APPLICATION IS HEREBY MADE TO

Blue Shield of California

(California Physicians' Service)

FOR A GROUP HEALTH SERVICE CONTRACT

BY: Santa Barbara County Fire Fighters Local 2046
9500 Topanga Canyon Blvd
Chatsworth, CA 91311

This Contract, number **W0071665-M0030623**, shall be effective **January 1, 2023**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Enrolling Group, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity, or organization affiliated with the Association, shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations to the Contractholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

The Contractholder shall sign, date and return this original application page to Blue Shield of California, 601 12th Street, 20th Floor, Oakland, CA 94607, Attention: Product Operations. The Contract shall be retained by the Contractholder. Payment of Dues and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

The Contractholder is responsible for communicating any changes to Benefits as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*. Please see this section for important timelines for distribution of information.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 ____

_____

(Legal Name of Contractholder)

By _____

Title _____

PLEASE SIGN, DATE AND RETURN THE ORIGINAL APPLICATION PAGE TO BLUE SHIELD OF CALIFORNIA AT THE ABOVE ADDRESS. RETAIN THE CONTRACT.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

blue of california

blue of california

601 12th Street
Oakland, CA 94607
(510) 607-2000

GROUP HEALTH SERVICE CONTRACT

Blue Shield of California Access+ HMO® Plan

between

Santa Barbara County Fire Fighters Local 2046
("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of Dues, Blue Shield agrees to provide Benefits of this Contract to covered Eligible Persons and their covered Dependents.

This Contract shall be effective as of **January 1, 2023**, for a term of 12 months, subject to the provisions entitled, "Changes: Entire Contract".

Ken Lautsch
Vice President
Premier Accounts
Blue Shield of California

Group Number: **W0071665-M0030623**

Original Effective Date: **January 1, 2021**

IMPORTANT

No person has the right to receive the Benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the *Continuation of group coverage, Extension of Benefits, and Continuity of Care* sections of the Evidence of Coverage and Disclosure Form (EOC). Other than noted exceptions, Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the EOC, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in *Part V. Dues, Part VIII. General Provisions, D. Changes: Entire Contract*, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

TABLE OF CONTENTS

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations, and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form (EOC) is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the "*Definitions*" section of the EOC, the following provisions apply to this Group Health Service Contract:

Enrolling Group – an employer, or other defined or otherwise legally established group, to whom this policy is issued (the Contractholder).

Eligible Person – an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

PART III. ELIGIBILITY

A. Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the *Eligibility for this plan* section of the EOC, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Eligible Persons who enroll during the initial enrollment period shall be determined as follows:

   a. Each such individual is an Eligible Person as determined by the Enrolling Group on the effective date of this Contract is eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the first of the month following the completion of any applicable waiting period established by the Enrolling Group.

   c. If associated Enrolling Groups are added, the effective date of the amendment adding an associated Enrolling Group shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Eligible Persons of such Enrolling Group.

2. The date of eligibility of a former Eligible Person, who has been re-employed, shall be determined as follows: The Eligible Person's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:

   a. he has resumed active work after such termination; or

   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights. However, there will be no waiting periods as prohibited by The Military & Veterans Code; or

   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Eligible Person entering the employ of the Enrolling Group on the date he resumed work and shall be eligible on the date he completes the period of service specified in *A.1.b.*

3. If any class of Eligible Persons is not eligible under *A.1.*, and if an Eligible Person transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Enrolling Group on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

4. The Enrolling Group agrees to offer health Benefits coverage to all Eligible Persons during the initial enrollment period and distribute information as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*. In addition, the Enrolling Group agrees to get the Eligible Person's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of the Eligible Person's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or at the Enrolling Group's next Open Enrollment Period, whichever is earlier, unless the Eligible Person meets the criteria specified in *paragraph 1.* of the definition of *Late Enrollee*. Blue Shield will not consider applications for earlier effective dates.

5. An Eligible Person may transfer enrollment for himself or his Dependent(s) from another group health plan sponsored by the Enrolling Group to the health Plan covered by this Contract only during the Enrolling Group's annual Open Enrollment Period. The effective date of Benefits for such Eligible Person and Dependent(s) shall be the first day of each subsequent January. Submission of evidence of acceptability is not required when application is made during this Open Enrollment Period.

6. The Enrolling Group shall timely report any additions or terminations of Eligible Persons or Dependents so that retroactive Dues adjustments are avoided and claims are not paid for ineligible individuals. However, if the Enrolling Group determines that it has made an administrative error in the processing of eligibility for an Eligible Person or Dependent, Blue Shield will accept the retroactive changes subject to the following limitations:

a. Blue Shield will accept enrollment of the Eligible Person or Dependent retroactively for a maximum of 90 days, as long as Dues are paid by the Enrolling Group for the entire retroactive enrollment period. If an Eligible Person or Dependent is retroactively enrolled pursuant to this, and the Eligible Person or Dependent received covered health care services during that retroactive period, Blue Shield will reimburse the Eligible Person for payments made for Covered Services received in accordance with the rules of the EOC, minus the Member's Copayments or Coinsurance as stated in the EOC;

b. Blue Shield will accept termination/disenrollment of the Eligible Person or Dependent retroactive for a maximum of 90 days and will refund appropriate Dues paid for the retroactive termination period. In such case, Blue Shield reserves the right to request refund from the Eligible Person for any payments made for services rendered during the retroactive termination period. In making a request for retroactive termination or disenrollment, Contractholder shall comply with all applicable state and federal law, including, but not limited to, the Patient Protection & Affordable Care Act and any related regulations.

7. The Enrolling Group agrees to comply with the requirements of Section 2708 of the Patient Protection & Affordable Care Act (Section 2708), which prohibits a group from imposing a prohibited waiting period. "Waiting period" means a period that is required to pass before an otherwise Eligible Person will be able to enroll in coverage under the Group Contract. Specifically, Enrolling Group agrees:

   a. Any conditions of eligibility or waiting periods imposed on the Eligible Person will comply with the requirements of Section 2708 and California state law and any rules and regulations implementing those requirements.

   b. Enrolling Group will notify Blue Shield if Enrolling Group imposes a waiting period on an Eligible Person that would exceed the time-period permitted by Section 2708.

   c. The Enrolling Group must ensure that any orientation period that may be imposed by the Enrolling Group prior to the start of the waiting period is consistent with federal regulations. The Enrolling Group will notify Blue Shield of the Eligible Person's eligibility for coverage after the orientation period.

   d. Enrolling Group will notify Blue Shield if any changes are made regarding these representations.

   e. Enrolling Group will hold Blue Shield harmless for any violation of the requirements of Section 2708 or California state law.

B. Associated Enrolling Groups

Eligible Persons of the following listed Enrolling Groups associated with the Enrolling Group as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Enrolling Groups shall be considered service with the Enrolling Group. The Enrolling Group may act for and on behalf of any associated Enrolling Groups in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Enrolling Group shall bind all associated Enrolling Groups.

list of associated Enrolling Groups

None

PART III. ELIGIBILITY

C. Termination of Benefits

In addition to the provisions contained in the *When coverage ends* section of the EOC, the following provisions apply to this Group Health Service Contract:

1. The Benefits of a Member shall cease on the first day of the month following the month in which the Subscriber retires, is pensioned, leaves voluntarily, or is dismissed from the Contractholder or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:

    a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Dues for that Subscriber shall continue coverage in force in accordance with the Enrolling Group's policy regarding such coverage; or,

    b. if the Enrolling Group 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 pursuant to such Acts, payment of Dues for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Enrolling Group is solely responsible for notifying Eligible Persons of the availability and duration of family leaves.

2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31st day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written or electronic application for the addition of the Dependent is submitted to and received by Blue Shield within 31 days following the effective date of coverage.

PART IV. GROUP RENEWAL PROVISIONS

A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract

The Enrolling Group shall be notified by Blue Shield of its intent to renew this Group Health Service Contract at least 180 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in *Part V. Dues, Paragraph D., or in Part VIII. General Provisions, Paragraph D. Changes: Entire Contract*.

B. Renewal of the Group Health Service Contract

Blue Shield will renew this Group Health Service Contract at the option of the Contractholder except in the following instances:

1. the Contractholder or an Enrolling Group violates a material contract provision relating to group contributions or group participation rates;
2. the Contractholder fails to pay the required Dues as specified under *Part V.* Dues;
3. the Contractholder commits fraud or other intentional misrepresentation of material fact;
4. the Contractholder relocates outside of California;
5. Blue Shield ceases to offer a plan type purchased by the Contractholder;
6. Blue Shield ceases to offer health benefit plans in the state (withdrawal of all products).

PART V. DUES

A. Dues

Monthly Dues

M0030623

Subscriber	$1,154.09
Additional for one Dependent	$992.51
Additional for two or more Dependents	$1,800.38

B. When and Where Payable

1. The first month's Dues must be paid to Blue Shield by the effective date of this Contract and subsequent Dues shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Dues payment has been received by Blue Shield.

2. Dues for Eligible Persons and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Dues for Eligible Persons and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

3. All Dues are payable by the Enrolling Group to Blue Shield of California. The payment of any Dues shall not maintain the Benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in *Part V. F.*

C. The terms of this Contract or the Dues payable therefor may be changed from time to time as set forth in *Part VIII., D. Changes: Entire Contract*.

D. The Enrolling Group shall remit to Blue Shield the amount specified in *Part V. A. ("the Dues")*. If a Federal, State or any other taxing or licensing authority imposes upon Blue Shield any tax or fee on account of any of the Enrolling Group's health benefit plans that is not included in the Dues, whether such tax or fee is based on Dues, gross receipts, enrollment or any other basis, Blue Shield may amend the Contract to increase the Dues by an amount sufficient to cover any such tax or fee rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice, which shall not be earlier than the date of the imposition of such tax or fee, by mailing a postage prepaid notice of the amendment to the Enrolling Group at its address of record with Blue Shield at least 60 days before the effective date of the amendment. In the case of Federal excise taxes, Blue Shield may also amend the Dues to include any increased Federal income taxes to Blue Shield associated with such Federal excise taxes.

E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under *Part V. D.*, the Dues charged therefor may be made, or the Dues credit therefor may be given, as of the effective date of such change.

F. A grace period of 30 days to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Enrolling Group shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Blue Shield will send a Notice of Start of Grace Period to the Enrolling Group after the last date of paid coverage. The 30-day grace period begins on the day the Notice of Start of Grace Period is dated. Cancellation for non-payment of Dues shall be in accordance with *PART VII.B.*

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Out-of-Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever a Member accesses services outside of California, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements available to Members under this agreement are described generally below.

When Members access services outside of California, they may obtain care from participating health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from non-participating health care providers in the Host Blue geographic area that do not have a contractual agreement with the Host Blue. Blue Shield's payment practices in both instances are described below.

The Blue Shield Access+ HMO plan covers only limited health care services received outside of California. As used in this section, Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care obtained outside of California. Any other services will not be covered when processed through an Inter-Plan Arrangement, unless authorized by Blue Shield.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Members access Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, the Host Blue will be responsible for contracting and handling substantially all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of Member liability on claims for Out-of-Area Covered Health Care Services processed through the BlueCard Program will be based on the lower of the provider's billed charges or the negotiated price made available to Blue Shield by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Blue Shield by the Host Blue may be represented by one of the following:

(i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed, without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed charges for Out-of-Area Covered Health Care Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated price, or average price. Host Blues using either an estimated price, or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., a prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Blue Shield in determining the Enrolling Group's Premiums.

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax, or other fee that applies to insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee in determining Enrolling Group's Premiums.

Non-Participating Providers Outside of California

When Out-of-Area Covered Health Care Services are received from non-participating providers outside of California, but within the BlueCard Service Area, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment Blue Shield will make for the Out-of-Area Covered Health Care Services as set forth in this paragraph.

Claims for covered Emergency Services are paid based on the Allowed Charges as defined in the EOC.

Blue Shield Global Core

If Members are outside the BlueCard Service Area, they 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 in the BlueCard Service Area. Although Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard Service Area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services. Details for Blue Shield Global Core claim submission are provided in the *Out-of-area services* section of the EOC.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The Enrolling Group may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

B. Cancellation for Non-Payment of Dues

Blue Shield may cancel this Contract for non-payment of Dues. If Dues are not received when due, coverage will end the day following the 30 day grace period, as described in Part V.F. hereof. The Enrolling Group will be liable for all Dues accrued while this Contract continues in force including those accrued during the 30-day grace period. In such case, Blue Shield will send a Notice of End of Coverage to the Enrolling Group and enrolled Eligible Persons no later than five calendar days after the date coverage ends. A new application for coverage will be required by the Enrolling Group and a new Contract will be issued only upon demonstration that the Enrolling Group meets all underwriting requirements at the time of application.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind this Contract within 24 months following issuance for fraud or intentional misrepresentation of material fact by the Enrolling Group; or with respect to coverage of Eligible Persons or Dependents, for fraud or intentional misrepresentation of material fact by the Eligible Person, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Enrolling Group) may, at the discretion of Blue Shield, result in the cancellation or rescission of this Contract. A rescission voids the Contract retroactively as if it was never effective. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to the Enrolling Group prior to any rescission. The Enrolling Group must provide enrolled Eligible Persons with a copy of the Notice of Cancellation, Rescission or Nonrenewal.

D. Grace Period

The Enrolling Group shall be entitled to a grace period of 30 days for payment of Dues, as described in *PART V.F.* hereof. If during a grace period written notice is given by the Enrolling Group to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Enrolling Group or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Enrolling Group shall be liable to Blue Shield for the payment of pro rata Dues for the period commencing with the last transmittal date and ending with the date of such discontinuance.

E. Payment or Refund of Dues Upon Cancellation

In the event of cancellation, the Enrolling Group shall promptly pay any earned Dues which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Enrolling Group the amount of prepaid Dues, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

F. Termination of Benefits

No Benefits shall be provided for Services rendered after the effective date of cancellation, except as specifically provided in the *Continuation of group coverage and Extension of Benefits* sections of the EOC.

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Dues, no further Benefits will be provided after cancellation unless the Member is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of Benefits in accordance with the *Extension of Benefits* section of the EOC.

G. Enrolling Group to Provide Subscribers with Notice of Cancellation, Rescission or Nonrenewal

If this Contract is rescinded, or cancelled by either party, the Enrolling Group shall notify all Enrolling Groups and Subscribers. If rescinded or cancelled by Blue Shield, the Enrolling Group shall promptly mail a copy of Blue Shield's Notice of Cancellation, Rescission or Nonrenewal to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the EOC, the following provisions apply to this Group Health Service Contract:

A. Choice of Providers

The Plan has established a network of primary care and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Services to Members. A Member must obtain or receive approval for all Covered Services from his Primary Care Physician. Each Subscriber must select a Primary Care Physician for himself and each of his Dependents from the list of Primary Care Physicians in the HMO Physician and Hospital Directory. The Physician and Hospital Directory will be given to Members at the time of enrollment. A Member's Primary Care Physician will be accessible to the Member on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements to assure coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Plan Hospitals. The list of Providers in the Physician and Hospital Directory includes the location and phone numbers of all Primary Care Physicians, Plan Hospitals, and Participating Hospice Agencies in the Primary Care Physician Service Area. Members should contact Member Services for information on Plan Non-Physician Health Care Practitioners in their Primary Care Physician Service Area.

B. Use of Masculine Pronoun

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. Workers' Compensation

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

D. Changes: Entire Contract

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Enrolling Group or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract, the Dues payable therefor, and the benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment and annual Out-of-Pocket Maximum amounts, may be changed from time to time. Blue Shield will provide at least 60 days' written notice of any such change, and these changes shall not become effective until at least 60 days after written notice of such change is delivered or mailed to the Enrolling Group's last address as shown on the records of Blue Shield. Benefits for services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

Notice of changes in Benefits, and any documents that may be delivered to the Enrolling Group or the Enrolling Group's representative for the purpose of informing Members of the details of their coverage under this Contract, will be distributed by the Enrolling Group or his representative as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*.

E. Statutory Requirements

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act ("HIPAA") and applicable Centers for Medicare and Medicaid Services ("CMS") requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

PART VIII. GENERAL PROVISIONS

F. Legal Process

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

G. Time of Commencement or Termination

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

H. Records and Information to be Furnished

The Enrolling Group shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Dues and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, group identification number and group size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

I. Inquiries and Complaints

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to the Plan at the address or telephone number indicated on page *GC-1* of this Contract. (See also the *How to contact Customer Service* section of the EOC.)

J. Confidentiality

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Plan to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, the Plan may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

K. Termination of a Plan Provider Contract

1. Blue Shield shall provide written notice to the Contractholder within a reasonable period of time of any termination or breach of Contract of a Plan Provider if such termination or breach may materially affect the Contractholder or its Subscribers.

2. Upon termination of a Plan Provider Contract, Blue Shield shall be liable for Benefits rendered by such provider to an eligible Member (other than for Copayments) until the authorized Services being rendered to the Member by the former Plan Provider are completed, unless Blue Shield makes reasonable and medically appropriate provision for the assumption of such Benefits by another Plan Provider.

L. Producer Service Fee

The Contractholder has selected and entered into an agreement with **John M. Fickewirth and Associates Insurance Services Inc.** ("Producer"), under which the Producer has agreed to provide consulting services to the Contractholder in connection with the Contractholder's Plan(s) (the "Service Agreement"), in return for payment from the Contractholder of compensation negotiated directly between the Contractholder and the Producer (the "Fee"). Blue Shield is not a party to the Service Agreement.

PART VIII. GENERAL PROVISIONS

The Contractholder requests that Blue Shield receive from the Contractholder and pay to the Producer certain amounts comprising payment for the Producer's services under the Service Agreement (the "Pass-Through Arrangement" or "Arrangement").

1. Blue Shield Duties and Responsibilities:

    a. Blue Shield agrees to accept from the Contractholder payment of the monthly Fee amount with the Contractholder's payment of Blue Shield's monthly Premium invoice to the Contractholder.

    b. Blue Shield will forward the Fee to the Producer within 30 days of receipt of the Fee from the Contractholder.

    c. Blue Shield will provide to the Contractholder a summary of the aggregate Fee paid by Blue Shield on behalf of the Contractholder to the Producer for each Calendar Year within 15 business days following the end of such Calendar Year.

    d. Blue Shield is not responsible for determining or confirming the correctness of any information provided by the Contractholder, including the amount of the Fee or the name or other payment information of the Producer to whom the Fee is to be paid; rather, Blue Shield is responsible only for the ministerial functions of receiving payment of the Fee and forwarding such payment to the Producer.

2. The Contractholder Duties and Responsibilities:

    a. The Contractholder acknowledges and agrees that the Fee is not a part of the Premium charged to the Contractholder by Blue Shield, that using the Producer or any other agent or broker is not a requirement for the Contractholder to obtain coverage from Blue Shield and the Contractholder may obtain insurance policies directly from Blue Shield, and that the Contractholder, and not Blue Shield owes and is fully responsible to the Producer for the Fee.

    b. The Contractholder agrees to pay the Fee at the same time payment is made for the Premium for Blue Shield coverages.

    c. The Contractholder will notify Blue Shield immediately if the Service Agreement between the Contractholder and the Producer is terminated.

    d. The Contractholder will be responsible for any and all tax reporting related to the payment of the Fee to the Producer, including Form 1099s, if required.

3. Payments and Adjustments:

    a. The Contractholder and the Producer have agreed that the amount of the Fee initially shall be 2.04% of the monthly Premium amount per month.

    b. The Contractholder will notify Blue Shield of any change to the Fee or the manner in which it is to be paid in writing. For purposes of Blue Shield's duties and responsibilities under this Arrangement, any such change will be effective the first day of the month following Blue Shield's receipt of such written notice of the change.

    c. The Contractholder will notify Blue Shield of a producer of record change in writing. For purposes of Blue Shield's duties and responsibilities under this Arrangement, any such change will be effective the first day of the month following Blue Shield's receipt of such written notice of the change. Following the change, Blue Shield will remit the Fee to the new producer.

    d. The parties acknowledge that any payment received by Blue Shield from the Contractholder will be applied first to Premiums due to Blue Shield, and any amount in addition to such Premiums to payment of the Fee. The Contractholder's failure to pay the Fee through Blue Shield will not subject the Contractholder to termination of any Blue Shield coverages for non-payment of Premium.

e. The Contractholder acknowledges and agrees that Blue Shield may deposit the Fee into a general account that may collect interest. Blue Shield may retain any interest or investment income on funds held in the account.

f. The Contractholder acknowledges and agrees that its Blue Shield coverages may, if otherwise eligible, be taken into account in the calculation of any bonus program offered by Blue Shield to the Producer.

4. Term and Termination:

a. This Pass-Through Arrangement will automatically terminate as of the effective date of the termination of the Contractholder's Blue Shield coverages.

b. The Contractholder may terminate this Arrangement at any time by providing written notice to Blue Shield. Such termination will be effective the first day of the month following Blue Shield's receipt of the notice of termination.

c. Blue Shield may terminate this Arrangement by providing no less than sixty (60) days' prior written notice to the Contractholder.

M. ERISA Plan Administrator

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

N. Continuity of Care

Blue Shield will administer continuity of care benefits as described in the Evidence of Coverage during the term of the Contract. Blue Shield will continue to administer continuity of care benefits for a maximum of 90 days following the date of receipt of notice of the termination of this Contract, as required under 42 USCS § 300gg-113.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder has various distribution of notices and Member materials and other notification requirements under this Group Health Service Contract. Some of the major Contractholder distribution and notification requirements are summarized below; however, this is a summary only and is not to be construed as an all-inclusive list.

A. Obtaining Declinations or Waivers of Coverage

All Eligible Persons will be offered health benefits coverage during the initial and subsequent enrollment periods. If an Eligible Person elects to decline or waive coverage, the Enrolling Group is responsible for obtaining the Eligible Person's signed acknowledgment of receipt of an explicit written notice in bold type specifying that failure to elect coverage during the Open Enrollment Period permits the Plan to impose an exclusion from coverage for a period of 12 months, or at the Enrolling Group's next Open Enrollment Period, whichever is earlier, unless the Eligible Person meets the criteria specified in the definition of Late Enrollee as set forth in the EOC.

B. Distribution of Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) will be issued by the Plan for all Eligible Persons and Dependents. The Enrolling Group is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The Enrolling Group will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The Enrolling Group shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the Enrolling Group does not distribute paper SBCs, then the Enrolling Group will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the Enrolling Group's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the Enrolling Group to the Subscriber and any Dependents no later than sixty (60) days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the Enrolling Group fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the Enrolling Group, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the Enrolling Group agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

C. Distribution of Member ID Cards and EOC Booklets

1. Member ID Cards

Membership identification cards will be issued by the Plan for all Subscribers and will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions.

2. EOC Booklets

An EOC which summarizes the Benefits of this Contract and how to obtain covered Services will be issued by the Plan for all Subscribers. The Plan will send the EOC to the Contractholder, and, the Contractholder is responsible for distributing the EOC to Subscribers whether in printed, hardcopy or electronic form.

EOCs will be provided to the Contractholder in electronic form (such as by Compact Disk (CD) or posted on Blue Shield's employer website) or in paper hard copy form. If Contractholder receives the EOC in electronic form, Contractholder is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the EOC after it is provided to Contractholder. If Contractholder receives the EOC in hard copy form, Contractholder will notify Subscribers that printed hard copies of the EOC are available and will promptly distribute to Subscribers.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

Contractholder may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Eligible Persons of Contractholder; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with Blue Shield's instructions for accessing the EOC from the Blue Shield website.

If Contractholder posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit Eligible Persons of Contractholder to download and print a complete and accurate copy of the EOC. Contractholder will notify Eligible Persons enrolled with Blue Shield that the EOC for their plan is available to review, download and print from Contractholder's intranet site, and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site.

Contractholder will provide a hard copy of the EOC to an Eligible Person upon request. If Blue Shield receives an inquiry from an Eligible Person of the Contractholder regarding obtaining a copy of the EOC, Blue Shield will refer that individual to Contractholder's human resources benefits staff with instructions that a copy of the EOC is available from Contractholder on request. Contractholder has the option to request a supply of hard copies of the EOC in an amount not to exceed 10% of the total subscriber count at no additional charge.

In the event Blue Shield reasonably concludes that Contractholder is either using the electronic EOC in a matter not permitted by this Agreement or is not providing Subscribers with access to the EOC in accordance herewith, then Blue Shield will print copies of the EOC, and Contractholder will cooperate with Blue Shield to ensure that printed copies of the EOC are timely provided to all Eligible Persons of Contractholder enrolled with Blue Shield. Contractholder agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the EOC documents.

D. Notice of Start of Grace Period or Notice of Cancellation, Rescission or Nonrenewal

Upon receipt of a Notice of Start of Grace Period or a Notice of Cancellation, Rescission or Nonrenewal from the Plan, the Enrolling Group shall promptly send any such Notice to each subscriber in a manner which complies with applicable law.

E. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). See the *Continuation of group coverage and Extension of Benefits* sections of the EOC for additional information.

1. COBRA

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations

To the extent required by COBRA, and upon timely receipt of Dues and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder is solely responsible for all aspects of the administration of COBRA and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder in the event that federal continuation of coverage requirements of COBRA apply to the Contractholder, include the following:

a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.

b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.

c. The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Enrolling Group's (Contractholder's) filing for reorganization under Title XI, United States Code.

d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.

e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and COBRA.

f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.

g. Contractholder or its COBRA administrator will provide notification of continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder 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.

h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.

i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

2. Cal-COBRA

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber’s termination or reduction in hours of employment within 30 days of the Qualifying Event.

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

An EOC booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this EOC and any applicable Supplements and are included as part of this Contract.

Note: In the EOC, references to "you" or "your" shall mean the eligible Subscriber and/or Dependent of this Plan. References to "we" or "us" shall mean the Plan and/or Blue Shield of California.

Combined Evidence of Coverage and Disclosure Form

Access+ HMO® Per Admit 20-250
Santa Barbara County Fire Fighters Local 2046
Group Number: W0071665-M0030623
Effective Date: January 1, 2023
Provider Network: Access+

blueshieldca.com

blue california

Table of contents

blue of california

Summary of Benefits

Group Plan
HMO Plan

Access+ HMO® Per Admit 20-250

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

Medical Provider Network: **Access+ HMO Network**

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. 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 Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$2,000
Family coverage	$2,000: individual
	$4,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Access+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$20/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$20/visit	
Teladoc consultation	$0	
Family planning • Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$20/visit	
Medical nutrition therapy, not related to diabetes	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$150/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$20/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
Outpatient Facility services		
Ambulatory Surgery Center	$50/surgery	
Outpatient Department of a Hospital: surgery	$200/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$250/admission	
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	$250/admission	
• Physician inpatient services	$0	
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	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
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	$0	
• Outpatient Department of a Hospital	$0	
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$20/visit	
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. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs, medical supplies, and visits by a nurse.		
Hemophilia home infusion services	$0	
Includes blood factor products.		
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	$100/day	
Hospital-based SNF	$100/day	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$20/visit	
• Medical nutrition therapy	$20/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, 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	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$250/admission	
Residential Care	$250/admission	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this 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.

Capitalized terms are defined 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 Plan.

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

3 Using 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.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

Notes

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

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

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

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

5 Separate Member Payments When Multiple Covered Services are Received:

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

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. 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.

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

Introduction

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

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

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

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

About this Evidence of Coverage

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

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

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

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

Tables and images

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

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

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

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

"You" means the Member

In this Evidence of Coverage, "you" or "your" means any Member enrolled in the plan, including the Subscriber and all Dependents. "The Trust Fund" means the Subscriber's Trust Fund.

Capitalized words have a special meaning

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

About this plan

This is a Health Maintenance Organization (HMO) plan. In an HMO plan, you have access to a network of providers who collaborate to bring you personal, efficient care. You will choose a Primary Care Physician (PCP) who is your first point of contact and manages your care. Your PCP is part of a group of Physicians called a Medical Group. Your PCP can refer you to Participating Providers in your Medical Group for specialized care and assist with other care needs. See the *How to access care* section for information about Participating Providers.

The Access+ HMO offers a wide choice of Physicians, Hospitals, and other Health Care Providers and includes special features such as Access+ Specialists.

How to contact customer service

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

- Download forms;
- View or print a temporary ID card;

- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

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

Contacting Customer Service

If you need information about	*You should contact*
Medical Benefits	Customer Service: 1-855-256-9404 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Mental Health and Substance Use Disorder services, including prior authorization	Mental Health Customer Service: (877) 263-9952 Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002

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

Your bill of rights

	As a Blue Shield Member, you have the right to:
1	Receive considerate and courteous care with respect for your right to personal privacy and dignity.
2	Receive information about all health services available to you, including a clear explanation of how to obtain them.
3	Receive information about your rights and responsibilities.
4	Receive information about your Blue Shield plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you.
5	Select a PCP and expect their team to provide or arrange for all the care you need.
6	Have reasonable access to appropriate medical and mental health services.
7	Participate actively with your PCP in decisions about your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8	A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your PCP, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
10	Receive Preventive Health Services.
11	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12	Have confidential health records, except when the law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your PCP.
13	Communicate with, and receive information from, Customer Service in a language you can understand.
14	Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
15	Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care.

	As a Blue Shield Member, you have the right to:
16	Voice complaints or grievances about your Blue Shield plan or the care provided to you.
17	Make recommendations on Blue Shield's Member rights and responsibilities policies.

Your responsibilities

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

How to access care

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

Health care professionals and facilities

This plan covers care from Participating Providers within your Medical Group.

Participating Providers

Participating Providers have a contract with a Medical Group in this plan's network. With an HMO plan, there is generally no coverage for services from providers outside of your Medical Group.

If a provider leaves your Medical Group, you will not have coverage for services received from that provider. See the *Continuity of Care* section for more information on how to continue treatment with a Non-Participating Provider.

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

Non-Participating Providers

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges as payment in full for Covered Services. Except for Emergency Services, Urgent Services, and services received at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, this plan does not cover services from Non-Participating Providers.

Non-Participating Providers at a Participating Provider facility

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

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants

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

Mental Health Service Administrator (Benefit Administrator)

Blue Shield contracts with the Mental Health Service Administrator (MHSA) to manage Mental Health and Substance Use Disorder services through their own network of providers. The MHSA authorizes services, processes claims, and addresses complaints and grievances for those Benefits on behalf of Blue Shield. If you receive a Covered Service from an MHSA Participating Provider, you should interact with the MHSA in the same way you would otherwise interact with your PCP.

Your Primary Care Physician

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

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

Selecting a PCP

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

PCPs may be:

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

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

Your relationship with your PCP

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

Your Medical Group

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

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

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

Changing your Medical Group

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

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

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

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

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

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

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

Specialist referrals

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

PCP referrals

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

Self-referral to an Access+ Specialist

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

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

You cannot self-refer to an Access+ Specialist for:

- Allergy testing;
- Endoscopic procedures;
- Diagnostic and nuclear imaging, including CT, MRI, or bone density measurement;
- Injectables, chemotherapy, or other infusion Drugs, other than vaccines and antibiotics;
- Infertility services;
- Inpatient services or any services that result in a facility charge, except for routine X-ray and laboratory services; or
- Services for which the Medical Group routinely allows you to self-refer without authorization from your PCP.

ID cards

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

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice. This fee will not be more than your Copayment or Coinsurance for the visit.

Continuity of care

Continuity of care may be available if:

- Blue Shield, the Medical Group, or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving;
- You are a newly-covered Member whose coverage choices do not include out-of-network Benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

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

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

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

Continuity of care with a Former Participating Provider

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

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

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

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

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

See the *Your payment information* section for more information about the Allowed Charges.

Second medical opinion

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

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

Your Medical Group will work with you to arrange for a second medical opinion.

Who provides your second medical opinion	
If you want a second opinion on	***It will come from***

Who provides your second medical opinion	
A proposed treatment plan from your PCP	Another PCP in your Medical Group
A proposed treatment plan from a Specialist	A Participating Provider in the same or equivalent specialty

Care outside of California

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

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

Away from Home Care

You or your Dependent may be able to enroll in Away from Home Care when you are on an extended stay within the service area of another Blue Cross or Blue Shield plan outside of California. Away from Home Care may be available for Dependents who are full-time students, Dependents of Subscribers who are required by court order to provide coverage, and long-term travelers. For more information on the program and which states participate, visit blueshieldca.com or call the Blue Shield of California Away from Home Care coordinators at (800) 622-9402.

Emergency Services

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

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

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the entire cost of that non-emergency service.

If you cannot find a Participating Provider

Your PCP will refer you to other providers in your Medical Group for the care you need. If these services cannot reasonably be obtained from a Participating Provider, you can ask your Medical Group for authorization to see a Non-Participating Provider. They will review your request for Medical Necessity, and if approved, your Medical Group will pay for Covered Services from the Non-Participating Provider. You will only be responsible for the Participating Provider Cost Share. If the Medical Group cannot provide the necessary care, you can call Customer Service for help finding a Participating Provider who can provide the requested services.

Other ways to access care

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

Teladoc

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

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

Telebehavioral health services

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

Urgent care centers

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

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

If you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your

Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.

Ambulatory Surgery Centers

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

Timely access to care

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

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

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

Health advice and education

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

NurseHelp 24/7SM

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

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

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

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

LifeReferrals 24/7SM

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

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

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

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

Health and wellness resources

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

- Prenatal and other health education programs;

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

Visit blueshieldca.com to explore these resources.

Medical management

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

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

Prior authorization and PCP referrals

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

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

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

Prescription Drugs administered by a Health Care Provider

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

When a decision will be made about your prior authorization request

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

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

While you are in the Hospital (inpatient utilization review)

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

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

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

After you leave the Hospital (discharge planning)

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

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. A Blue Shield care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Customer Service. A case manager can:

- Help you identify and access appropriate services;

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

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

Managing a serious illness (palliative care services)

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

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

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

Your payment information

Paying for coverage

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

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

Paying for Covered Services

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

Your Cost Share includes any:

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

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

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Services provided or arranged by Blue Shield, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections. Covered Services provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them.

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

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

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Services before Blue Shield begins payment. Blue Shield will pay for some Covered Services before you meet your Deductible.

Amounts you pay toward your Deductible count toward your Out-of-Pocket Maximum.

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for an individual Member and an entire Family.

If you have a Family plan, there is an individual Deductible within the Family Deductible. This means an individual family member can meet the individual Deductible before the entire Family meets the Family Deductible.

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

See the *Summary of Benefits* section for details on which Covered Services are subject to the Deductible and how the Deductible works for your plan.

Prior carrier Deductible credit

If you pay all or part of a Deductible for another Trust Fund-sponsored health plan in the same Calendar Year you enroll in this plan, that amount will be applied to this plan's Deductible if:

- You were enrolled in a Trust Fund-sponsored health plan with another carrier during the same Calendar Year this contract becomes effective and you enroll as of the original effective date of coverage under this contract;
- You were enrolled in another Blue Shield plan sponsored by the same Trust Fund which this plan is replacing; or
- You were enrolled in another Blue Shield plan sponsored by the same Trust Fund and you are transferring to this plan during open enrollment.

Copayment and Coinsurance

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

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

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

Calendar Year Out-of-Pocket Maximum

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

If you have a Family plan, you will have a separate Out-of-Pocket Maximum for each individual Member and one for the entire Family.

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

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

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

- Charges for services that are not covered;
- Charges over the Allowed Charges; and
- Charges for services over any Benefit maximum.

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

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

Accrual balance

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

Cost Share concepts in action

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

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

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

Deductible: **$500**

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

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

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

Participating Provider Copayment: **$30**

Blue Shield Allowed Charges for the doctor's visit: **$100**

	Participating Provider
You pay	**$30** ($30 Copayment)
Blue Shield pays	$70 (Allowed Charges minus your Cost Share)
Total payment to the doctor	$100 (Allowed Charges)

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

Claims for Emergency or Urgent Services

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

Claim forms are available at blueshieldca.com. Please submit your claim form and medical records within one year of the service date.

See the *Out-of-area services* section in the *Other important information about your plan* section for more information on claims for Emergency or Urgent Services outside of California.

Your coverage

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

Eligibility for this plan

To be eligible for coverage as a Subscriber, you must meet all of the Trust Fund's eligibility requirements and complete any waiting period established by the Trust Fund.

Dependent eligibility

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

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

Enrollment and effective dates of coverage

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

You are eligible for coverage as a Subscriber on the day following the date you complete any applicable waiting period established by the Trust Fund. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan

are not available before the effective date of coverage. This Contract has a 12-month term that begins on the Trust Fund's effective date of coverage.

Open enrollment period

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

Special enrollment period

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

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

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

For a complete list of Qualifying Events, see ***Special enrollment period*** on page 71 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Trust Fund Member or Dependents qualify for a special enrollment period, coverage will begin no later than the 1st of the month following the date Blue Shield receives the request for special enrollment from the Trust Fund.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

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

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

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

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

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

Plan changes

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

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

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

Coordination of benefits

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

When coverage ends

Your coverage will end if:

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

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

If the Trust Fund cancels coverage

The Trust Fund may cancel coverage at any time. To cancel coverage, The Trust Fund must provide written notice to Blue Shield and its Trust Fund Members.

If the Subscriber cancels coverage

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

Reinstatement

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

If Blue Shield cancels coverage

Blue Shield can cancel coverage if:

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

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

Cancellation for Trust Fund's nonpayment of Premiums

Blue Shield can cancel coverage if the Trust Fund does not pay the required Premiums in full and on time. The Trust Fund is responsible for all Premiums during the term of coverage, including the 30-day grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send a Notice of End of Coverage to you and the Trust Fund no later than five calendar days after the date coverage ends.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

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

Extension of Benefits

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

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

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

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

Continuation of group coverage

Please examine your options carefully before declining this coverage.

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

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

COBRA

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

Cal-COBRA

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

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

Cal-COBRA qualifying event

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

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

A child born to or placed for adoption with a covered Subscriber or Domestic Partner during the Cal-COBRA group coverage continuation period may be immediately added as a Dependent provided the Trust Fund is properly notified of the birth or placement for adoption, and the child is enrolled within 31 days of the birth or placement for adoption.

Notification of a qualifying event

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

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

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

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

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

Duration and extension of group continuation coverage

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

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

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

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

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

Payment of Premiums

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

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

Effective date of the continuation of group coverage

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

Termination of group continuation coverage

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

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

Continuation of group coverage while on leave

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

Family leave

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

on family leave. The Trust Fund is solely responsible for notifying their Trust Fund Member of the availability and duration of family leaves.

Military leave

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

Your Benefits

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

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

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the medical management section; and
- The terms, conditions, limitations, and exclusions of this Evidence of Coverage.

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

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

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

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

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

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

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

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and

- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

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

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

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

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

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

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

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

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

- It is a drug trial conducted under an investigational new drug application reviewed by the FDA;
- It is a drug trial exempt under federal regulations from a new drug application; or
- It is federally funded or approved by one or more of the following:

- One of the National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services; or
- A designated Agency affiliate or research entity as described in the Affordable Care Act, including the Departments of Veterans Affairs, Defense, or Energy if the study has been reviewed and approved according to Health and Human Services guidelines.

Diabetes care services

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

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

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

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

Self-management training and medical nutrition therapy

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

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

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

Benefits include:

- Diagnostic and therapeutic imaging services, such as X-rays and ultrasounds;
- Radiological and nuclear imaging, including CT, PET, and MRI scans;

- COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing;
- Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month. See the *Claims* section for information about how to submit a claim for repayment for this Benefit;
- Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit. A Physician or other Health Care Provider's order must be provided for coverage;
- Clinical pathology services;
- Laboratory services;
- Other areas of diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

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

For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services. During the federal COVID-19 Public Health Emergency, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing and related services from Non-Participating Providers.

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

Dialysis Benefits

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

Benefits include:

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

Benefits do not include:

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

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your

medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

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

Benefits do not include:

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

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefits Rider, if the Trust Fund selected it as an optional Benefit.

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

Orthotic equipment and devices

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

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;

- Knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

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

Prosthetic equipment and devices

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

Benefits include:

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

Benefits do not include:

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

Emergency Benefits

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

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

Benefits include:

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

After your condition stabilizes

Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

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

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

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

Family planning and Infertility Benefits

Family planning

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

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Tubal ligation; and
- Vasectomy.

Family planning services may also be covered under the Preventive Health Services Benefit and the Prescription Drug Benefits Rider, if the Trust Fund selected it as an optional Benefit.

Infertility Benefits

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

Fertility preservation services

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

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

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

Benefits include:

- Intermittent home care for skilled services from:
  - Registered nurses;
  - Licensed vocational nurses;
  - Physical therapists;
  - Occupational therapists;
  - Speech and language pathologists;
  - Licensed clinical social workers; and
  - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

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

Benefits are limited to a visit maximum as shown in the *Summary of Benefits* section for home health agency visits. For this Benefit, coverage includes:

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

Benefits do not include:

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

Home infusion and injectable medication services

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

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Parenteral nutrition services and associated supplies and solutions;
- Enteral nutrition services and associated supplies and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

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

This Benefit does not include:

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

Hemophilia home infusion services

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

Benefits include:

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

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

Benefits do not include:

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

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

Hospice program services

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

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

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

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;
- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;

- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

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

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
  - Semiprivate Hospital room, or private room if Medically Necessary;
  - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
  - General and specialized nursing care; and
  - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
  - Operating, recovery, labor and delivery, and other specialized treatment rooms;
  - Anesthesia, oxygen, medicines, and IV solutions;
  - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
  - Dialysis services and supplies;
  - Blood and blood products;
  - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
  - Radiation therapy, chemotherapy, and associated supplies;
  - Therapy services, including physical, occupational, respiratory, and speech therapy;
  - Acute detoxification;
  - Acute inpatient rehabilitative services; and
  - Emergency room services resulting in admission.

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

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

Benefits include:

- Treatment of gum tumors;
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;

- Surgical treatment of temporomandibular joint syndrome (TMJ);
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:
    - The Member is younger than seven years old; or
    - The Member is developmentally disabled; or
    - The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

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

Mental Health and Substance Use Disorder Benefits

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

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

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

Office visits

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

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

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health and Substance Use Disorders. You can receive these other outpatient services in a facility, office, home, or other non-institutional setting.

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

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

Benefits do not include:

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

Inpatient Services

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

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

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

Physician and other professional services

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

Benefits include:

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

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

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for conditions other than diabetes. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to receive medical nutrition therapy as long as your treatment is Medically Necessary. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

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

Benefits include:

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

Benefits do not include:

- Grocery store foods used by the general population; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

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

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

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

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

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
  - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
  - Screening for HPV;
  - Screening for osteoporosis; and
  - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;

- Adverse Childhood Experiences screenings;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. See the *Family planning Benefits* section for more information.

If there is a new recommendation or guideline in any of the resources described above, Blue Shield will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the plan year that begins after that year. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

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

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

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

Benefits do not include:

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

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

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

Rehabilitative and habilitative services

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

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

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

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

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

Physical therapy

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

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage as a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan.

Occupational therapy

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

Speech therapy

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

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

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the *Summary of Benefits* section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

Transplant services

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

Tissue and kidney transplants

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

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

Special transplants

Benefits are available for special transplants only if:

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

Special transplants are:

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

Donor services

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

Donor services include:

- Donor evaluation;

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

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health.

If you need to visit an urgent care center and you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.

See the Out-of-area services section for information on urgent care services outside California.

Exclusions and limitations

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

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

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

General exclusions and limitations

	of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.
14	Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits, or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
15	Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program.
16	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
17	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
18	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.
19	Select physical and occupational therapies, such as: • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
20	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or

General exclusions and limitations

	to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.
21	Services or Drugs that are Experimental or Investigational in nature.
22	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.
23	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
24	Member convenience items, such as internet, phones, televisions, guest trays, and personal hygiene items.
25	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.
26	Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.
27	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
28	Drugs dispensed by a Physician or Physician's office for outpatient use.

Grievance process

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

Submitting a grievance

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

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

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

Where to mail grievances

Type of grievance	*Address*
Medical Benefits, and prescription Drug Benefits if selected as an optional Benefit by the Trust Fund	Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762
Mental Health and Substance Use Disorder services from an MHSA Participating Provider	Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171

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

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

If the Trust Fund selected the optional Prescription Drug Benefits Rider, and Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may request an external exception request review. Blue Shield will ensure a decision within 72 hours. Blue Shield will make a decision within 24 hours when there are exigent

circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

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

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

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

California Department of Managed Health Care review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-256-9404** 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, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **(www.dmhc.ca.gov)** has complaint forms, IMR application forms, and instructions online.

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

Independent medical review

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

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

You can apply to the Department of Managed Health Care (DMHC) for an independent medical review of the denial. For a Medical Necessity denial, you must first submit a grievance to Blue Shield and wait for at least 30 days before requesting an

independent medical review. However, if the request qualifies for an expedited review as described above, or if it involves a determination that the requested service is Experimental or Investigational, you may request an independent medical review as soon as you receive a notice of denial from Blue Shield. The DMHC's application for independent medical review is included with your appeal outcome letter.

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

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

ERISA review

If the Trust Fund'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 the Trust Fund-sponsored plan may have other voluntary alternative dispute resolution options, such as mediation.

Other important information about your plan

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

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 37 in the ***Your coverage*** section.

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

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

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

Cancellation for Trust Fund's nonpayment of Premiums

Premium grace period

After payment of the first Premium, the Trust Fund has a 30-day grace period from the due date to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. Coverage will continue through the grace period. However, if the Trust Fund does not pay all outstanding Premiums within the grace period, coverage will end the day following the 30-day grace period. The Trust Fund will be liable for all Premiums owed, even if coverage is canceled. This includes Premiums for coverage during the 30-day grace period. Blue Shield will send a Notice of End of Coverage to you and the Trust Fund no later than five calendar days after the day coverage ends.

Out-of-area services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you access services outside of California, you may obtain care from one of two kinds of providers. Most providers are participating providers and contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Some providers are non-participating providers because they don't contract

with the Host Blue. Blue Shield's payment practices in both instances are described in this section.

The Blue Shield Access+ HMO plan provides limited coverage for health care services received outside of California. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Arrangement unless authorized by Blue Shield.

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

Inter-Plan Arrangements

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, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Evidence of Coverage. 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.

The BlueCard® Program enables you to obtain Out-of-Area Covered Health Care Services outside of California, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance, and Deductible amounts, if any, as stated in the *Summary of Benefits*.

When you receive Out-of-Area Covered Health Care Services outside of California and the claim is processed through the BlueCard® Program, the amount you pay for covered health care services, if not a flat dollar Copayment, is calculated based on the lower of:

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

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

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

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

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully-insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee as part of the claim charges passed on to you. Claims for covered Emergency Services are paid based on the Allowed Charges as defined in this Evidence of Coverage.

Non-participating providers outside of California

Coverage for health care services provided outside of California and within the BlueCard® Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state or federal 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 Out-of-Area Covered Health Care Services as described 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.

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services, as listed in the Summary of Benefits.

Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (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 not served by a Host Blue. As such, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider

information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global® Core claim

When you pay directly for Out-of-Area Covered Health Care 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 with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. 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 (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Limitation for duplicate coverage

Medicare

Blue Shield will provide Benefits before Medicare when:

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

Blue Shield will provide Benefits after Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs less than 20 Trust Fund Members (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs less than 100 Trust Fund Members (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

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

Medi-Cal

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

Qualified veterans

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

Coverage by another government agency

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

Exception for other coverage

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

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

Reductions – third-party liability

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

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance, or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for Benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay you or your representatives. For purposes of this provision, your representatives include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is Blue Shield's right of recovery.
- Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery you receive as a result of the injury or illness. This includes any amount awarded to you or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party

or third-party insurer, related to the illness or injury (the "Recovery"), whether or not you have been "made whole" by the Recovery. The amount Blue Shield seeks as restitution, reimbursement, or other available remedy will be calculated in accordance with California Civil Code Section 3040.

- Blue Shield will not reduce its share of any Recovery unless, in the exercise of our discretion, Blue Shield agrees in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. You must not take any action that may prejudice Blue Shield's right of recovery.
- You must tell Blue Shield promptly if you have made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for. You must seek recovery of Blue Shield's payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of your claim in order to be reimbursed to the full amount of Benefits Blue Shield has paid or will pay.

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

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

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

- Ensure that any recovery is kept separate from and not comingled with any other funds or your general assets;
- Agree in writing that the portion of any recovery required to satisfy the lien or other right of recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield; and
- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

Coordination of benefits, continued

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

Section 1300.67.13 to determine the order of benefit payments between two group health plans:

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

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

General provisions

Independent contractors

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

Assignment

The Benefits of this plan may not be assigned without the written consent of Blue Shield. Participating Providers are paid directly by Blue Shield or the Medical Group.

When you are authorized to receive Covered Services from a Non-Participating Provider, Blue Shield, at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider.

Plan interpretation

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

Public policy participation procedure

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

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

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

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

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

At least one third of the Board of Directors is comprised of Subscribers who are not Trust Fund Members, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from the Sr. Manager, Regulatory Filings as listed above.

Access to information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this plan and the Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in the Member's possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be

disclosed without the Member's consent, except as otherwise permitted or required by law.

Right of recovery

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

Definitions

Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Adverse Childhood Experiences	An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.
Allowed Charges	• For a Participating Provider: the amounts a Participating Provider agrees to accept as payment from Blue Shield. • For a Non-Participating Provider: (1) the amounts paid by Blue Shield when services from a Non-Participating Provider are covered and are paid as a Reasonable and Customary amount, or (2) if applicable, the amount determined under state and federal law.
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
ASH Participating Provider	A Physician or Health Care Provider under contract with ASH Plans to provide Covered Services to Members.
Behavioral Health Treatment (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Benefit Administrator	Administrator for specialized Benefits such as Mental Health and Substance Use Disorder Benefits.
Blue Shield of California	California Physicians' Service, d/b/a Blue Shield of California, is a California not-for-profit corporation, licensed as a health

	care service plan. It is referred to throughout this Evidence of Coverage as Blue Shield.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Deductible	The Calendar Year amount you must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Contract.
Dependent	The spouse, Domestic Partner, or child of an eligible Trust Fund Member, who is determined to be eligible and who is not independently covered as an eligible Trust Fund Member or Subscriber. • A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber.

	• A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Evidence of Coverage. • A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

Domestic Partner	An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements:
	• Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
	• The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
	• The partners are:
	  o not currently married to someone else or a member of another domestic partnership, and
	  o not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
	• Both partners are capable of consenting to the domestic partnership; and
	• The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Trust Funds may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by the Trust Fund, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner"

	established under Section 297 of the California Family Code). The domestic partnership is deemed created on the date when both partners meet the above requirements.
Emergency Medical Condition	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.
Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department

	where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.
Employer	Any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 101 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that 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 that 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 that 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.
Former Participating Provider	A Former Participating Provider is a provider of services to the Member under any of the following conditions: • A provider who is no longer available to you as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section. • A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former*

	Participating Provider table in the *Continuity of care* section.
	• A provider who is a Participating Provider with Blue Shield or the MHSA but no longer available to you as a Participating Provider or an MHSA Participating Provider because:
	  ○ The Employer has terminated its contract with Blue Shield; and
	  ○ The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider or the MHSA Participating Provider in its network; and
	  ○ At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider table* in the *Continuity of care* section.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care	Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include: • Peer-reviewed scientific studies and medical literature; • Clinical practice guidelines and recommendations of nonprofit health care provider professional associations; • Specialty societies and federal government agencies; and • Drug labeling approved by the United States Food and Drug Administration.
Group Health Service Contract (Contract)	The contract for health coverage between Blue Shield and the Trust Fund (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.
Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • Audiologist; • Board certified behavior analyst (BCBA);

	• Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Massage therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law; • Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • Registered respiratory therapist; • Speech and language pathologist.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia. A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria:

	• A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.
Infertility	May be either of the following: • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.
Intensive Outpatient Program	An outpatient treatment program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.
Inter-Plan Arrangements	Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Late Enrollee	An eligible Trust Fund Member 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 Trust Fund's next open enrollment period.
Medical Group	An organization of Physicians who are generally located in the same facility and provide Benefits to Members, or an independent practice association (a group of Physicians in individual offices who form an organization to contract, manage, and share financial responsibilities for providing Benefits to Members).

Medical Group Service Area	The geographic area served by the Medical Group.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are: • Consistent with Blue Shield medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants. This definition does not apply to services which Blue Shield is required by law to cover for Reconstructive Surgery or to Mental Health and Substance Use Disorders. Medically

	Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.
Medically Necessary Treatment of a Mental Health or Substance Use Disorder	A Covered Service or product addressing the specific needs of a Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: • In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder care; • Clinically appropriate in terms of type, frequency, extent, site, and duration; and • Not primarily for the economic benefit of the disability insurer and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.
Member	An individual who is enrolled and maintains coverage in the plan pursuant to the Contract as either a Subscriber or a Dependent. Use of "you" in this document refers to the Member.
Mental Health and Substance Use Disorder(s)	A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Mental Health Service Administrator (MHSA)	The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to administer Blue Shield's Mental Health and Substance Use Disorder services through a separate network of MHSA Participating Providers.
MHSA Non-Participating Provider	A provider who does not have an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.
MHSA Participating Provider	A provider who has an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.
Non-Participating (Non-Participating Provider)	Any provider who does not participate in this plan's network and does not contract with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as

	payment in full for Covered Services. Also referred to as an out-of-network provider.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorders, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.

Participating Hospice or Participating Hospice Agency	An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits.
Participating (Participating Provider)	A provider who participates in this plan's network and has an agreement to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan Service Area	A geographical area designated by the plan within which a plan shall provide health care services.
Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician. Your PCP will provide your primary care and refer, authorize, supervise, and coordinate the provision of your Benefits.
Psychological Testing	Testing to diagnose a mental health condition when referred by an MHSA Participating Provider.
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
Reasonable and Customary	In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider. Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits or if applicable, the amount determined under state and federal law.
Reconstructive Surgery	Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: • Improve function; or

	• Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and • Other designated as appropriate.
Subacute Care	Skilled Nursing or skilled rehabilitation provided in a hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Subscriber	An eligible Trust Fund Member who is enrolled and maintains coverage under the Contract.
Third-Party Corporate Telehealth Provider	A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.

Total Disability (Totally Disabled)	In the case of a Trust Fund Member, or Member otherwise eligible for coverage as a Trust Fund Member, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity. In the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.
Trust Fund (Contractholder)	Santa Barbara County Fire Fighters Local 2046.
Trust Fund Member	An individual who meets the eligibility requirements set forth in the Group Health Service Contact between Blue Shield of California and Santa Barbara County Fire Fighters Local 2046.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
Urgent Services	Those Covered Services rendered outside of the Medical Group Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Medical Group Service Area.

Notices about your plan

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

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

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

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

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

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

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

Notice about telehealth: You have the right to access your medical records. The records of any services provided to you through a Third-Party Corporate Telehealth Provider will be shared with your PCP, unless you object.

You can receive Covered Services on an in-person basis or via telehealth, if available, from your PCP, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the Timely Access to Care section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

blue of california

Outpatient Prescription Drug Rider

Group Rider
HMO/POS

Enhanced Rx $15/30/45 with $0 Pharmacy Deductible Summary of Benefits

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

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) 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 Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

	When using a Participating[2] Pharmacy	
Calendar Year Pharmacy Deductible	*Per Member* $0	
Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$15/prescription	
Tier 2 Drugs	$30/prescription	
Tier 3 Drugs	$45/prescription	
Tier 4 Drugs	20% up to $250/prescription	
Retail pharmacy prescription Drugs		
Per prescription, up to a 90-day supply from a 90-day retail pharmacy.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$45/prescription	
Tier 2 Drugs	$90/prescription	

Prescription Drug Benefits[3,4]	Your payment	
	When using a Participating Pharmacy[2]	CYPD[1] applies
Tier 3 Drugs	$135/prescription	
Tier 4 Drugs	20% up to $750/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$30/prescription	
Tier 2 Drugs	$60/prescription	
Tier 3 Drugs	$90/prescription	
Tier 4 Drugs	20% up to $500/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy 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 Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD 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 Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

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

3 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 do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 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 Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy 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 Drug tier Copayment or Coinsurance.

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

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

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

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

Prescription Drug Benefits

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

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

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

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

Outpatient Drug Formulary

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

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

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

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

Formulary Drug tiers	
Drug Tier	***Description***
Tier 1	• Most Generic Drugs or low cost preferred Brand Drugs
Tier 2	• Non-preferred Generic Drugs • Preferred Brand Drugs • Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
Tier 3	• Non-preferred Brand Drugs • Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost • Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	• Drugs that are biologics, and Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than $600 (net of rebates) for a one-month supply

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

Obtaining outpatient prescription Drugs at a Participating Pharmacy

You must present a Blue Shield ID Card at a Participating Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. See the *Obtaining Specialty Drugs from a Network Specialty Pharmacy* section for more information. If you obtain Drugs at a Non-Participating Pharmacy, Blue Shield will deny the claim and will not pay anything toward the cost of the Drugs, unless they are for a covered emergency.

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

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted

rate is less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

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 only when Medically Necessary.

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 pay the difference in cost, plus your Tier 1 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 Tier 1 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 difference in cost, plus the Tier 1 Copayment or Coinsurance. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility.

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 *Prior authorization/exception request/step therapy process* section for more information on the approval process and exception requests. If the request is approved, you pay only the applicable tier Copayment or Coinsurance.

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

Obtaining extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy

You also have an option to receive up to a 90-day supply of prescription Drugs at a pharmacy in the Rx90 Retail network when you take maintenance Drugs for an ongoing condition. If your

Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed.

You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

Obtaining outpatient prescription Drugs at a Non-Participating Pharmacy in an emergency

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

Blue Shield of California
P.O. Box 52136
Phoenix, AZ 85072-2136

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

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

Obtaining outpatient prescription Drugs from the mail service pharmacy

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

You must pay the applicable mail service prescription Drug Copayment or Coinsurance for each prescription Drug.

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

Obtaining Specialty Drugs from a Network Specialty Pharmacy

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

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

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

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

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

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

Prior authorization/exception request/step therapy process

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

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy; and
- Some brand contraceptives, in order to be covered without a Copayment or Coinsurance.

You pay the Tier 3 Copayment or Coinsurance for covered compounded medications.

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

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

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a Drug should be used, nationally recognized treatment guidelines, medical studies, information from the Drug manufacturer, and the relative cost of treatment for a condition. If your Physician or Health Care Provider believes that step therapy coverage requirements for a prescription need not be met and that the Drug is Medically Necessary, the step therapy exception process must be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

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

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

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

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

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

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

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

You may receive up to a 90-day supply of Drugs at a pharmacy in the Rx90 Retail network or from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will dispense that amount and you are responsible for the applicable Copayment or Coinsurance listed in the *Summary of Benefits* section. Refill authorizations cannot be combined to reach a 90-day supply.

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

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

You may refill covered prescriptions at a Medically Necessary frequency.

Exclusions and limitations

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

	Outpatient prescription Drug exclusions and limitations
1	Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained on an emergency or urgent basis.
2	Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Evidence of Coverage.
3	Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital services* and *Skilled Nursing Facility (SNF) services* sections of your Evidence of Coverage.
4	Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician.
5	Drugs that are Experimental or Investigational in nature.
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 *Durable medical equipment* section of your Evidence of Coverage.
7	Blood or blood products. See the *Hospital services* section of your Evidence of Coverage.
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 services, Home infusion and injectable medication services, PKU formulas and special food products* sections of your Evidence of Coverage.
10	Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home health services, Home infusion and injectable medication services, Hospice program services,* or *Family Planning* sections of your Evidence of Coverage.
11	All Drugs related to assisted reproductive technology.

Outpatient prescription Drug exclusions and limitations

12	Compounded medications unless all of the following requirements are met: • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially available, medically appropriate alternatives; and • The compounded medication is self-administered.
13	Replacement of lost, stolen or destroyed Drugs.
14	If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice program services* section of your Evidence of Coverage.
15	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.
16	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list.
17	Immunizations and vaccinations solely for the purpose of travel.
18	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
19	Prescription Drugs that are repackaged by an entity other than the original manufacturer.

Definitions

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

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

Formulary	A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.
Generic Drugs	Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency

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

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

blue of california

Acupuncture and Chiropractic Services Rider

Group Rider
HMO/POS

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
Acupuncture Services		
Office visit	$10/visit	Not covered
Chiropractic Services		
Office visit	$10/visit	Not covered
Chiropractic Appliances	All charges above $50	Not covered

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

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

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.

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

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.

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Services to Members.
Musculoskeletal and Related Disorders	Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

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

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

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

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

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

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

Language access services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

(Intentionally left blank)