Custom PPO 250 80/70

Combined Evidence of Coverage and Disclosure Form

County of San Bernardino
Group Number: W0051658-M0020208
Effective Date: July 20, 2019

an independent member of the Blue Shield Association

blue of california

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Blue Shield of California

Evidence of Coverage and Disclosure Form

Custom PPO 250 80/70

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

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.

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

Notice About This Group Health Plan: Blue Shield makes this Health Plan available to Employees through a contract with the County. The Group Health Service Contract includes the terms in this EOC, as well as other terms. A copy of the Contract is available upon request. A Summary of Benefits is provided with, and is incorporated as part of, the EOC. The Summary of Benefits sets forth the Member's share-of-cost for Covered Services under the benefit Plan.

Please read this EOC carefully and completely to understand which services are Covered Services, and the limitations and exclusions that apply to the Plan. Pay particular attention to those sections of the EOC that apply to any special health care needs.

For questions about this Plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this EOC.

Notice About Plan Benefits: No Member has the right to receive Benefits for services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Continuation of Group Coverage provision in this EOC.

Benefits are available only for services and supplies furnished during the term this Health Plan is in effect and while the individual claiming Benefits is actually covered by this Group Contract.

Benefits may be modified during the term as specifically provided under the terms of this EOC, the Group Contract or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Bene-

fits 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.

Notice About Reproductive Health Services: 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 provided on the back page of this EOC to ensure that you can obtain the health care services that you need.

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

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

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

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

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

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.

Blue Shield of California

Subscriber Bill of Rights

As a Blue Shield 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 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 Health Plan or the care provided to you.
16) Participate in establishing Public Policy of the Blue Shield health Plan, as outlined in your EOC.

Blue Shield of California

Subscriber Responsibilities

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

1) Carefully read all Blue Shield 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 membership as explained in the EOC.
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 Blue Shield need to provide appropriate care for you.
4) Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
5) Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6) Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7) Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
8) Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.
9) Offer suggestions to improve the Blue Shield 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 Blue Shield personnel respectfully and courteously as partners in good health care.
13) Pay your Premiums, Copayments, Coinsurance and charges for non-covered services on time.
14) For all Mental Health and Substance Use Disorder Services, follow the treatment plans and instructions agreed to by you and the Mental Health Services Administrator (MHSA) and obtain prior authorization as required.
15) Follow the provisions of the Blue Shield Benefits Management Program.

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blue of california

County of San Bernardino-Actives
Effective July 20, 2019
PPO Benefit Plan

Summary of Benefits

County of San Bernardino Custom PPO 250 80/70

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

Provider Network: **Full PPO Network**

This benefit Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$250
	Family coverage	$250: individual
		$500: Family

Calendar Year Out-of-Pocket Maximum[5]

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

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$1,750	$2,250
Family coverage	$1,750: individual	$2,250: individual
	$3,500: Family	$4,500: Family

No Lifetime Benefit Maximum

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

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Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]	$0		30%	✔
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$10/visit		30%	✔
Specialist care office visit	$10/visit		30%	✔
Allergy injection services (serum not included)	$15/visit		$15/visit	
Office visit for allergy testing	20%		30%	✔
Physician home visit	20%		30%	✔
Physician or surgeon services in an Outpatient Facility	20%	✔	30%	✔
Physician or surgeon services in an inpatient facility	20%	✔	30%	✔
Other professional services				
Other practitioner office visit	$10/visit		30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	20%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	20%	✔	30%	✔
Up to 30 visits per Member, per Calendar Year.				
Teladoc consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		30%	✔
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		30%	✔
• Tubal ligation	$0		50%	✔
• Vasectomy	30%	✔	50%	✔
• Infertility services	Not covered		Not covered	
Podiatric services	$10/visit		30%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	20%	✔	30%	✔
Physician services for pregnancy termination	20%	✔	30%	✔
Emergency services				
Emergency room services	$50/visit plus 20%		$50/visit plus 20%	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room Physician services	20%	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Urgent care center services	$10/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	20%	✔	30%	✔
Outpatient department of a Hospital: surgery	20%	✔	30%	✔
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	30%	✔
Inpatient facility services				
Hospital services and stay	20%	✔	30%	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	20%	✔	Not covered	
• Physician inpatient services	20%	✔	Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and Outpatient Physician services payments apply.*				
Inpatient facility services	20%	✔	Not covered	
Outpatient Facility services	20%	✔	Not covered	
Physician services	20%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	20%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient department of a Hospital	20%	✔	30%	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30%	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30%	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	30%	✔
• Outpatient department of a Hospital	20%	✔	30%	✔
Rehabilitative and Habilitative Services				
Includes Physical Therapy, Occupational Therapy, and Respiratory Therapy.				
Office location	20%		30%	✔
Outpatient department of a Hospital	20%		30%	✔
Speech Therapy services				
Office location	20%		20%	
Outpatient department of a Hospital	20%		30%	✔
Durable medical equipment (DME)				
DME	20%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	20%	✔	30%	✔
Prosthetic equipment and devices	20%	✔	30%	✔
Home health services				
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period, except hemophilia and home infusion nursing visits.				
Home health agency services	20%	✔	Not covered	
Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.				
Home visits by an infusion nurse	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Home health medical supplies	20%	✔	Not covered	
Home infusion agency services	20%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	20%	✔	20%	✔
Hospital-based SNF	20%	✔	30%	✔
Hospice program services				
Pre-Hospice consultation	$0		Not covered	
Routine home care	$0		Not covered	
24-hour continuous home care	20%	✔	Not covered	
Short-term inpatient care for pain and symptom management	20%	✔	Not covered	
Inpatient respite care	$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	30%	✔
• Self-management training	20%		30%	✔
Dialysis services	20%	✔	30%	✔
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum	20%	✔	30%	✔
Eye examination *One comprehensive eye examination in a consecutive 12-month period provided through the contracted VPA.*				
Ophthalmologic exam	$0		$0 up to $60/year plus 100% of additional charges	
Optometric exam	$0		$0 up to $50/year plus 100% of additional charges	

Mental Health and Substance Use Disorder Benefits

Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).	Your payment: When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$0 for the first 3 visits, then $10/visit		30%	✔
Other outpatient services, including intensive outpatient care, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0		30%	✔
Partial Hospitalization Program	20%	✔	30%	✔
Psychological Testing	20%	✔	30%	✔
Inpatient services				
Physician inpatient services	20%	✔	30%	✔
Hospital services	20%	✔	30%	✔
Residential Care	20%	✔	30%	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from Non-Participating Providers
- Mental health services, except outpatient office visits
- Hospice program services

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

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

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

If this benefit Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

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

3 Using Participating Providers:

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

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

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

This benefit Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

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

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example,

you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a Participating Provider. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
JM040919; PB042519

The Blue Shield PPO Health Plan

Introduction to the Blue Shield of California Health Plan

This Blue Shield of California (Blue Shield) Evidence of Coverage and Disclosure Form (EOC) describes the health care coverage that is provided under the Group Health Service Contract between Blue Shield and the County. A Summary of Benefits is provided with, and is incorporated as part of, this EOC.

Please read both this EOC and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about Member responsibilities, such as payment of Copayments, Coinsurance and Deductibles and obtaining prior authorization for certain services (see the *Benefits Management Program* section).

Capitalized terms in this EOC have special meaning. Please see the *Definitions* section to understand these terms. Please contact Blue Shield with questions about Benefits. Contact information can be found on the last page of this EOC.

How to Use This Health Plan

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

Choice of Providers

This Blue Shield Health Plan is designed for Members to obtain services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members may choose to seek services from Non-Participating Providers for most services. Covered Services obtained from Non-Participating Providers will usually result in a higher share of cost for the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider.

Please be aware that a provider's status as a Participating Provider or an MHSA Participating Provider may change. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHSA Participating Provider prior to obtaining coverage.

Call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider. Call the MHSA to determine if a provider is an MHSA Participating Provider. See the sections below and the Summary of Benefits for more details. See the *Out-of-Area Services* section for services outside of California.

Blue Shield Participating Providers

Blue Shield Participating Providers include primary care Physicians, specialists, Hospitals, and Alternate Care Services Providers that have a contractual relationship with Blue Shield. Participating Providers are listed in the Participating Provider directory.

Participating Providers agree to accept Blue Shield's payment, plus the Member's payment of any applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified Benefit maximums as payment-in-full for Covered Services, except as provided under the *Exception for Other Coverage* and the *Reductions – Third Party Liability* sections. This is not true of Non-Participating Providers.

If a Member receives services from a Non-Participating Provider, Blue Shield's payment for that service may be substantially less than the amount billed. The Subscriber is responsible for the difference between the amount Blue Shield pays and the amount billed by the Non-Participating Provider.

If a Member receives services at a facility that is a Participating Provider, Blue Shield's payment for Covered Services provided by a health professional at the Participating Provider facility will be paid at the Participating Provider level of Benefits, whether the health professional is a Participating Provider or Non-Participating Provider. The Member's share of cost will not exceed the Copayment or Coinsurance due to a participating Provider under similar circumstances.

Some services are covered only if rendered by a Participating Provider. In these instances, using a Non-Participating Provider could result in a higher

share of cost to the Member or no payment by Blue Shield for the services received.

Payment for Emergency Services rendered by a Physician or Hospital that is not a Participating Provider will be based on Blue Shield's Allowable Amount and will be paid at the Participating level of Benefits. The Member is responsible for notifying Blue Shield within 24 hours, or as soon as reasonably possible following medical stabilization of the emergency condition.

Please call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider.

MHSA Participating Providers

For Mental Health Services and Substance Use Disorder Services, Blue Shield has contracted with a Mental Health Service Administrator (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 and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

MHSA Participating Providers are those providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health and Substance Use Disorder Services to Blue Shield Members. A Blue Shield Participating Provider may not be an MHSA Participating Provider. It is the Member's responsibility to ensure that the provider selected for Mental Health and Substance Use Disorder Services is an MHSA Participating Provider. MHSA Participating Providers are identified in the Blue Shield Behavioral Health Provider Directory. Additionally, Members may contact the MHSA directly by calling 1-877-263-9952.

If a Member receives services at a facility that is an MHSA Participating Provider, MHSA's payment for Mental Health and Substance Use Disorder Services provided by a health professional at the MHSA Participating Provider facility will be paid at the MHSA Participating Provider level of Benefits, whether the health professional is an MHSA Participating Provider or MHSA Non-Participating Provider. The Member's share of cost will not exceed the Copayment or Coinsurance due to an MHSA Participating Provider under similar circumstances.

Continuity of Care

Continuity of care with a Non-Participating Provider is available for the following Members: for Members who are currently seeing a provider who is no longer in the Blue Shield; or for newly-covered Members whose previous health plan was withdrawn from the market.

Members who meet the eligibility requirements listed above may request continuity of care if they are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness. Continuity of care may also be requested for children who are up to 36 months old, or for Members who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment.

To request continuity of care, visit www.blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will review the request. The Non-Participating Provider must agree to accept Blue Shield's Allowable Amount as payment in full for ongoing care. When authorized, the Member may continue to see the Non-Participating Provider for up to 12 months at the Participating Provider rate.

Second Medical Opinion Policy

Members who have questions about their diagnoses, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may make an appointment with another Physician for a second medical opinion. The Member's attending Physician may also offer a referral to another Physician for a second opinion.

The second opinion visit is subject to the applicable Copayment, Coinsurance, Calendar Year Deductible and all Plan Contract Benefit limitations and exclusions.

State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To

request a copy of these timelines, you may call the Customer Service Department at the number provided on the back page of this EOC.

Services for Emergency Care

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

For Emergency Services from either a Participating Provider or a Non-Participating Provider, the Member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowable Amount Blue Shield is obligated to pay.

Members who reasonably believe that they have an Emergency Medical Condition which requires an emergency response are encouraged to use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital. 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 Provider's office.

NurseHelp 24/7 SM

The NurseHelp 24/7 program offers Members access to registered nurses 24 hours a day, seven days a week. Registered nurses can provide assistance in answering many health-related questions, including concerns about:

1) symptoms the patient is experiencing;
2) minor illnesses and injuries;
3) chronic conditions;
4) medical tests and medications; and
5) preventive care.

Members may obtain this service by calling the toll-free telephone number at 1-877-304-0504 or by participating in a live online chat at www.blueshieldca.com. There is no charge for this confidential service.

In the case of a medical emergency, call 911. For personalized medical advice, Members should consult with their physicians.

Life Referrals 24/7

The Life Referrals 24/7 program offers Members access to professional counselors 24 hours a day, seven days a week for psychosocial support services. Professional Counselors can provide confidential telephone support, including concerns about:

1) information;
2) consultations; and
3) referrals for health and psychosocial issues.

Members may obtain this service by calling the toll-free telephone number at 1-800-985-2405. There is no charge for this confidential service.

Retail-Based Health Clinics

Retail-based health clinics are outpatient facilities, usually attached or adjacent to retail stores and pharmacies that 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 Participating Provider directory or the online provider directory located at www.blueshieldca.com. See the *Blue Shield Participating Providers* section for information on the advantages of choosing a Participating Provider.

Blue Shield Online

Blue Shield's Internet site is located at www.blueshieldca.com. Members with Internet access may view and download healthcare information.

Health Education and Health Promotion Services

Blue Shield offers a variety of health education and health promotion services including, but not limited to, a prenatal health education program, interactive online healthy lifestyle programs, and a monthly e-newsletter.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Participating Providers.

Urgent Care	**Access to Care**
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	**Access to Care**
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	**Access to Care**
Access to a health professional for telephone screenings	24 hours/day, 7 days/week

Note: For availability of interpreter services at the time of the Member's appointment, consult the Participating Provider directory available at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the *Notice of the Availability of Language Assistance Services* section of this EOC.

Cost-Sharing

The Summary of Benefits provides the Member's Copayment, Coinsurance, Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum amounts.

Calendar Year Medical Deductible

The Calendar Year Medical Deductible is the amount an individual or a Family must pay for Covered Services each year before Blue Shield begins payment in accordance with this EOC. The Calendar Year Medical Deductible does not apply to all plans. When applied, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. Information specific to the Member's Plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Medical Deductible applies to a particular Covered Service.

There are individual and Family Calendar Year Medical Deductible amounts. The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Medical Deductible within the Family Medical Deductible. This means Blue Shield will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met.

Once the respective Deductible is reached, Covered Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

For Covered Services received from Non-Participating Providers, excluding Covered Services provided at a Participating Provider facility by a health professional who is a Non-Participating Provider, the Member is responsible for the applicable Copayment or Coinsurance and for amounts billed in excess of Blue Shield's Allowable Amount. Charges in excess of Blue Shield's Allowable Amount do not accrue to the Calendar Year Medical Deductible.

Calendar Year Out of Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. If a benefit plan has any Calendar Year Medical Deductible, it will accumulate toward the applicable Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers. The individual Calendar Year Out-of-Pocket Maximum applies when an individual is covered by the plan. The Family Calendar Year Out-of-Pocket Maximum applies when a Family is covered by the plan.

There is also an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means that any Family member who meets the individual Out-of-Pocket Maximum will receive 100% Benefits for Covered Services, before the Family Out-of-Pocket Maximum is met.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amounts for Participating Providers and Non-Participating Providers at both the individual and Family levels. When the respective maximum is reached, Covered Services will be paid by Blue Shield at 100% of the Allowable Amount or contracted rate for the remainder of the Calendar Year.

Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate, do not accrue to the Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Prior Carrier Deductible Credit

If a Member satisfies all or part of a medical Deductible under a Health Plan sponsored by the County under any of the following circumstances, that amount will be applied to the Deductible required under this Health Plan within the same Calendar Year:

1) The Member was enrolled in a Health Plan sponsored by the County with a prior carrier during the same Calendar Year this Contract becomes effective and the Member enrolls as of the original effective date of coverage under this Contract;
2) The Member was enrolled under another Blue Shield plan sponsored by the County which is being replaced by this Health Plan;
3) The Member was enrolled under another Blue Shield plan sponsored by the County and is transferring to this Health Plan during the County's Open Enrollment Period.

This Prior Carrier Deductible Credit provision applies only in the circumstances described above.

Submitting a Claim Form

Participating Providers submit claims for payment directly to Blue Shield, however there may be times when Members and Non-Participating Providers need to submit claims.

Except in the case of Emergency Services, Blue Shield will pay Members directly for services rendered by a Non-Participating Provider. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to the Blue Shield address listed on the last page of this EOC.

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the Subscriber's name, home address, Group Contract number, Subscriber number, a copy of the provider's billing showing the services rendered, dates of treatment and the patient's name.

Members should submit their claims for all Covered Services even if the Calendar Year Deductible has not been met. Blue Shield will keep track of

the Deductible for the Member. Blue Shield also provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Out-of-Area Services

Overview

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

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. Blue Shield's payment practices for both kinds of providers are described below and in the *Choice of Providers* section of this EOC.

Inter-Plan Arrangements

Emergency Services

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

BlueCard Program

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

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

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

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

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

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

Prior authorization may be required for non-emergency services. Please see the *Benefits Management Program* section for additional information on prior authorization and emergency admission notification.

Non-participating Providers Outside of California

When Covered Services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Covered Services as set forth in this paragraph.

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

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. Blue Shield pays claims for covered Emergency Services based on the Allowable Amount as defined in this EOC.

Blue Shield Global Core

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

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

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

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

Submitting a Blue Shield Global Core Claim

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

Special Cases: Value-Based Programs

Blue Shield Value-Based Programs

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

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

BlueCard® Program

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

Utilization Management

State law requires that Health Plans disclose to Members and Health Plan providers the process used to authorize or deny health care services under the Plan. Blue Shield has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing Blue Shield's Utilization Management Program is available online at www.blueshieldca.com or Members may call the Customer Service Department at the number provided on the back page of this EOC to request a copy.

Benefits Management Program

The Benefits Management Program applies utilization management and case management principles to assist Members and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this Health Plan.

The Benefits Management Program includes prior authorization requirements for various medical benefits, including inpatient admissions, outpatient services, and prescription Drugs administered in the office, infusion center or provided by a home infusion agency, as well as emergency admission notification, and inpatient utilization management. The program also includes Member services such as, discharge planning, case management and, palliative care services.

The following sections outline the requirements of the Benefits Management Program.

Prior Authorization

Prior authorization allows the Member and provider to verify with Blue Shield or Blue Shield's MHSA that (1) the proposed services are a Benefit of the Member's Plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Member and provider when Benefits are limited to services rendered by Participating Providers or MHSA Participating Providers (See the Summary of Benefits).

For all Prior Authorizations, except prescription Drugs covered under the medical benefit: A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Member and provider within two business days of the decision. For Urgent Services when the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Member's condition, not to exceed 72 hours from receipt of the request.

For Prior Authorizations of prescription Drugs covered under the medical benefit: Drugs administered in the office, infusion center or provided by a home infusion agency are covered as a medical benefit. For these prescription Drugs, once all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

If prior authorization was not obtained, and services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Member or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed within California on an outpatient, non-emergency basis:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedures utilizing nuclear medicine

For authorized services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained and the radiological or nuclear imaging services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior Authorization for Medical Services and Prescription Drugs Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical services and select prescription Drugs that require prior authorization. Members are encouraged to work with their providers to obtain prior authorization. Members and providers may call Customer Service at the number provided on the back page of this EOC to inquire about the need for prior authorization. Members and Providers may also access the Prior Authorization List on the Blue Shield website at www.blueshieldca.com.

Failure to obtain prior authorization for hemophilia home infusion products and services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage. To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back page of this EOC.

For authorized services and Drugs from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to services rendered by a Participating Provider. If prior authorization was not obtained and the medical services or Drugs provided to the Member are determined not to be a Benefit of the Plan, were not medically necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient Rehabilitative Services, Skilled Nursing care, special transplant and bariatric surgery. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When inpatient Hospital admission is authorized to a Non-Participating Hospital, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained for an inpatient Hospital admission and the services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary coverage will be denied.

Prior authorization is not required for an emergency Hospital admission; See the *Emergency Admission Notification* section for additional information.

Prior Authorization for Mental Health or Substance Use Disorder Hospital Admissions and Other Outpatient Services

Prior authorization is required for all non-emergency mental health or substance use disorder Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Other Outpatient Mental Health and Substance Use Disorder Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), electroconvulsive therapy, Office-Based Opioid Treatment (OBOT), Psychological Testing, and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA.

If prior authorization was not obtained for an inpatient mental health or substance use disorder Hospital admission or for any Other Outpatient Mental Health and Substance Use Disorder Services and the services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

For an authorized admission to a Non-Participating Hospital or authorized Other Outpatient Mental Health and Substance Use Disorder Services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency mental health or substance use disorder Hospital admission; See the *Emergency Admission Notification* section for additional information.

Emergency Admission Notification

When a Member is admitted to the Hospital for Emergency Services, Blue Shield, or Blue Shield's MHSA should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an inpatient Hospital stay may be extended or reduced as warranted by the Member's condition. When a determination is made that the Member no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Member. If discharge does not occur within 24 hours of notification, the Member is responsible for all inpatient charges accrued beyond the 24 hour time frame.

Maternity Admissions: the minimum length of the inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter inpatient stay is adequate.

Mastectomy: The length of the inpatient stay is determined post-operatively by the attending Physician in consultation with the Member.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield or Blue Shield's MHSA will work with the Member, the attending Physician and the Hospital discharge planners to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Member access necessary services and to make the most efficient use of Plan Benefits. The Member's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Member, the provider, and Blue Shield or Blue Shield's MHSA, and will not exceed the standard Benefits available under this Plan.

The approval of alternative benefits is specific to each Member for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this Health Plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other Member in any other instance.

Palliative Care Services

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

Principal Benefits and Coverages (Covered Services)

Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurance and charges in excess of Benefit maximums, Participating Provider provisions and Benefits Management Program provisions. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Contract, including any conditions or limitations set forth in the Benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this EOC. All Benefits must be Medically Necessary to be covered. 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 Copayment and Coinsurance amounts for Covered Services, if applicable, are shown on the Summary of Benefits. The Summary of Benefits is provided with, and is incorporated as part of, this EOC.

Except as may be specifically indicated, for services received from Non-Participating Providers, Subscribers will be responsible for all charges above the Allowable Amount in addition to the indicated Copayment or Coinsurance amount.

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, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.

Allergy Testing and Treatment Benefits

Benefits are provided for allergy testing and treatment, including allergy serum.

Ambulance Benefits

Benefits are provided for (1) emergency 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) pre-authorized, non-emergency ambulance transportation (surface and air) from one medical facility to another. Ambulance services are required to be provided by a licensed ambulance or a psychiatric transport van.

Ambulatory Surgery Center Benefits

Benefits are provided for surgery performed in an Ambulatory Surgery Center.

Bariatric Surgery Benefits

Benefits are provided for Hospital and professional services in connection with 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, whether the Member is a resident of a designated or non-designated county. See the *Benefits Management Program* section for more information.

Services for Residents of Designated Counties

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric services (see the list of designated counties below), Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1) performed at a Participating Hospital or Ambulatory Surgery Center, and by a Participating Provider, that have both contracted with Blue Shield as a Bariatric Surgery Services Provider to provide the procedure;
2) the services are consistent with Blue Shield's medical policy; and
3) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

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: (1) the medical circumstances of each patient; and (2) 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 Participating Hospital or Ambulatory Surgery Center by a Bariatric Surgery Services Provider will result in denial of claims for this Benefit.

Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must also be provided by a Physician participating as a Bariatric Surgery Services Provider.

The following are the designated counties in which Blue Shield has designated Bariatric Surgery Services Providers 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

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric services at a Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider 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 Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider. All requests for travel expense reimbursement must be prior authorized 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 round trip:
   a. for the Member for a maximum of three trips:
      i) one trip for a pre-surgical visit;
      ii) one trip for the surgery; and
      iii) one trip for a follow-up visit.
   b. for one companion for a maximum of two trips:
      i) one trip for the surgery; and
      ii) one 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 two days per trip:
      i) one trip for a pre-surgical visit; and
      ii) one trip for a follow-up visit.
   b) for one companion for a maximum of four days for the duration of the surgery admission.
      i) 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 four 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.

Services for Residents of Non-Designated Counties

Bariatric surgery services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section 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 Chiropractic Services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, 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 or Coinsurance as shown under the Outpatient X-ray, Pathology & Laboratory Benefits section.

Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition where the clinical trial has a therapeutic intent and when prior authorized by Blue Shield, and:

1) the Member's Physician or another 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 Member; or
2) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

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.

"Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in re-

lation 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. a 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 interrupted.

Diabetes Care Benefits

Diabetic Equipment

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

1) blood glucose monitors, including those designed to assist the visually impaired;
2) insulin pumps and all related necessary supplies;
3) podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; and
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 Benefits* Supplement if selected as an optional Benefits by the County.

Diabetic Outpatient Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member 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 avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

Dialysis Benefits

Benefits are provided for dialysis services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

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

Durable Medical Equipment Benefits

Benefits are provided for Durable Medical Equipment (DME) 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. 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 pumps 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 Durable Medical Equipment items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

No DME Benefits are provided for the following:

1) rental charges in excess of the purchase cost;
2) replacement of Durable Medical Equipment except when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the Outpatient Prescription Drug Benefit Supplement, if selected as an optional Benefit by the County, for benefits for asthma inhalers and inhaler spacers);
3) breast pump rental or purchase when obtained from a Non-Participating Provider;
4) repair or replacement due to loss or misuse;
5) 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; and
6) backup or alternate items.

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 Disease or Terminal Illness and related conditions are provided by the Hospice Agency.

Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services and emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Provider's office.

Emergency Services are services provided for an Emergency Medical Condition, including a psychiatric Emergency Medical Condition or active labor, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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.

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition.

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 dis-

ease 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:

1) family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; and
2) vasectomy.

See also the *Preventive Health Benefits* section for additional family planning services.

For plans with a Calendar Year Deductible for services by Participating Providers, the Calendar Year Deductible applies only to male sterilizations.

Home Health Care Benefits

Benefits are provided for home health care services from a Participating home health care agency when the services are ordered by the Member's 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, Copayments and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Member 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 four visits per day, two hours per visit up to the Calendar Year visit maximum (including all home health visits) by any of the following professional providers:

1) registered nurse;
2) licensed vocational nurse;
3) physical therapist, occupational therapist, or speech therapist; or
4) medical social worker.

Intermittent and part-time visits by a home health agency to provide services from a Home Health Aide are covered up to four hours per visit, and are included in the Calendar Year visit maximum.

For the purpose of this Benefit, each two-hour increment of visit from a nurse, physical therapist, occupational therapist, speech therapist, or medical social worker counts as a separate visit. Visits of two hours or less shall be considered as one visit. For visits from a Home Health Aide, each four-hour increment counts as a separate visit. Visits of four hours or less shall be considered as one visit.

Medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan and related laboratory services are covered in conjunction with the professional services rendered by the home health agency.

This Benefit does not include medications, or injectables covered under the *Home Infusion and Home Injectable Therapy Benefit* or under the *Outpatient Prescription Drug Benefit* Supplement if selected as an optional Benefit by the County.

See the *Hospice Program Benefits* section for information about admission into a Hospice program and specialized Skilled Nursing services for Hospice care.

For information concerning diabetic self-management training, see the *Diabetes Care Benefits* section.

Home Infusion and Home Injectable Therapy Benefits

Benefits are provided for home infusion and injectable medication therapy. Services include home infusion agency Skilled Nursing visits, infu-

sion therapy provided in infusion suites associated with a Participating home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit, medications injected or administered intravenously, related laboratory services, when prescribed by a Doctor of Medicine and provided by a Participating home infusion agency. Services related to hemophilia are described separately.

This Benefit does not include medications, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Supplement if selected as an optional Benefit by the County, and Services related to hemophilia which are described below.

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the Non-Participating home infusion agency and Blue Shield. Shift care and private duty nursing 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 and must be provided by a Participating Hemophilia Infusion Provider. (Note: most Participating home health care and home infusion agencies are not Participating Hemophilia Infusion Providers.) To find a Participating Hemophilia Infusion Provider, consult the Participating Provider directory. Members may also verify this information by calling Customer Service at the telephone number shown on the last page of this EOC.

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

Following Member evaluation by a Doctor of Medicine, 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 by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a Participating Hemophilia Infusion Provider, and services to treat complications of hemophilia replacement therapy are not covered under this Benefit.

No Benefits are provided for:

1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications;
2) services from a hemophilia treatment center or any Non-Participating 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 Outpatient Prescription Drug Benefits if selected as an optional Benefit by the County, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

Hospice Program Benefits

Benefits are provided for services through a Participating Hospice Agency when an eligible Member requests admission to, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by his or her Participating Provider's certification and must receive prior approval from Blue Shield for the admission. Members with a Terminal Disease or Terminal Illness who have not yet elected to enroll in a Hospice program may receive a pre-hospice consultative visit from a Participating Hospice Agency.

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experi-

encing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver and the family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Participating Hospice Agency.

1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.

2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:

   a. Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;

   b. Home Health Aide services to provide personal care (supervised by a registered nurse);

   c. homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);

   d. bereavement services for the immediate surviving family members for a period of at least one year following the death of the Member;

   e. medical social services including the utilization of appropriate community resources;

   f. counseling/spiritual services for the Member and family;

   g. dietary counseling;

   h. medical direction provided by a licensed Doctor of Medicine acting as a consultant to the interdisciplinary Hospice team and to the Member's Participating Provider with regard to pain and symptom management and as a liaison to community physicians;

   i. physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;

   j. respiratory therapy;

   k. volunteer services.

3) Drugs, durable medical equipment, and supplies.

4) Continuous home care when Medically Necessary to achieve palliation or management of acute medical symptoms including the following:

   a. 8 to 24 hours per day of continuous skilled nursing care (8-hour minimum);

   b. homemaker or Home Health Aide Services up to 24 hours per day to supplement skilled nursing care.

5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.

6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members may receive hospice care for two 90-day periods followed by unlimited 60-day periods of care, depending on their diagnosis. The extension of care continues through another Period of Care if the Physician recertifies that the Member is Terminally Ill.

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.

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

1) Semi-private room and board unless a private room is Medically Necessary.
2) General nursing care, and special duty nursing.
3) Meals and special diets.
4) Intensive care services and units.
5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.
6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.
8) Drugs and oxygen.
9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.
10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.
11) Dialysis, radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.
13) Subacute Care.
14) Medical social services and discharge planning.
15) 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.
16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder detoxification is prior authorized by Blue Shield.

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

1) Dialysis services.
2) Outpatient Care.
3) Surgery.
4) Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
5) Routine newborn circumcision performed within 18 months of birth.

Covered Physical Therapy, Occupational Therapy and Speech Therapy Services provided in an outpatient Hospital setting are described under the *Rehabilitative and Habilitative Benefits (Physical, Occupational and Respiratory Therapy)* and *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* sections.

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

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

1) treatment of tumors of the gums;
2) treatment of damage to natural teeth caused solely by an Accidental Injury (limited to palliative services necessary for the initial medi-

cal stabilization of the Member as determined by Blue Shield);

3) 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) treatment of maxilla and mandible (jaw joints and jaw bones);
6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;
7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair;
8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck;
9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's 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.

No Benefits are provided for:

1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;
2) dental implants (endosteal, subperiosteal or transosteal);
3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
4) 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; and
5) fluoride treatments except when used with radiation therapy to the oral cavity.

Mental Health and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services and Substance Use Disorder Services for Blue Shield Members within California. See the *Out-Of-Area Services, BlueCard Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health and Substance Use Disorder Services, including Residential Care, and Other Outpatient Mental Health and Substance Use Disorder Services are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the *Benefits Management Program* section for complete information

Office Visits for Outpatient Mental Health and Substance Use Disorder Services

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

Other Outpatient Mental Health and Substance Use Disorder Services

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

1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which de-

velop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

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

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

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

3) Intensive Outpatient Program – an outpatient mental health or substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

4) Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment

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

6) Psychological Testing – testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

7) Transcranial Magnetic Stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

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

Benefits are provided for inpatient and professional services in connection with Residential Care admission for the treatment of Mental Health Conditions or Substance Use Disorder Conditions.

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

Orthotics Benefits

Benefits are provided for orthotic appliances and devices for maintaining normal Activities of Daily Living only. Benefits include:

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

4) 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 adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

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 not listed above. No Benefits are provided for backup or alternate items, or replacement due to loss or misuse.

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 X-ray services, diagnostic testing, clinical pathology, and laboratory services when provided to diagnose illness or injury.

Benefits are provided for genetic testing for at-risk Members according to Blue Shield medical policy and for prenatal genetic screening and diagnostic services as follows:

1) prenatal genetic screening to identify women who are at increased risk for carrying a fetus with a specific genetic disorder;
2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy.

See the section on *Radiological and Nuclear Imaging Benefits* for additional diagnostic procedures which require prior authorization by Blue Shield.

Routine laboratory services performed as part of a preventive health screening are covered under the *Preventive Health Benefits* section.

PKU Related Formulas and Special Food Products Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products for the dietary treatment of phenylketonuria (PKU). All formulas and Special Food Products must be prescribed and ordered through the appropriate health care professional.

Podiatric Benefits

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

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

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

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

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

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

Preventive Health Benefits

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

1) evidence-based items, drugs or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

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

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

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

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

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

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

Professional (Physician) Benefits

Benefits are provided for services of Physicians for treatment of illness or injury, as indicated below.

1) Office visits.

2) Services of consultants, including those for second medical opinion consultations.

3) Mammography and Papanicolaou's 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. Chemotherapy for cancer, including catheterization, and associated drugs and supplies.

8) Extra time spent when a Physician is detained to treat a Member in critical condition.

9) Necessary preoperative treatment.

10) Treatment of burns.

11) Outpatient routine newborn circumcision performed within 18 months of birth.

12) Diagnostic audiometry examination.

13) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc. The Teladoc Physician can provide diagnosis and treatment

for routine medical conditions and can also prescribe certain medications.

Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation Services are not intended to replace services from your Physician but are a supplemental service. You do not need to contact your Physician before using Teladoc consultation Services.

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

Note: If medications are prescribed, and the County selected the optional *Outpatient Prescription Drug Benefit Supplement* as a Benefit, the applicable Copayment or Coinsurance will apply. Teladoc consultation services are not available for specialist services or Mental Health and Substance Use Disorder Services. However, telehealth services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers.

14) A Participating Provider 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 Participating Provider at an extended office hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found online at www.blueshieldca.com or from Customer Service.

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 above are described under the *Outpatient X-ray, Pathology and Laboratory Benefits* section.

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

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

1) Tracheoesophageal voice prosthesis (e.g. Blom-Singer device), artificial larynx or other prosthetic device for speech following laryngectomy, artificial limbs and eyes;
2) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;
3) contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia following cataract surgery when no intraocular lens has been implanted. These contact lenses will not be covered under this Plan if the Member has coverage for contact lenses through a Blue Shield vision plan;
4) supplies necessary for the operation of prostheses;
5) initial fitting and replacement after the expected life of the item; and
6) repairs, except for loss or misuse.

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

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

Radiological and Nuclear Imaging Benefits

The following radiological and nuclear imaging procedures, when performed on an Outpatient, non-emergency basis, require prior authorization under the Benefits Management Program. See the Benefits Management Program section for complete information.

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

Reconstructive Surgery Benefits

Benefits are provided 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. Benefits include dental and orthodontic services that are an integral part of this surgery for cleft palate procedures. Reconstructive Surgery is covered to create a normal appearance only when it 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 and developed in conjunction with plastic and reconstructive surgeons.

Rehabilitative and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy)

Benefits are provided for outpatient Physical, Occupational, and Respiratory Therapy for the treatment of functional disability in the performance of activities of daily living. Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous level of functioning or to keep, learn, or improve skills and functioning.

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

Benefits for Speech Therapy are described in the *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* section.

See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitative/Habilitative services rendered in the home.

Skilled Nursing Facility Benefits

Benefits are provided for Skilled Nursing services in a Skilled Nursing unit of a Hospital or a free-standing Skilled Nursing Facility, up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Benefit Period, except that room and board charges in excess of the facility's established semi-private room rate are excluded. A "Benefit Period" begins on the date the Member is admitted into the facility for Skilled Nursing services, and ends 60 days after being discharged and Skilled Nursing services are no longer being received. A new Benefit Period can begin only after an existing Benefit Period ends.

Speech Therapy Benefits (Rehabilitative and Habilitative Services)

Benefits are provided for outpatient Speech Therapy for the treatment of (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous performance level or to keep, learn, or improve skills and functioning. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity.

Note: See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Speech Therapy Services rendered in the home. See the *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

Transplant Benefits

Transplant benefits include coverage for donation-related services for a living donor (including a potential donor), or a transplant organ bank. Donor services must be directly related to a covered transplant and must be prior authorized by Blue Shield. Donation-related services include harvesting of the organ, tissue, or bone marrow and treatment of medical complications for a period of 90 days following the evaluation or harvest service.

Tissue and Kidney Transplants

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

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

Special Transplants

Benefits are provided for certain procedures, listed below, only if: (1) performed at a Special Transplant Facility contracting with Blue Shield 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 through the Benefits Management Program and (3) the recipient of the transplant is a Subscriber or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

Failure to obtain prior written authorization 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 kidney and pancreas transplants in combination.
5) Human liver transplants.
6) Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational.
7) Pediatric human small bowel transplants.
8) Pediatric and adult human small bowel and liver transplants in combination.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

1) routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. 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;
2) hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;

3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;

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

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

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

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

8) hearing aid instruments, examinations for the appropriate type of hearing aid, device checks, electroacoustic evaluation for hearing aids and other ancillary equipment unless the County has purchased hearing aids coverage as an optional Benefit, in which case an accompanying Supplement provides the Benefit description;

9) eye exams and refractions (except as specifically provided under Eye Examination Benefit), lenses and frames for eyeglasses, contact lenses, except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;

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

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

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

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

14) cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages);

15) reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

16) sexual dysfunctions and sexual inadequacies,

except as provided for treatment of organically based conditions;

17) 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, except for Medically Necessary treatment of medical complications;

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

19) services incident to bariatric surgery services, except as specifically provided under *Bariatric Surgery Benefits;*

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

21) genetic testing except as described in the Outpatient X-ray, Pathology and Laboratory Benefits;

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

23) services performed in a Hospital by house officers, residents, interns, and other professionals in training without the supervision of an attending physician in association with an accredited clinical education program;

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

25) services (except for services received under the Behavioral Health Treatment benefit under *Mental Health and Substance Use Disorder Benefits*) provided by an individual or entity that:

    - is not appropriately licensed or certified by the state to provide health care services;
    - is not operating within the scope of such license or certification; or
    - does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;

26) massage therapy that is not Physical Therapy or a component of a multimodality Rehabilitative Services treatment plan;

27) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits or Preventive Health Services. 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;

28) 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;

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

30) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the ba-

sis 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;

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

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

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

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

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

36) drug's dispensed by a Physician or Physician's office for outpatient use;

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

38) services not specifically listed as a Benefit. 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.

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 right to independent medical review.

Medical Necessity Exclusion

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

Limitation for Duplicate Coverage

Medicare Eligible Members

1) Blue Shield will provide Benefits before Medicare in the following situations:

   a. When the Member is 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 the Member is 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 the Member is 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) Blue Shield will provide Benefits after Medicare in the following situations:

   a. When the Member is 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 the Member is 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 the Member is 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 the Member is retired and age 65 years or older.

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

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

If the Member is a qualified veteran Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided at a Veterans Administration facility for a condition that is not related to military service. If the Member is a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided at a Department of Defense facility, even if provided for conditions related to military service.

Members Covered by Another Government Agency

If the Member is 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 this Blue Shield group Plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowable Amount).

Contact Customer Service if you have any questions about how Blue Shield coordinates your group Plan Benefits in the above situations.

Exception for Other Coverage

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

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 another person or entity, through an act or omission, causes a Member to suffer an injury or illness, and if Blue Shield paid Benefits for that injury or illness, the Member must agree to the provisions listed below. In addition, if the Member is

injured and no other person is responsible but the Member receives (or is entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, the Member must agree to the following provisions.

1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for Benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.

2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (1) because the Member does not receive the full amount of damages that the Member claimed or (2) because the Member had to pay attorneys' fees.

4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

If the Member does seek damages for his or her illness or injury, the Member must tell Blue Shield promptly that the Member has made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for, the Member must seek recovery of Blue Shield's Benefit payments and liabilities, and the Member must tell us about any recoveries the Member obtains, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of the Member's claim in order to reimburse Blue Shield to the full amount of Benefits Blue Shield has paid or will pay. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code Section 3040.

Blue Shield may request that the Member sign a reimbursement agreement consistent with this provision.

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 Blue Shield is held in trust for the sole benefit of Blue Shield 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 Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

Coordination of Benefits

Coordination of Benefits is utilized when a Member is covered by more than one group Health Plan.

Payments for allowable expenses will be coordinated between the two plans up to the maximum benefit amount payable by each plan separately. Coordination of Benefits ensures that benefits paid by multiple group Health Plans do not exceed 100% of allowable expenses. The coordination of benefits rules also provide consistency in determining which group Health Plan is primary and avoid delays in benefit payments. Blue Shield follows the rules for Coordination of Benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group Health Plans. The following is a summary of those rules.

1) When a plan does not have a coordination of benefits provision, that plan 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.

2) Coverage for dependent children:

   a. When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

   b. When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.

   c. When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.

   d. When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:

      i. The plan of the custodial parent

      ii. The plan of the stepparent

      iii. The plan of the non-custodial parent.

3) If the above rules do not apply, the plan which has covered the Member for the longer period of time is the primary plan. There may be exceptions for laid-off or retired employees.

4) When Blue Shield is the primary plan, Benefits will be provided without considering the other group Health Plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.

5) Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

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

Conditions of Coverage

Eligibility and Enrollment

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.

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the County of San Bernardino. An Employee that meets the County eligibility rules is 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. The Employee's spouse or Domestic Partner and all Dependent children are eligible for coverage at the same time.

An Employee or the Employee's Dependents may enroll when initially eligible or during the County's annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the approved retroactive adjustments, a date 12 months from the date a written request for

enrollment is made, the County's annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in the health program offered by the County. Please see the definition of Late Enrollee and Special Enrollment Period in the *Definitions* section for details on these rights. For additional information on enrollment periods, please contact the County or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be covered immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 90 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, then they are both eligible for Dependent benefits. Their children may be eligible and may be enrolled as a Dependent of both parents. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their eligibility under this Health Plan solely because of age, may be eligible for coverage if they continue to meet the definition of Dependent. See the *Definitions* section.

The County must meet specified County eligibility, participation and contribution requirements to be eligible for this group Health Plan. If the County fails to meet these requirements, this coverage will terminate. See the *Termination of Benefits* section of this EOC for further information. Employees will receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

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

Effective Date of Coverage

Blue Shield will notify the eligible Employee/Subscriber of the effective date of coverage for the Employee and his or her Dependents. Subject to the County's eligibility and enrollment rules, coverage starts at 12:01 a.m. Pacific Time on the effective date.

Dependents may be enrolled within 31 days of the Employee's eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the County's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents qualify for a Special Enrollment Period, and the premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Employee qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 31 days of the event, the effective date of enrollment will be the first day of the pay period following the pay period in which the qualifying event occurred.

Premiums

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. Blue Shield will provide the County with information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the County

to Blue Shield. Any amount the Subscriber must contribute is set by the County. The County will receive notice of changes in Premiums at least 60 days prior to the change. The County will notify the Subscriber immediately.

Grace Period

After payment of the first Premium, the Contractholder is entitled to a grace period of 180 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, the Contract will remain in force. However, the Contractholder 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)

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 and terms of this Health Plan, including but not limited to, Covered Services, Deductible, Copayment, Coinsurance and annual Out-of-Pocket Maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days written notice of any such change.

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

Renewal of the Group Health Service Contract

This Contract has a 12-month term beginning with the eligible County's effective date of coverage. So long as the County continues to qualify for this Health Plan and continues to offer this plan to its Employees, Employees and Dependents will have an annual Open Enrollment period of 30 days before the end of the term to make changes to their coverage. The County will give notice of the annual Open Enrollment period.

Blue Shield will offer to renew the County's Group Health Service Contract except in the following instances:

1) non-payment of Premium;
2) fraud, or intentional misrepresentation of a material fact;
3) failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4) termination of plan type by Blue Shield;
5) County relocates outside of California; or
6) County is an association and association membership ceases.

Termination of Benefits (Cancellation and Rescission of Coverage)

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 of this Health Plan following termination of a Member's coverage.

Cancellation at Member Request

If the Subscriber is making any contribution towards coverage for himself or herself, or for Dependents, the Subscriber may request termination of this coverage. Subject to the County's eligibility and enrollment rules, if coverage is terminated at the Subscriber's request, coverage will end at 11:59 p.m. Pacific Time on the last date for which Premiums have been paid.

Cancellation of Member's Enrollment by Blue Shield

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber and the County:

1) Providing false or misleading material information on the enrollment application or otherwise to the County or Blue Shield; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;
2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
3) Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the County does not meet the applicable eligibility, participation and contribution requirements of the Contract, Blue Shield will cancel this coverage after 30 days' written notice to the County.

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

Blue Shield 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 section.

Cancellation by the County

This Health Plan may be cancelled by the County at any time provided written notice is given to all Employees and Blue Shield to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for County's Non-Payment of Premiums

Blue Shield may cancel this Health Plan for nonpayment of Premiums. If the County fails to pay the required Premiums when due, coverage will terminate upon expiration of the 180-day grace period and 30 day notice of intent period following notice of termination for nonpayment of premium. The County will be liable for all Premium accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will mail the County a Cancellation Notice (or Notice Confirming Termination of Coverage). The County must provide enrolled Employees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the 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. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the County prior to any rescission.

In the event the Contract is rescinded or cancelled, either by Blue Shield or the County, it is the County's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

If a Member is hospitalized or undergoing treatment for an ongoing condition and the Contract is cancelled for any reason, including non-payment of Premium, no Benefits will be provided unless the Member obtains an Extension of Benefits. (See the *Extension of Benefits* section for more information.)

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates:

1) the date the County Group Health Service Contract is discontinued;
2) the last day of the month in which the Subscriber's employment terminates, unless a dif-

ferent 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); or

4) the last day of the month in which the Subscriber and Dependents become ineligible for coverage, except as provided below.

Even if a Subscriber remains covered, his Dependents' coverage may end if a Dependent become ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible on the last day of the pay period following the pay period in which his or her 26th birthday occurs, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 90 days following that Dependent's birth or placement for adoption, Benefits under this Health Plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the County or Blue Shield for information on options for continued group coverage or individual options. 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), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The County is solely responsible for notifying their Employee of the availability and duration of family leaves.

Reinstatement

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact Blue Shield or the County regarding reinstatement options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or Dependents qualify for a Special Enrollment Period (see Special Enrollment Periods in the Definitions section). The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under this health plan and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits, 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) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on which a replacement carrier provides coverage to the Member.

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

Group Continuation Coverage

Please examine group continuation coverage options carefully before declining this coverage.

A Member can continue his or her coverage under this group Health Plan when the Subscriber's 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 Subscriber's 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 may elect to continue group coverage under this Plan if the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Contractholder 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).

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 Contractholder 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):
   a. the death of the Subscriber;
   b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct);
   c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility;
   d. the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership;
   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.

   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.
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 County 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 his or her 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 Group Continuation 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 continuation of coverage under Cal-COBRA. If the enrollee is eligible and chooses to continue coverage under Cal-COBRA, the enrollee must notify Blue Shield of their Cal-COBRA election at least 30 days before COBRA termination.

Payment of Premiums

Premiums for the Member continuing coverage shall be 102 percent of the applicable group Premium rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Premium 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 Premium 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 Premium 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 Premium contributions to Blue Shield in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premiums must be paid within 45 days of the date the Member provided written notification to Blue Shield of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The Premium 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 Group Continuation Coverage

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

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 the County or to Blue Shield 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 Member's

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

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 and its Participating Providers stipulates that the Subscriber shall not be responsible to the Participating Provider for compensation for any services to the extent that they are provided in the Member's Group Contract. Participating Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments and Coinsurance, and amounts in excess of specified Benefit maximums, or as provided under the *Exception for Other Coverage* and *Reductions-Third Party Liability* sections.

If services are provided by a Non-Participating Provider, the Member is responsible for all amounts Blue Shield does not pay.

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

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.

No Lifetime Benefit Maximum

There is no maximum limit on the aggregate payments made by Blue Shield for Covered Services provided under the Contract and this Health Plan.

No Annual Dollar Limits on Essential Health Benefits

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

Independent Contractors

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts, or omissions of any person 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. Possession of a Blue Shield ID card confers no right to Covered Services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber or Dependent who has been accepted by the County and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

Participating Providers are paid directly by Blue Shield.

If the Member receives services from a Non-Participating Provider, payment will be made directly

to the Subscriber, and the Subscriber is responsible for payment to the Non-Participating 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 shall have the power and complete authority to construe and interpret the provisions of the group health service contract , to determine the Benefits of this Plan and determine eligibility to receive Benefits under the contract. Blue Shield shall exercise this authority for the benefit of all Members entitled to receive Benefits under the group health service contract.

Public Policy Participation Procedure

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

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

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

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

Please follow the following procedure:

1) 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) Please include name, address, phone number, Subscriber number, and group number with each communication.
3) The public 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) Public 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. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes within 10 business days after the minutes have been approved.

Confidentiality of Personal and Health Information

Blue Shield protects the privacy of individually identifiable personal information, including Protected Health Information. Individually identifiable personal information includes health, financial, and/or demographic information such as name, address, and social security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this EOC, or by accessing Blue Shield's internet site at www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Access to Information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Contract. By enrolling in this Health Plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in the Member's possession.

Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

Grievance Process

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

Medical Services

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

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member 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 Member may also submit the grievance online by visiting www.blueshieldca.com.

For all grievances except denial of coverage for a Non-Formulary Drug: Blue Shield will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days.

Members can 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. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service.

For grievances due to denial of coverage for a Non-Formulary Drug: If the County selected the optional Outpatient Prescription Drug Benefits Supplement as a Benefit and Blue Shield denies an exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

For all grievances: The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction.

Mental Health and Substance Use Disorder Services

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

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Department. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms should be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting 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 five 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 Member'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 Member should contact the Blue Shield Customer Service Department as shown on the back page of this EOC.

Members can 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. The MHSA 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. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE 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

For grievances involving claims 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).

Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member 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 the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's physician will receive copies of the opinions of the external review agency. 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 and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member 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 **1-855-599-2657** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-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.

Customer Service

For questions about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care, contact Blue Shield's Customer Service Department. Customer Service can answer many questions over the telephone. Contact Information is provided on the last page of this EOC.

For all Mental Health and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and Substance Use Disorder Services, MHSA Participating Providers, or Mental Health and Substance Use Disorder Benefits. Members 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

Definitions

When the following terms are capitalized in this EOC, they will have the meaning set forth below:

Accidental Injury — a definite trauma, resulting from a sudden, unexpected and unplanned event,

occurring by chance, and 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 considered ADL.

Allowable Amount (Allowance) — the total amount Blue Shield allows for Covered Service(s) rendered, or the provider's billed charge for those Covered Services, whichever is less. The Allowable Amount, unless specified for a particular service elsewhere in this EOC, 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 Covered Service(s) rendered.
2) For a Non-Participating Provider who provides Emergency Services, anywhere within or outside of the United States:
   a. Physicians and Hospitals — the amount is the Reasonable and Customary Charge; or
   b. All other providers — the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount.
3) For a Non-Participating Provider in California, who provides services (other than Emergency Services): the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
   a. Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable and Customary Charge.
4) For a provider outside of California (within or outside of the United States), that 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 the Covered Service(s) rendered.
5) For a Non-Participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield Plan, who provides services (other than Emergency Services): the amount that the local Blue Cross and/or Blue Shield Plan would have allowed for a non-participating provider performing the same services. Or, if the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

Alternate Care Services Provider — refers to a supplier of Durable Medical Equipment, or a certified orthotist, prosthetist, or prosthetist-orthotist.

Ambulatory Surgery Center — an outpatient surgery facility providing outpatient services 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.

Bariatric Surgery Services Provider — a Participating Hospital, Ambulatory Surgery Center, or a Physician that has been designated by Blue Shield to provide bariatric surgery services to Members who are residents of designated counties in California (described in the Covered Services section of this EOC).

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

Benefits (Covered Services) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to the Group Health Service Contract.

BlueCard Service Area — the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

Blue Shield of California — a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this EOC, as Blue Shield.

Calendar Year — the 12-month consecutive period beginning on January 1 and ending on December 31 of the same calendar year.

Care Coordination — Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's health-care needs across the continuum of care.

Care Coordinator — An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee — A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

Coinsurance — the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Copayment — the specific dollar amount that a Member is required to pay for 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 Medically Necessary services and supplies 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 County 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 insurance, 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) The Medicare Program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as Medi-Cal in California).
4) Any other publicly sponsored program of medical, hospital or surgical care, provided in this state or elsewhere.
5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq.
6) A medical care program of the Indian Health Service or of a tribal organization.
7) A state health benefits high risk pool.
8) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.
9) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
10) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).

11) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial Care 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 Doctor of Medicine) or care furnished to a person 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 individual to live outside an institution providing such care; or
2) when, despite such treatment there is no reasonable likelihood that the disability will be so reduced.

Deductible — the Calendar Year amount which the Member must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Group Health Service Contract.

Dependent — the spouse or Domestic Partner, or child, of an eligible Employee, who is determined to be eligible.

1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in this Agreement.
3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child 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 must submit 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 must be submitted to Blue Shield on the following schedule:
      i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
      ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

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

Domestic Partner — an individual who is personally related to the Member by a registered domestic partnership.

Both persons must 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 oppo-

site 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.

Emergency Medical Condition (including a psychiatric emergency) — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1) placing the Member's health in serious jeopardy;
2) serious impairment to bodily functions;
3) serious dysfunction of any bodily organ or part.

Emergency Services — the following services provided for an Emergency Medical Condition:

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

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

"Post-Stabilization Care" means Medically Necessary services received after the treating physician determines the Emergency Medical Condition is stabilized.

Emergency Services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition. If the Member reasonably should have known that an Emergency Medical Condition did not exist, the services will be covered at the applicable Participating or Non-Participating Provider level of Benefits.

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

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 for health coverage binding both Blue Shield and the County that establishes the Benefits that Subscribers and Dependents are entitled to receive for Group Medical benefits.

Habilitative Services — Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people

with disabilities in a variety of inpatient or outpatient settings, or both.

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

Hemophilia Infusion Provider — a provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

Note: A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

Home Health Aide — an individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the patient's home.

Hospice or Hospice Agency — an entity which provides hospice services to persons with a Terminal Disease or Illness and holds a license as a hospice pursuant to California Health and Safety Code Section 1747, or a home health agency licensed pursuant to California Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital — an entity which is:

1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the 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;
2) a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

A facility which is principally a rest home, nursing home, or home for the aged, is not included in this definition.

Host Blue — The local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the BlueCard Service Area.

Infertility —

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

Intensive Outpatient Program — an outpatient mental health or substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.

Inter-Plan Arrangements — Blue Shield's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

Late Enrollee — an eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage , provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the date a written request for coverage is made or at the County's next Open Enrollment Period. An eligible Employee or Dependent may qualify for a Special Enrollment Period.

Medical Necessity (Medically Necessary) —

Benefits are provided only for services that are Medically Necessary.

1) Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:
   a. consistent with Blue Shield medical policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2) If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.
3) Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services that are not Medically Necessary include hospitalization:
   a. for diagnostic studies that could have been provided on an outpatient basis;
   b. for medical observation or evaluation;
   c. for personal comfort;
   d. in a pain management center to treat or cure chronic pain; and
   e. for inpatient Rehabilitative Services that can be provided on an outpatient basis.
4) Blue Shield reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member — an individual who is enrolled and maintains coverage in the Group Health Service Contract as either a Subscriber or a Dependent.

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

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

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

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health or Substance Use Disorder Services.

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

Negotiated Arrangement (Negotiated National Account Arrangement) — An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Non-Participating (Non-Participating Provider) — refers to any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as pay-

ment in full for Covered Services provided to Members.

This definition does not apply to providers of Mental Health and Substance Use Disorder Services, which is defined separately under the MHSA Non-Participating Provider definition.

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

Office Visits for Outpatient Mental Health and Substance Use Disorder Services — professional office visits for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions, including the individual, family or group setting.

Open Enrollment Period — that period of time set forth in the Contract during which eligible Employees and their Dependents may enroll in this coverage, or transfer from another health benefit plan sponsored by the County to this coverage.

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

Other Outpatient Mental Health and Substance Use Disorder Services — Outpatient Facility and professional services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions, including, but not limited to the following:

1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
4) Office-Based Opioid Treatment
5) Transcranial Magnetic Stimulation
6) Behavioral Health Treatment
7) Psychological Testing

These services may also be provided in the office, home or other non-institutional setting.

Other Providers — independent practitioners, including licensed vocational nurses; licensed practical nurses; registered nurses; licensed nurse practitioners; registered dieticians; certified nurse midwives; enterostomal therapists; dental technicians; and lab technicians.

Out-of-Area Covered Health Care Services — Medically Necessary Emergency Services, Urgent Services, or Out-of-Area Follow-up Care provided outside the Plan Service Area.

Out-of-Area Follow-up Care — non-emergent Medically Necessary services to evaluate the Member's progress after Emergency or Urgent Services provided outside the service area.

Out-of-Pocket Maximum — the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate, do not accrue to the Calendar Year Out-of-Pocket Maximum.

Outpatient Facility — a licensed facility which provides medical and/or surgical services on an outpatient basis. The term does not include a Physician's office or a Hospital.

Partial Hospitalization Program (Day Treatment) — an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Patients may be admitted directly to this level of care, or transferred from inpatient care following stabilization.

Participating Hospice or Participating Hospice Agency — an entity which: (1) provides Hospice services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification; and (2) 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 (Participating Provider) — refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

This definition does not apply to providers of Mental Health Services and Substance Use Disorder Services, which is defined separately under the MHSA Participating Provider definition.

Period of Care — the timeframe the Participating Provider certifies or recertifies that the Member requires and remains eligible for Hospice care, even if the Member lives longer than one year. A Period of Care begins the first day the Member receives Hospice services and ends when the certified timeframe has elapsed.

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

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.

Plan — the Blue Shield PPO Plan.

Premium — the monthly prepayment made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Group Health Service Contract.

Preventive Health Services — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically described in the *Preventive Health Benefits* section of this EOC.

Provider Incentive — An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

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

Psychological Testing — testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

Reasonable and Customary Charge —

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

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 surgery for cleft palate procedures.

Rehabilitative Services — inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses and Severe Emotional Disturbances of a Child, in order to restore an individual's ability to function to the maximum extent practical. Rehabilitative Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

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

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

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.

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.

Skilled Nursing — services performed by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Public Health as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing unit within a Hospital.

Special Enrollment Period — a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this Health Plan outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee's Dependent has a 30-day Special Enrollment Period, except as otherwise stated in items 5 and 6, if any of the following occurs:

1) The eligible Employee or Dependent meets all of the following requirements:

    a. The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time he was offered enrollment under this Plan;

    b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that, if he was covered under another employer health plan or had other health insurance coverage, he 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;

    c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment; or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and

d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or

2) A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

3) 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, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of up to 12 months, unless he or she meets the criteria specified in paragraphs 1 or 2 above; or

4) For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal 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

5) For 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

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

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 Doctor of Medicine and provided by a licensed speech pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by diagnosed illness or injury.

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

Subscriber — an eligible Employee who is enrolled and maintains coverage under the Group Health Service Contract.

Substance Use Disorder Condition — drug or alcohol abuse or dependence.

Substance Use Disorder Services — services provided to treat a Substance Use Disorder Condition.

Terminal Disease or Terminal Illness (Termi-

nally Ill) — a medical condition resulting in a life expectancy of one year or less, if the disease follows its natural course.

Total Disability (or 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.

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

Value-Based Program (VBP) — An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

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 مجانی 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

សេវាកម្មភាសាឥតគិតថ្លៃ ។ 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 Kev 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

Outpatient Prescription Drug Rider

Group Rider

PPO

Summary of Benefits

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

Calendar Year Brand Drug Deductible (CYD)[1]

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

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

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Formulary Generic	$15/prescription		25% plus $15/prescription	
Formulary Brand	$30/prescription		25% plus $30/prescription	
Non-Formulary Brand	$30/prescription		25% plus $30/prescription	
Contraceptive Drugs and devices	$0		Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Formulary Generic Drugs	$30/prescription		Not covered	
Formulary Brand Drugs	$60/prescription		Not covered	
Non-Formulary Brand Drugs	$60/prescription		Not covered	
Contraceptive Drugs and devices	$0		Not covered	
Specialty Pharmacies	$15/prescription		Not covered	
Per prescription, up to a 30-day supply.				
Per prescription. Specialty Drugs are covered only when dispensed by a Network Specialty Pharmacy. Specialty Drugs from Non-Participating Pharmacies are not covered except in emergency situations.				

Notes

1 **Calendar Year Brand Drug Deductible (CYD):**

Blue Shield of California is an independent member of the Blue Shield Association

Notes

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

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

Outpatient prescription Drugs not subject to the Calendar Year Brand Drug Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Brand Drug Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

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

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

3 Using Non-Participating Pharmacies:

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

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

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

5 Outpatient Prescription Drug Coverage:

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

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

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

Outpatient Prescription Drug Benefit

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

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from a Participating Pharmacy, except as noted below.

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section. You, your Physician or Health Care Provider may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs.

Blue Shield's Formulary is established by Blue Shield's Pharmacy and Therapeutics Committee. This Committee consists of physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, health benefit based on the medical evidence, and comparative cost. They review new Drugs, dosage forms, usage and clinical data to update the Formulary during scheduled meetings four times a year. Note: Your Physician or Health Care Provider might prescribe a Drug even though the Drug is not included on the Formulary.

The Formulary is categorized into drug tiers as described in the chart below. Your Copayment or Coinsurance will vary based on the drug tier.

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

You can find the Drug Formulary at https://www.blueshieldca.com/bsca/pharmacy/home.sp. You can also contact Customer Service at the number provided on the back page of your EOC to ask if a specific Drug is included in the Formulary, or to request a printed copy.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

You must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs under the Outpatient Prescription Drug benefit. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. You can locate a retail Participating Pharmacy by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service at the number listed on the Identification Card. If you obtain Drugs without a Blue Shield Identification Card, Blue Shield will deny your claim, unless it is for a covered emergency.

Blue Shield negotiates contracted rates with Participating Pharmacies for covered Drugs. If your plan has a Brand Drug Deductible, you are responsible for paying the full contracted rate for Drugs until you meet the Member Calendar Year Brand Drug Deductible. Formulary Generic Drugs are not subject to, and will not accrue to the Calendar Year Brand Drug Deductible.

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

There is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See the *Prior Authorization/Exception Request Process/Step Therapy* section.

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you must pay the difference in cost, plus your Formulary Generic Drug Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Generic Drug Copayment or Coinsurance. For example, you select Brand Drug "A" when there is an equivalent Generic Drug "A" available. The Participating Pharmacy's contracted rate for Brand Drug "A" is $300, and the contracted rate for Generic Drug "A" is $100. You would be responsible for paying the $200 differ-

ence in cost, plus your Formulary Generic Drug Copayment or Coinsurance. This difference in cost does not apply to the Member Calendar Year Brand Drug Deductible or the Calendar Year Out-of-Pocket Maximum.

If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you can request an exception to paying the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity. See the section on *Prior Authorization/Exception Request Process/Step Therapy* below for more information on the approval process. If the request is approved, you pay only the applicable Copayment or Coinsurance.

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

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

When you obtain Drugs from a Non-Participating Pharmacy:

- You must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim form for reimbursement to:

  Blue Shield of California
  P.O. Box 419019,
  Dept. 191
  Kansas City, MO 64141
- You will be reimbursed as shown on the Summary of Benefits, based on the price you paid for the Drugs.

If you obtain Drugs from a Non-Participating Pharmacy for a covered emergency, Blue Shield will reimburse you based on the price you paid for the Drugs, minus any applicable Deductible, Copayment or Coinsurance.

You may obtain a claim form by calling Customer Service or by visiting www.blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

You have an option to use Blue Shield's Mail Service Prescription Drug Program when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of your Drug and may help you to save money. You may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. Your Physician or Health Care Provider must indicate a prescription quantity equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

You must pay the applicable Mail Service Prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit www.blueshieldca.com or call Customer Service to get additional information about the Mail Service Prescription Drug Program.

Obtaining Specialty Drugs through the Specialty Drug Program

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

Specialty Drugs are available exclusively from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or upon your request, will transfer the Specialty Drug to an associated retail store for pickup. See *Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA. To select a Network Specialty Pharmacy, you may go to http://www.blueshieldca.com or call Customer Service.

Go to http://www.blueshieldca.com for a complete list of Specialty Drugs. Most Specialty Drugs require prior authorization for Medical Necessity by Blue Shield, as described

in the *Prior Authorization/Exception Request Process/Step Therapy* section.

Prior Authorization/Exception Request Process/Step Therapy

Some Drugs and Drug quantities require prior approval for Medical Necessity before they are eligible for coverage under the Outpatient Prescription Drug Benefit. This process is called prior authorization.

The following Drugs require prior authorization:

- Some Formulary, compound Drugs, and most Specialty Drugs require prior authorization.
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.
- Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance.

Blue Shield covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug,
- There are no FDA-approved, commercially available, medically appropriate alternative,
- The compounded medication is self-administered, and
- Medical literature supports its use for the diagnosis.

You must pay the Non-Formulary Brand Drug Copayment or Coinsurance for covered compound Drugs.

You, your Physician or Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, we will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

To request coverage for a Non-Formulary Drug, you, your representative, or Health Care Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If step therapy coverage requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, you, your representative, or Health Care Provider can file a grievance with Blue Shield.

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

Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill

1. Except as otherwise stated below, you may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.
2. If you or your Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, your Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.
3. Blue Shield has a Short Cycle Specialty Drug Program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows you to receive a 15-day supply of your Specialty Drug and determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save out of pocket expenses if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You or your Physician may choose a full 30-day supply for the first fill.

   If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug. You can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service.
4. You may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable Mail Service Copayment or Coinsurance.

Refill authorizations cannot be combined to reach a 90-day supply.

5. 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.
6. You may receive up to a 12-month supply of contraceptive Drugs.
7. You may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

Blue Shield does not provide coverage in the Outpatient Prescription Drug Benefit for the following. You may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your EOC to determine if the Plan covers Drugs under that Benefit.

1. Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional (Physician) Benefits* and *Hospital Benefits (Facility Services)* sections of your EOC.
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of your EOC.
3. Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC) including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug.
4. Drugs for which you are 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 listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits,* and the *Orthotics Benefits* sections of your EOC.
7. Blood or blood products. See the *Hospital Benefits* section of your EOC.
8. Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.
9. Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of your EOC.
10. Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, Hospice Program Benefits,* or *Family Planning Benefits* sections of your EOC.
11. All Drugs for the treatment of infertility.
12. Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases prior authorization by Blue Shield is required.
13. Contraceptive drugs or devices which do not meet all of the following requirements:
    - Are FDA-approved,
    - Are ordered by a Physician or Health Care Provider,
    - Are generally purchased at an outpatient pharmacy, and
    - Are self-administered.

    Other contraceptive methods may be covered under the *Family Planning Benefits* section of your EOC.
14. Compounded medication(s) which do not meet all of the following requirements:
    - The compounded medication(s) include at least one Drug,
    - There are no FDA-approved, commercially available, medically appropriate alternatives,
    - The compounded medication is self-administered, and
    - Medical literature supports its use for the diagnosis.
15. Replacement of lost, stolen or destroyed Drugs.
16. If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice Program Benefits* section of your EOC.
17. Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to:
    - Antibiotics prescribed to treat infection,
    - Drugs prescribed to treat pain, or
    - Drug treatment related to surgical procedures

for conditions affecting the upper/lower jawbone or associated bone joints.

18. Except for a covered emergency, Drugs obtained from a pharmacy:
    - Not licensed by the State Board of Pharmacy, or
    - Included on a government exclusion list.
19. Immunizations and vaccinations 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).

Definitions

When the following terms are capitalized in this Outpatient Prescription Drug Supplement, they will have the meaning set forth below:

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

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

Calendar Year Brand Drug Deductible — the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug benefit.

Drugs — for coverage under the Outpatient Prescription Drug Benefit, Drugs are:

1. FDA-approved medications that require a prescription either by California or Federal law;
2. Insulin, and disposable hypodermic insulin needles and syringes;
3. Pen delivery systems for the administration of insulin, as Medically Necessary;
4. Diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets);
5. Over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;
6. Contraceptive drugs and devices, including:
    - diaphragms,
    - cervical caps,
    - contraceptive rings,
    - contraceptive patches,
    - oral contraceptives,
    - emergency contraceptives, and
    - female OTC contraceptive products when ordered by a Physician or Health Care Provider;
7. Inhalers and inhaler spacers for the management and treatment of asthma.

Formulary — a list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee. It is designed to assist Physicians and Health Care Providers 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 Drug, (2) contain the same active ingredient as the Brand Drug, and (3) typically cost less than the Brand 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 Customer Service number on your Blue Shield Identification Card.

Non-Formulary Drugs — Drugs that Blue Shield's Pharmacy and Therapeutics Committee has determined do not have a clear advantage over Formulary Drug alternatives.

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

Participating Pharmacy — a pharmacy which has agreed to a contracted rate for covered Drugs for Blue Shield Members. These pharmacies participate in the Blue Shield Pharmacy Network.

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

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

Contacting Blue Shield of California

For information, including information about claims submission:

Members may call Customer Service toll free at 1-855-599-2657

The hearing impaired may call Customer Service through Blue Shield's toll-free TTY number at 711 .

For prior authorization:

Please call the Customer Service telephone number listed above.

For prior authorization of Benefits Management Program radiological services:

Please call 1-888-642-2583.

For prior authorization of inpatient Mental Health and Substance Use Disorder Services:

Please contact the Mental Health Service Administrator at 1-877-263-9952.

Please refer to the *Benefits Management Program* section of this EOC for additional information on prior authorization.

Please direct correspondence to:

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

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blue of california

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

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

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

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

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

Phone: (844) 831-4133 (TTY: 711) Fax:
(916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

Blue Shield of California is an independent member of the Blue Shield Association A49726-REV (10/16)

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

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

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

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

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

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

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

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

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

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

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)