members must be current patients of the Preferred Physician.

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

Prosthetic Appliances Benefits

Medically Necessary 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 appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

Benefits are provided for Medically Necessary Prostheses for Activities of Daily Living, including the following:

1. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

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

Benefits are provided for contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia following cataract surgery when no intra-ocular lens has been implanted. Note: These contact lenses will not be covered under your Plan if the County provides supplemental Benefits for vision care that cover contact lenses through a vision plan purchased through Blue Shield. There is no coordination of benefits between the health Plan and the vision plan for these Benefits.

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

Radiological and Nuclear Imaging Benefits

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by Blue Shield under the Benefits Management Program. Failure to obtain this authorization will result in the Service being paid at a reduced amount or may 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. any cardiac diagnostic procedure utilizing Nuclear Medicine.

Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

Benefits are provided for Outpatient Physical, Occupational, 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 the section on Speech Therapy Benefits. Blue Shield reserves the right to periodically review the provider's treatment plan and records. If Blue Shield determines that continued treatment is not Medically Necessary, Blue Shield will notify the Subscriber of this determination and benefits will not be provided for services rendered after the date of the written notification.

Services provided by a chiropractor are not included in this Rehabilitation Benefit. See the section on Chiropractic Benefits.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation Services rendered in the home.

Note: Covered lab and X-ray Services provided in conjunction with this Benefit are paid as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

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 Member 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

Outpatient Benefits for Speech Therapy Services are covered when diagnosed and ordered by a Physician and provided by an appropriately licensed speech therapist, pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, or (2) evaluate the effectiveness of treatment, and when rendered in the provider's office or Outpatient department of a Hospital.

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 Members diagnosed with Mental Health Conditions.

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

Except as specified above and as stated under the Home Health Care Benefits and 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. See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits and the Hospice Program Benefits section.

TRANSPLANT BENEFITS – CORNEA, KIDNEY OR SKIN

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants only to the extent that:

1. they are provided in connection with the transplant of a cornea, kidney, or skin; and
2. the recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

TRANSPLANT BENEFITS - SPECIAL

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield of California to provide the procedure, or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield, (2) prior authorization is obtained, in writing, from Blue Shield's Medical Director and (3) the recipient of the transplant is a Subscriber or Dependent.

Blue Shield reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding benefits based on (1) the medical circumstances of each Member, and (2) consistency between the treatment proposed and Blue Shield medical policy. 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.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank.

PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Unless exceptions to the following exclusions are specifically made elsewhere in this booklet or the Group Health Service Contract, no benefits are provided for the following services:

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 Member'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 any services whatsoever relating to the diagnosis or treatment of any Substance Abuse Condition, unless the County has purchased substance abuse coverage as an optional Benefit, in which case an accompanying supplement provides the Benefit description, limitations and Copayments;
8. for hearing aids;
9. for mammographies, Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Preferred Providers;
10. for eye refractions (except as specifically provided under Eye Examination Benefit), surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
11. 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;
12. 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;
13. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;
14. 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;
15. 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;

16. 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 Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
17. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
18. for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;
19. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
20. which are Experimental or Investigational in nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits;
21. 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 Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
22. for hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
23. 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);
24. 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);
25. incident to organ transplant, except as explicitly listed under Transplant Benefits;
26. 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 a Blue Shield of California 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;

27. 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;

28. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
29. for which the Member is not legally obligated to pay, or for services for which no charge is made;
30. incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield of California provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield of California for the treatment of such injury or disease;
31. 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;
32. 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 Benefits, and except as provided through a Participating Hospice Agency;
33. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
34. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits;
35. 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;
36. incident to bariatric surgery Services, except as specifically provided under Bariatric Surgery Benefits for Residents of Designated Counties in California;
37. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), ser-

vices 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 Services for Pregnancy and Maternity Care under a Blue Shield health plan;

38. 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;
39. for massage therapy performed by a massage therapist;
40. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member 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;
41. not specifically listed as a Benefit.

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

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. Blue Shield of California reserves the right to review all claims to determine if a service or supply is medically necessary. Blue Shield of California may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. Blue Shield of California 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 Subscriber 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 Subscriber 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 Subscriber 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 Subscriber 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 Blue Shield'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 Blue Shield'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 Blue Shield would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield'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 Blue Shield 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

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

Claims shall be paid within 30 days from the date of receipt in accordance with the provisions contained within this Evidence of coverage. Blue Shield will provide written notice to the regarding additional information needed to determine claim amounts and responsibility.

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

REDUCTIONS – THIRD PARTY LIABILITY

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to the Member on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield's right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. Blue Shield's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield for the Benefits it paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The Member is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within 10 days after any Recovery has been obtained.

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

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

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

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or the Member's general assets and agree in writing that the portion of any Recovery required to satisfy the lien or other right of Recovery of the plan is held in trust for the sole benefit of the plan until such time it is conveyed to Blue Shield;
2. Direct any legal counsel retained by the Member or any other person acting on behalf of the Member 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.

COORDINATION OF BENEFITS

When a Member 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 Member 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 Member 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 Member as an Employee will provide its benefits before the plan covering the Member 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 Member 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 Member 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 stepparent 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 Member for the longer period of time will determine its benefits first, provided that:

   a. a plan covering a Member as a laid-off or retired Employee, or as a Dependent of that Member will determine its benefits after any other plan covering that Member 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 Member, 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 Blue Shield of California 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 Member (1) assigns to Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the benefits which Blue Shield of California actually pays and the amount that Blue Shield of California would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

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

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

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

Termination of Benefits and Cancellation 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.

Subject to the County's eligibility and enrollment rules, coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Group Health Service Contract is discontinued, (2) the last day of the pay period in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the County, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the County (see "Cancellation for Non-Payment of Premiums – Notices"), or (4) the last day of the pay period in which you or your Dependents become ineligible. A spouse or domestic partner also becomes ineligible following the entry of a final decree of divorce, dissolution of domestic partnership, annulment or dissolution of marriage from the Subscriber and coverage shall be terminated the last day of the pay period in which the qualifying event occurred.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, contact the County about possibly continuing group coverage. Also see the Individual Conversion Plan provision, and, if applicable, the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If the County 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 Premiums will keep your coverage in force for such period of time as specified in such Act(s). The County is solely responsible for notifying you of the availability and duration of family leaves.

Blue Shield of California may terminate your and your Dependent's coverage for cause immediately upon written notice to you and the County for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to the County or Blue Shield of California; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;
2. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain Services; or
3. Obtaining or attempting to obtain Services or Benefits under the Group Health Service Contract 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 Blue Shield within the 60 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 60th day at 11:59 p.m. Pacific Time.

REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS

Reinstatement

If you had been making contributions toward coverage for you and your Dependents and voluntarily cancelled such coverage, you may apply for reinstatement. You or your Dependents must wait until the earlier of 12 months from the date of application to be reinstated or at the County's next open enrollment period. Outside of approved retroactive adjustments, Blue Shield will not consider applications for earlier effective dates.

Cancellation Without Cause

This group health Plan may be cancelled by the County in accordance with contract provisions, at any time provided written notice is given to Blue Shield of California to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Non-Payment of Premiums - Notices

Blue Shield of California may cancel this group health Plan for non-payment of Premiums. If the County fails to pay the required Premiums when due, coverage will end 45 days after the date for which Premiums are due. The County will be liable for all Premiums accrued while this Plan continues in force including those accrued during the 45-day grace period and 30 day notice of intent period.

Blue Shield of California will mail the County a Notice Confirming Termination of Coverage. The County must provide you with a copy of the Notice Confirming Termination of Coverage.

In addition, Blue Shield of California will send you a HIPAA certificate which will state the date on which your coverage terminated, the reason for the termination, and the number of months of creditable coverage which you have. The certificate will also summarize your rights for continuing coverage on a guaranteed issue basis under HIPAA and on Blue Shield of California's conversion plan. For more information on conversion coverage and your rights to HIPAA coverage, please see the section on "Availability of Blue Shield of California Individual Plans".

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield of California may cancel or rescind the group contract for fraud or intentional misrepresentation of material fact by the County, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative.

If you are hospitalized or undergoing treatment for an ongoing condition and the group contract is cancelled for any reason, including non-payment of Premiums, no benefits will be provided unless you obtain an Extension of Benefits.

Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the County) may, at the discretion of Blue Shield, result in the cancellation or rescission of this group health Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

In the event the contract is rescinded or canceled, either by Blue Shield of California or the County, it is the County's responsibility to notify you of the rescission or cancellation.

Right of Cancellation

If you are making any contributions toward coverage for yourself or your Dependents, you may cancel such coverage to be effective at the end of any period for which Premiums have been paid.

This is subject to the County's eligibility guidelines.

If the County does not meet the applicable eligibility, participation and contribution requirements of the group contract, Blue Shield of California will cancel this Plan after 30 days' written notice to the County. This would be subject to the Group contract.

Any Premiums paid Blue Shield of California for a period extending beyond the cancellation date will be refunded to the County. The County will be responsible to Blue Shield of California for unpaid Premiums prior to the date of cancellation.

Blue Shield of California will honor all claims for covered Services provided prior to the effective date of cancellation.

See the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision for termination for misrepresentations of material fact or omissions.

GRACE PERIOD

After payment of the first Premiums, the County is entitled to a grace period of 45 days for the payment of any Premiums due. The County shall also be afforded a 30-day notice of intent to terminate. During this grace period and notice of intent period, the Contract will remain in force. However, the County will be liable for payment of Premiums accruing during the period the Contract continues in force. (Subject to the terms of the Letter of Agreement, Group Health Services Contract and any/all attachments and amendments)

EXTENSION OF BENEFITS

If a Member becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the group contract terminates, Blue Shield of California 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 Member is no longer Totally Disabled; (3) the date on which the covered Member's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Member.

No extension will be granted unless Blue Shield of California 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 Blue Shield of California.

GROUP CONTINUATION COVERAGE AND INDIVIDUAL CONVERSION PLAN

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 Members when the County is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The County should be contacted for more information.

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

Note: A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member 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 Subscriber:
   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 Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the County is properly notified of the birth or placement for adoption, and such children are enrolled within 60 days of the birth or placement for adoption):

*Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

a. the death of the Subscriber; or

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

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

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

e. the Subscriber'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. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the County'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 or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees:

The Member is responsible for notifying the County 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 County is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, the Subscriber's Medicare entitlement or the County'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 44 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

2. With respect to Cal-COBRA enrollees:

The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this Plan. Such notice must be given 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. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The County is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 60 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If the Member does not notify Blue Shield within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the County, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Continuation of Group Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

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

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

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

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

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

Payment of Premiums

Premiums for the Member continuing coverage shall be 102 percent of the applicable group Premiums rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Premiums rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the Premiums for months 19 through 29 shall be 150 percent of the applicable group Premiums rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, Premiums for Cal-COBRA coverage shall be 110 percent of the applicable group Premiums rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the County shall be responsible for collecting and submitting all Premiums contributions to Blue Shield of California in the manner and for the period established under this Plan.

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

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Member'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 Premiums 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 service contract (if the County continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required Premiums to the COBRA administrator or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which Premiums were paid;
3. the Member becomes covered under another group health plan;
4. the Member becomes entitled to Medicare;
5. the Member commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months (combined as applicable).

Continuation of Group Coverage for Members on Military Leave

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

Availability of Blue Shield of California Individual Plans

Blue Shield's Individual Plans described below may be available to Members whose group coverage, COBRA or Cal-COBRA coverage is terminated or expires while covered under this group Plan.

INDIVIDUAL CONVERSION PLAN

Continued Protection

Regardless of age, physical condition, or employment status, you may continue Blue Shield of California coverage when you retire, leave the job, or become ineligible for group coverage. If you have held group coverage for three or more consecutive months, you and your enrolled Dependents may apply to transfer to an individual conversion plan then being issued by Blue Shield.

The County is solely responsible for notifying you of the availability, terms, and conditions of the individual conversion plan within 15 days of termination of the Plan contract.

An application and first Premiums payment for the individual conversion plan must be received by Blue Shield of California within 63 days of the date of termination of your group coverage. However, if the group contract is replaced by the County with similar coverage under another contract within 15 days, transfer to the individual conversion health plan will not be permitted. You will not be permitted to transfer to the individual conversion plan under any of the following circumstances:

1. You failed to pay amounts due the Plan;
2. You were terminated by the Plan for good cause or for fraud or misrepresentation;
3. You knowingly furnished incorrect information or otherwise improperly obtained the Benefits of the Plan;
4. You are covered or eligible for Medicare;
5. You are covered or eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; and,
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in your group Plan.

A conversion plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for Dependent coverage under the group Plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse or Domestic Partner of a Subscriber if their marriage or domestic partnership has been terminated;
5. Dependents, when continuation of coverage under COBRA and/or Cal-COBRA expires, or is terminated.

When a Dependent reaches the limiting age for coverage as a Dependent, or if a Dependent becomes ineligible for any of the other reasons given above, it is your responsibility to inform Blue Shield. Upon receiving notification, Blue Shield of California will offer such Dependent an individual conversion plan for purposes of continuous coverage.

Guaranteed Issue Individual Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and under California law, you may be entitled to apply for certain of Blue Shield's individual health plans on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons if you meet the other eligibility requirements, you live or work in Blue Shield's service area and you agree to pay all required Premiums). You may also be eligible to purchase similar coverage on a guaranteed issue basis from any other health plan that sells individual coverage for hospital, medical or surgical benefits. Not all Blue Shield individual plans are available on a guaranteed issue basis under HIPAA. To be eligible, you must meet the following requirements:

- You must have at least 18 or more months of creditable coverage.
- Your most recent coverage must have been group coverage (COBRA and Cal-COBRA are considered group coverage for these purposes).
- You must have elected and exhausted all COBRA and/or Cal-COBRA coverage that is available to you.
- You must not be eligible for nor have any other health insurance coverage, including a group health plan, Medicare or Medi-Cal.
- You must make application to Blue Shield for guaranteed issue coverage within 63 days of the date of termination from the group plan.

If you elect Conversion Coverage or other Blue Shield individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Customer Service representative at the telephone number noted on your ID Card.

GENERAL PROVISIONS

LIABILITY OF SUBSCRIBERS IN THE EVENT OF NON-PAYMENT BY BLUE SHIELD

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield of California and its Participating Providers and Preferred Providers stipulates that the Subscriber 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 Subscriber's group contract. 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 Subscriber 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 Subscriber 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 Blue Shield of California. Possession of a Blue Shield of California ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Member must be a Subscriber who has been accepted by the County and enrolled by Blue Shield of California and who has maintained enrollment under the terms of this Plan.

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

If the Member receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the Non-Preferred Provider. The Member or the provider of Service may not request that the payment be made directly to the provider of Service.

PLAN INTERPRETATION

Blue Shield of California shall have the power and complete discretionary authority to construe and interpret the provisions of the group health service contract, to determine the Benefits of the contract and determine eligibility to receive Benefits under the contract. Blue Shield of California shall exercise this authority for the benefit of all Members entitled to receive Benefits under the group health service contract.

PUBLIC POLICY PARTICIPATION PROCEDURE

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

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

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

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

Please follow the following procedure:

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

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield of California protects 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. 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 in the back of this booklet, or by accessing Blue Shield of California's internet site located at http://www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

Access to Information

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

Right of Recovery

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

Customer Service

For all Services other than Mental Health

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 Blue Shield's Customer Service Department as noted on the last page of this booklet.

The hearing impaired may contact Blue Shield's 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 of California has established a procedure for our Subscribers and Dependents to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other 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.

For all Mental Health Services

For all Mental Health Services Blue Shield of California has contracted with the Plan's MHSA. The MHSA should be contacted for questions about Mental Health Services, MHSA network Providers, or Mental Health Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

The MHSA can answer many questions over the telephone.

Note: The MHSA has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. The MHSA shall make a decision and notify the Subscriber and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other 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 the MHSA at the number listed above.

GRIEVANCE PROCESS

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Subscribers' grievances with Blue Shield of California.

For all Services other than Mental Health

Subscribers, a designated representative, or a provider on behalf of the Subscriber may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Subscribers may contact the Plan at the telephone number as noted on the last page of this booklet. If the telephone inquiry to Customer Service does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Subscriber may also submit the grievance online by visiting our web site at http://www.blueshieldca.com.

Blue Shield will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health Services

Subscribers, a designated representative, or a provider on behalf of the Subscriber may contact the MHSA by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Subscribers may contact the MHSA at the telephone number as noted below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the MHSA's Customer Service Department. If the Subscriber wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Subscriber may also submit the grievance to the MHSA online by visiting http://www.blueshieldca.com.

1-877-263-9952

Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

If the grievance involves an MHSA Non-Participating Provider, the Subscriber should contact the appropriate Blue Shield Customer Service Department as shown on the last page of this booklet.

Note: If the County'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.

EXTERNAL INDEPENDENT MEDICAL REVIEW

If your grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agen-

cy. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the Service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan at **1-800-642-6155** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, **(http://www.hmohelp.ca.gov),** has complaint forms, IMR application forms, and instructions online.

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

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.).

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.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health Services. Note: MHSA Non-Participating Providers may include Blue Shield Preferred/Participating Providers if the Provider does not also have an agreement with the MHSA.

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

Non-Participating Home Health Care and Home Infusion agency — an agency which has not contracted with Blue Shield and whose services are not covered unless prior authorized by 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 or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider.

Note: This definition does not apply to Mental Health Services. For Non-Participating Providers for Mental Health Services, see the MHSA Non-Participating Provider definition above.

Non-Preferred Bariatric Surgery Services Providers — any provider that has not contracted with Blue Shield to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery Services provider by Blue Shield. Non-Preferred bariatric surgery Services Providers may include Blue Shield Preferred/Participating Providers if

the provider does not also have an agreement with Blue Shield to provide bariatric surgery Services.

Note: Bariatric surgery services are not covered for Members who reside in designated counties in California if the service is provided by a Non-Preferred Bariatric Surgery Services Provider. (See the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for more information.)

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 Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice service benefits pursuant to the California Health and Safety Code Section 1368.2.

Participating Physician — a selected Physician who has agreed to accept Blue Shield of California's payment, plus Subscriber payments of any applicable Deductibles and Copayments, as payment-in-full for covered Services. Refer to the Covered Services section of this booklet for Copayment information.

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 of California to furnish Services and to accept Blue Shield of California's payment, plus applicable Deductibles and Copayments, as payment in full for covered Services.

Note: This definition does not apply to Mental Health Services or Hospice Program Services. For Participating Providers for Mental Health Services and Hospice Program Services, see the MHSA Participating Provider and 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 Bariatric Surgery Services Provider — a Preferred Hospital or a Physician Member that has contracted with Blue Shield to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield.

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.

Note: For Participating Providers for Mental Health Services, see the MHSA Participating Provider definition above.

Preferred Provider — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider. Note: For Participating Providers for Mental Health Services, see the MHSA Participating Provider definition above.

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.

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 — the Blue Shield of California Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The 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 have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a non-participating provider anywhere within or outside of the United States who provides Emergency Services:
   a. For Physicians and Hospitals – the Reasonable and Customary Charge;
   b. All other providers – the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield have agreed upon some other amount; or
3. For a Non-Participating Provider in California, including an Other Provider, who provides Services on other than an emergency basis:
   a. For Services prior authorized by Blue Shield to be received from a Non-Preferred Dialysis Center – the Reasonable and Customary Charge, as defined;
   b. For all other Non-Participating/Non-Preferred Providers including Other Providers - the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
4. 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
5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local plan has no non-participating provider allowance, Blue Shield will assign the Allowable Amount used for a Non-Participating Provider in California.

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

Benefits (Services) — those Services which a Member is entitled to receive pursuant to the Group Health Service Contract.

Calendar Year — a period beginning 12:01 a.m., January 1 and ending 12:01 a.m., 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.

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

Copayment — the amount that a Member 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.

County — shortened name for the County of San Bernardino.

Covered Services (Benefits) — those Services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. Title XVIII of the Social Security Act, e.g., Medicare.
3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored or funded program of medical care.

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 Member who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing 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 Subscriber's legally married spouse who is not legally separated from the Subscriber;

   or,

2. a Subscriber's Domestic Partner;

   or,

3. a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Subscriber 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 of California as a Dependent and has maintained membership in accordance with the Contract.

Note: Children of Dependent children (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner) are not Dependents unless the Subscriber, 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 Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the County's or Blue Shield's request; and

   c. 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 Depend-

ent child becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner — an individual who is personally related to the Member by a domestic partnership that meets the following requirements:

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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 of California determines are Durable Medical Equipment.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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.

Employee — an individual who meets the eligibility requirements set forth in the Group Health Service Contract between Blue Shield of California and the County.

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 Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued binding both Blue Shield and the County that establishes the services that Subscribers and Dependents are entitled to receive for Group Medical benefits.

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 Member 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.

Intensive Outpatient Care Program — an Outpatient Mental Health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least 3 hours per day, 3 times per week.

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 60 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 a County'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 60 days after termination of coverage or County contribution toward coverage provided under another employer health benefit plan; or

2. The County 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 60 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 County 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 60 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 of California 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 of California 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.

Member — either a Subscriber or Dependent.

Mental Health Condition —mental disorders listed in the most current edition of the "Diagnostic & Statistical Manual of Mental Disorders" (DSM).

Mental Health Services — Services provided to treat a Mental Health Condition.

Mental Health Service Administrator (MHSA) — Blue Shield of California has contracted with the Plan's MHSA. The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care, and will underwrite and deliver Blue Shield's Mental Health Services through a separate network of MHSA Participating Providers.

Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period — that period of time during which eligible employees and their Dependents may transfer to and from another health benefit plan sponsored by the County.

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

Physical Therapy — treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Blue Shield of California and/or the Blue Shield PPO Plan.

Premiums — the monthly prepayment that is made to the Plan on behalf of each Member by the County.

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.

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 — services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for Acute Care or Skilled Nursing Services. This definition does not apply to Services rendered under the Hospice Program Benefit.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

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 or speech therapist, to improve or retrain a patient's vocal 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.

Subscriber — an individual who satisfies the eligibility requirements of an Employee, who has been enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Blue Shield of California coverage under the group contract.

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 (Totally Disabled) —

1. in the case of an Employee or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;

2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

免費語言服務：您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198 번으로 문의해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

خدمات جانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

លេខាកម្មវិធីភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Key Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

Supplement A — Outpatient Prescription Drug Benefits

Summary of Benefits

Member Calendar Year Brand Name Drug Deductible	Deductible Responsibility	
	Participating Pharmacy	**Non-Participating Pharmacy**
Per Member There is no Brand Name Drug deductible requirement.	$0	

Benefit	Member Copayment	
	Participating Pharmacy	**Non-Participating Pharmacy**[1] Member pays copayment below plus 25% of billed charges:
Retail Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	$10 per prescription	$10 per prescription
Formulary Brand Name Drugs	$15 per prescription	$15 per prescription
Non-Formulary Brand Name Drugs	$15 per prescription	$15 per prescription
Drugs used for the treatment of Sexual Dysfunction	50% per prescription	50% per prescription
Mail Service Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	$10 per prescription	Not covered
Formulary Brand Name Drugs	$15 per prescription	Not covered
Non-Formulary Brand Name Drugs	$15 per prescription	Not covered
Specialty Pharmacies		
Specialty Drugs	$10 per prescription	Not covered

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

[2] If a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member 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 Calendar Year Maximum Co-payment, and the Coordination of Benefits provision do not apply to this Outpatient Prescription Drug Benefit; however, the general provisions and exclusions of the group health service contract shall apply.

Benefits are provided for Outpatient prescription Drugs which meet all of the requirements specified in this supplement, are prescribed by a Physician, and, except as noted below, 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 Specialty Drugs require prior authorization by Blue Shield for Medical Necessity, including appropriateness of therapy and efficacy of lower cost alternatives. You or 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 Member's Physician will prescribe it for a particular medical condition.

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

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

Definitions

Brand Name 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 name as that of the manufacturer with the original FDA approval.

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, and 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 contraceptives when ordered by a Physician, (7) smoking cessation Drugs which require a prescription, (8) inhalers and inhaler spacers for the management and treatment of asthma.

Note: To be considered for coverage, all Drugs require a valid prescription by the Member'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 to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) typically cost less than the Brand Name Drug equivalent.

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 Member Services number on your Blue Shield Identification Card.

Non-Formulary Drugs — Drugs determined by the Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary Drug alternatives. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Co-payment.

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 Members. 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 Blue Shield Identification Card.

Specialty Drugs - Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheu-

matoid arthritis, cancer, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in Blue Shield's Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy and Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

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

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

The Member 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 Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand Name 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 Member's Copayment, the Member will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Name 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 Name Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

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

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. The Member 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 Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services -Emergency Claims, P. O. Box 7168, San Francisco, CA 94120. The Member 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 Member may obtain the Drug through Blue Shield's Mail Service Prescription Drug Program by enrolling online or by phone or mail. Members should allow 14 days to receive the Drug. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

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

For information about the Mail Service Prescription Drug Program, Members may visit www.blueshieldca.com or call Customer Service.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand Name contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authori-

zation for Medical Necessity to be covered without a Copayment.

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

If this Outpatient Prescription Drug Benefit has a Brand Name 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 Name Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

If the Member requests a Mail Service Brand Name Drug when a Mail Service Generic Drug is available, and the Brand Name Drug Deductible has been satisfied (when applicable), the Member is responsible for the difference between the contracted rate for the Mail Service Brand Name 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 Name Drug when a Mail Service Generic Drug equivalent is available, the Member is responsible for paying the applicable Mail Service Brand Name Drug Copayment.

Prior Authorization Process for Select Formulary, Non-Formulary and Specialty Drugs

Select Formulary Drugs, as well as most Specialty Drugs may require prior authorization for Medical Necessity. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compound 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 Name Drug Copayment applies. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. 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 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 allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. Initial prescriptions for select Specialty Drugs may be limited to a quantity not to exceed a 15 day supply. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated based on the number of days supply.
3. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member'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 Evidence of Coverage and Disclosure Form – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Any drug provided or administered while the Member 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 Evidence of Coverage and Disclosure Form);
2. 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 Evidence of Coverage and Disclosure Form);
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drug Benefit), which can be obtained without a prescrip-

tion 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;

4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered to be experimental or investigational;
6. 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 Evidence of Coverage and Disclosure Form). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
7. Blood or blood products (see the Hospital Benefits (Facility Services) section of your Evidence of Coverage and Disclosure Form);
8. 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;
9. 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 Evidence of Coverage and Disclosure Form);
10. Any drugs which are not self-administered. These medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits and Family Planning Benefits sections of the health plan;
11. All Drugs for the treatment of infertility;
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) require a Physician's prescription, (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) it is being prescribed for an FDA-approved indication;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to a Member enrolled in a Hospice Program through a Participating Hospice Agency;
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
18. 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;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
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).

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

Supplement B — Substance Abuse Condition Benefits

Summary of Benefits

Benefit	Member Copayment[1]	
Benefits are provided for Services for Substance Abuse Conditions (including Partial Hospitalization[2]) as described in this supplement.		
	MHSA Participating Provider	**MHSA Non-Participating Provider**
Hospital Facility Services		
Inpatient Services	Your Plan's Hospital Benefits (Facility Services), Inpatient Services Copayment	Your Plan's Hospital Benefits (Facility Services), Inpatient Services Copayment
Outpatient Services	Your Plan's Hospital Benefits (Facility Services), Outpatient Services, Services for illness or injury Copayment	Your Plan's Hospital Benefits (Facility Services), Outpatient Services, Services for illness or injury Copayment
Partial Hospitalization[2]	Your Plan's Ambulatory Surgery Center Benefits Copayment applies per Episode	Your Plan's Ambulatory Surgery Center Benefits Copayment applies per Episode
Professional (Physician) Services		
Inpatient Services	Your Plan's Professional (Physician) Benefits, Inpatient Physician Benefits Copayment	Your Plan's Professional (Physician) Benefits, Inpatient Physician Benefits Copayment
Outpatient Service	You pay nothing (first three visits); thereafter, $10 per visit	30%

1 The Copayments below are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan, except Outpatient Professional (Physician) Services by Preferred Providers.

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

In addition to the Benefits described in your Evidence of Coverage and Disclosure Form, your Plan provides coverage for Substance Abuse Condition Services as described in this supplement. All Services must be Medically Necessary. For a definition of Substance Abuse Condition, see the Definitions section of your Evidence of Coverage and Disclosure Form.

This supplemental Benefit does not include Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification, which are covered as part of the medical Benefits of your health plan and not considered to be treatment of the Substance Abuse Condition itself.

Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver Mental Health Services as well as the Substance Abuse Condition Services described in this supplement. These Services are provided through a separate network of MHSA Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Substance Abuse Condition Services to Blue Shield Member. A Blue Shield Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your Copayment, as payment-in-full for covered Substance Abuse Condition Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Substance Abuse Condition Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Substance Abuse Condition Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. For questions about these Substance Abuse Condition Benefits, or for assistance in selecting an MHSA Participating Provider, Members should call the MHSA at 1-877-263-9952.

Prior authorization by the MHSA is required for Non-Emergency Substance Abuse Condition Services as specified below.

Inpatient Hospital and Professional Services;

Prior to obtaining the Substance Abuse Condition Services listed above, you or your Physician must call the MHSA at 1-877-263-9952 to obtain prior authorization.

Failure to obtain prior authorization or to follow the recommendations of the MHSA or Blue Shield for Non-Emergency Substance Abuse Condition Services as specified above will result in the following:

for Inpatient Hospital and Professional Services, an additional Member payment of $250 for each Hospital admission;

Benefits are provided for Medically Necessary Services for Substance Abuse Conditions, as defined in your Evidence of Coverage and Disclosure Form, and as specified in this supplement.

This Benefit is subject to the general provisions, limitations and exclusions listed in your Evidence of Coverage and Disclosure Form.

NOTES

For claims submission and information contact Blue Shield of California.

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

Subscribers may call Blue Shield's Customer Service Department toll free:

1-800-642-6155

The hearing impaired may call Customer Service through Blue Shield's toll-free
TTY number: 1-800-241-1823

Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the Customer Service telephone number indicated on the back of the Member's identification card

For prior authorization of Benefits Management Program Radiological Services: 1-888-642-2583

For prior authorization for Inpatient Mental Health Services,
contact the Mental Health Service Administrator at:
1-877-263-9952

Please refer to the Benefits Management Program section of
this Evidence of Coverage and Disclosure Form booklet for information.