Shield Signature
Low Option

Combined Evidence of Coverage and Disclosure Form

County of San Bernardino

Group Number: W0052236-M0015474

Effective Date: January 1, 2018

Blue Shield of California

Evidence of Coverage and Disclosure Form

Shield Signature Low Option

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

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

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

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

Notice About This Group Health Plan: Blue Shield makes this health plan available to Retirees through a contract with the County. The Group Health Service Contract (Contract) includes the terms in this Evidence of Coverage and Disclosure Form, 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 and Disclosure Form. The Summary of Benefits sets forth the Member's share-of-cost for Covered Services under the benefit plan.

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

For questions about this plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this Evidence of Coverage and Disclosure Form.

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

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

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

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

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

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

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

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

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

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

Shield Signature

Member Bill of Rights

As a Shield Signature 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 Shield Signature plan, the Services we offer you, the Physicians and other practitioners available to care for you.
5. Select a Primary Care Physician and expect his/her team of health workers to provide or arrange for all the care that you need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
8. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
9. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
10. Receive preventive health Services.
11. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Primary Care Physician .
13. Communicate with and receive information from Member Services 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. Obtain a referral from your Primary Care Physician for a second opinion.
16. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints or grievances about the Shield Signature or the care provided to you.
18. Participate in establishing Public Policy of the Shield Signature plan, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.
19. Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

Shield Signature

Member Responsibilities

As a Shield Signature Member, you have the responsibility to:

1. Carefully read all Shield Signature plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Shield Signature plan membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that your Physician, and/or Blue Shield need to provide appropriate care for you.
4. Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical appointments and inform the Shield Signature Physician ahead of time when you must cancel.
8. Communicate openly with the Primary Care Physician you choose so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Shield Signature plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.
11. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
12. Select a Primary Care Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection.
13. Treat all plan personnel respectfully and courteously as partners in good health care.
14 Pay your Premiums (Dues), Copayments and charges for non-covered services on time.
15. For all Mental Health and Substance Use Disorder Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA).

Table of Contents

Page

Table of Contents

Page

Table of Contents

Page

INTRODUCTION TO SHIELD SIGNATURE

BLUE SHIELD OF CALIFORNIA'S SHIELD SIGNATURE FOR THE COUNTY OF SAN BERNARDINO IS A SINGLE PRODUCT WITH TWO DISTINCT LEVELS OF CARE TO MEET YOUR HEALTH NEEDS. THESE SHIELD SIGNATURE LEVELS OF CARE ARE FULLY DESCRIBED IN THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM BOOKLET.

Shield Signature Level I: Health Maintenance Organization (HMO)

Shield Signature Level I is an established network of Primary Care Physician s and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Services to Members. To receive Shield Signature Level I Benefits, a Member must obtain or receive approval for all Covered Services from his Primary Care Physician . Each Member must select a Primary Care Physician from the list of Primary Care Physician s 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 for coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Shield Signature Hospitals. The list of Providers in the Physician and Hospital Directory includes the location and phone numbers of all Primary Care Physician s, Hospitals and Participating Hospice Agencies in the Primary Care Physician Service Area. Members should contact Member Services for information on Non-Physician Health Care Practitioners in their Primary Care Physician Service Area.

For coverage at Level I all non-emergency Mental Health inpatient Hospital admissions including Residential Care, and Non-Routine Outpatient Mental Health Services must be arranged through and authorized by the MHSA and provided by a MHSA Participating. Members are not required to coordinate Mental Health Services through their Primary Care Physician . A list of MHSA Participating Providers is available in the online Blue Shield of California Provider Directory or you may contact the MHSA for information on and to select a MHSA Provider by calling 1-877-263-9952. Additional information can be found under the section Mental Health Services and Shield Signature Level I (HMO) Benefits Mental Health Benefits of your Evidence of Coverage and Disclosure Form Booklet.

Shield Signature Level I Benefits

For a complete description of Services covered under Shield Signature Level I please read this booklet's Summary of Benefits, the Shield Signature Level I Benefits section and Principal Limitations, Exceptions, Exclusions and Reduction. There is no medical deductible for Shield Signature Level I and the Calendar Year Out-of-Pocket Maximum for Covered Services is $3,000 per individual, $6,000 per 2- persons or $9,000 per family. There is no lifetime maximum.

- Allergy Testing and Treatment
- Ambulance Benefits
- Ambulatory Surgery Center Benefits*
- Bariatric Surgery*
- Clinical Trial for Cancer Benefits*
- Chemical Dependency Services (Substance Use Disorder)*
- Diabetic Care Benefits
- Dialysis Center Benefits*
- Durable Medical Equipment*
- Emergency Room Benefits
- Eye Examination Benefit
- Family Planning and Infertility Benefits
- Home Health Care Benefits*
- Home Infusion/Home Injectable Therapy Benefits*
- Hospice Program Benefits*
- Hospital Benefits (Facility Services)*
- Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bone Benefits
- Mental Health Benefits
- Orthotics Benefits*
- Outpatient Prescription Drug Benefits
- Outpatient X-Ray, Pathology and Laboratory Benefits
- PKU Related Formulas and Special Food Products*
- Pregnancy and Maternity Care Benefits*
- Preventive Health Benefits
- Professional (Physician) Benefits
- Prosthetic Appliance Benefits *
- Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)
- Skilled Nursing Facility Benefits*
- Speech Therapy Benefits
- Transplants*
- Urgent Care Benefits

*** This benefit is only covered under Shield Signature Level I**

Shield Signature Level II: Blue Shield PPO Network Outpatient Professional Services Provided In An Office Setting

The Shield Signature Level II benefits are designed to supplement the full range of benefits covered under your Shield Signature Level I. Under Shield Signature Level II you have the option of receiving outpatient professional services that are provided in an office setting from any Participating Provider in Blue Shield's PPO network without receiving prior authorization from your Shield Signature Level I Primary Care Physician .

Please note that while the additional PPO outpatient benefits enhance your range of covered services, you will be responsible for applicable Copayments and non-covered charges. There is neither a calendar-year medical deductible nor a Calendar Year Out-of-Pocket Maximum for Shield Signature Level II covered services. There is no lifetime maximum. You are still required to receive all Inpatient care from a Hospital or other inpatient facility, Participating Hospice Agencies, and other Inpatient provider services under your Shield Signature Level I HMO coverage.

Under Shield Signature Level II, you may choose to receive covered Mental Health Services for Outpatient Professional Services provided in an office setting from an MHSA Non-Participating Provider. For Covered Services from MHSA Non-Participating Providers the Member is responsible for any amounts billed in excess of the Allowable Amount.

Shield Signature Level II Benefits

The following outpatient benefits are covered under Shield Signature Level II by Participating Providers in the Blue Shield PPO Network. For a complete description of Services covered under Shield Signature Level II please read this booklet's Summary of Benefits, the Shield Signature Level II Benefits section and Principal Limitations, Exceptions, Exclusions and Reductions.

- Allergy testing or treatment visits provided in an office setting
- Ambulance Benefits
- Diabetes self-management training provided by Physician or a registered dietician or registered nurse that are certified diabetic educators provided in an office setting
- Emergency room services resulting in hospital admission only until Member can be transferred to a Covered HMO hospital
- Laboratory and x-rays provided in an outpatient office setting are covered. Laboratory, x-ray and diagnosis tests performed elsewhere such as in an outpatient facility, hospital or other inpatient facility are not covered.
- Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bone Benefits provided in an outpatient office setting
- Mental Health outpatient visits provided in an office setting
- Physician and specialists office visits*
- Preventive health services provided in an office setting
- Rehabilitation Services by a physical, occupational, or respiratory therapist provided in an office setting
- Speech Therapy Services provided in an office setting

*** Note: If a Blue Shield PPO Network Shield Signature Level II physician or specialist believes a Member requires hospitalization, the Member must contact his or her Shield Signature Level I Primary Care Physician for treatment including referral**

blue of california

Summary of Benefits

County of San Bernardino – Retirees
Effective: January 1, 2018
Shield Signature Benefit Plan

County of San Bernardino Retirees
Custom Shield Signature Low Option

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

Provider Network: **Shield Signature Network**

This benefit plan uses a specific network of health care providers, called the Shield Signature provider network. This plan provides benefits at two different levels:

- **Shield Signature Level I (HMO participating providers):** Services must be provided or prior authorized by your primary care physician or medical group/IPA, with some exceptions. Please review your EOC for details about how to access care under this level.
- **Shield Signature Level II (PPO participating providers):** Services are provided by participating providers for outpatient professional services provided in an office setting. Any Copayment or Coinsurance is calculated from the allowable amount.

You are responsible for any Copayment or Coinsurance and any charges over the allowable amount. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A calendar year deductible (CYD) is the amount a member pays each calendar year before Blue Shield pays for covered services under the benefit plan. Blue Shield pays for some covered services before the calendar year deductible is met, as noted in the Benefits chart below.

		Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating providers[3]
Calendar year medical deductible	*Individual coverage*	$0	$0
	Family coverage	$0: individual $0: family	$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 Notes section at the end of this Summary of Benefits.

	Shield Signature Level I HMO Plan providers[3]	Shield Signature Level II Participating providers[3]
Individual coverage	$3,000	No maximum
Family coverage	$3,000: individual $9,000: family	

No Lifetime Benefit Maximum

Under this benefit plan there is no dollar limit on the total amount Blue Shield will pay for covered services in a member's lifetime.

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	CYD[2] applies	Shield Signature Level II Participating providers[3]	CYD[2] applies
Preventive Health Services[6]	$0		$80/visit	
Physician services				
Primary care office visit	$50/visit		$80/visit	
Specialist care office visit	$70/visit		$80/visit	
Office visit for allergy serum injection	$0		$0	
Office visit for allergy testing	$0		$80/visit	
Physician home visit	$50/visit		Not covered	
Physician inpatient, outpatient, and surgery services	$0		Not covered	
Other professional services				
Other practitioner office visit	$50/visit		$80/visit	
Includes nurses, nurse practitioners, and therapists.				
Acupuncture services	Not covered		Not covered	
Chiropractic services	Not covered		Not covered	
Teladoc consultation	$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	$50/surgery		Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	$70/visit		$80/visit	
Pregnancy and maternity care[6]				
Physician office visits: prenatal and postnatal	$50/visit		Not covered	
Physician services for pregnancy termination	$150/surgery		Not covered	
Emergency services and urgent care				
Emergency room services	$250/visit		$250/visit	
If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room physician services	$0		$0	
Urgent care physician services	$10/visit		$10/visit	
Ambulance services	$300/transport		$300/transport	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating providers[3]**	**CYD[2] applies**
Outpatient facility services				
Ambulatory surgery center	$750/surgery		Not covered	
Outpatient department of a hospital: surgery	$750/surgery		Not covered	
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		Not covered	
Inpatient facility services				
Hospital services and stay	$1,000/admission		Not covered	
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	$1,000/admission		Not covered	
• Physician inpatient services	$0		Not covered	
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient facility services and Outpatient physician services payments apply.				
Inpatient facility services	$1,000/admission		Not covered	
Outpatient facility services	$750/surgery		Not covered	
Physician services	$0		Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolau (Pap) test.				
• Laboratory center	$0		$0	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating providers[3]**	**CYD[2] applies**
Under Level II, services are only covered if received in a physician's office.				
• Outpatient department of a hospital	$0		Not covered	
• California Prenatal Screening Program	$0		$0	
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$0		$0	
Under Level II, services are only covered if received in a physician's office.				
• Outpatient department of a hospital	$0		Not covered	
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		$0	
Under Level II, services are only covered if received in a physician's office.				
• Outpatient department of a hospital	$0		Not covered	
Radiological and nuclear imaging services				
• Outpatient radiology center	$0		Not covered	
• Outpatient department of a hospital	$0		Not covered	
Rehabilitation and habilitative services				
Includes physical therapy, occupational therapy, and respiratory therapy services. Under Level II, up to 12 visits per member, per calendar year.				
Office location	$40/visit		$80/visit	
Outpatient department of a hospital	$0		Not covered	
Speech therapy services				
Office location	$40/visit		$80/visit	
Outpatient department of a hospital	$0		Not covered	
Durable medical equipment (DME)				
DME	$0		Not covered	
Breast pump	$0		Not covered	

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating providers[3]**	**CYD[2] applies**
Orthotic equipment and devices	$0		Not covered	
Prosthetic equipment and devices	$0		Not covered	
Home health services				
Home health agency services	$50/visit		Not covered	
Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.				
Home visits by an infusion nurse	$50/visit		Not covered	
Home health medical supplies	$0		Not covered	
Home infusion agency services	$0		Not covered	
Hemophilia home infusion services	$0		Not covered	
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	$1,000/admission		Not covered	
Hospital-based SNF	$1,000/admission		Not covered	
Hospice program services	$0		Not covered	
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	$0		Not covered	
• Self-management training	$0		$30/visit	
Dialysis services	$0		Not covered	
PKU product formulas and special food products	$0		Not covered	
Allergy serum	$0		$0	
Clinical trial for treatment of cancer or life-threatening conditions	$0		Not covered	
Travel immunizations and vaccinations	$0		$0	
Eye examination				

Benefits[5]	Your payment			
	Shield Signature Level I HMO Plan providers[3]	**CYD[2] applies**	**Shield Signature Level II Participating providers[3]**	**CYD[2] applies**
One comprehensive eye examination in a consecutive 12-month period provided through the contracted VPA.				
• Ophthalmologic exam	$10/visit		$0 up to $60/year plus 100% of additional charges	
• Optometric exam	$10/visit		$0 up to $50/year plus 100% of additional charges	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder benefits are provided through Blue Shield's mental health services administrator (MHSA).	**Shield Signature Level I MHSA Participating providers[3]**	**CYD[2] applies**	**Shield Signature Level II MHSA Non-Participating Providers[3]**	**CYD[2] applies**
Outpatient services				
Office visit, including physician office visit	$0 for the first 3 visits, then $10/visit		$0 for the first 3 visits, then $10/visit	
Intensive outpatient care	$30/visit		Not covered	
Behavioral health treatment in an office setting	$0 for the first 3 visits, then $10/visit		$0 for the first 3 visits, then $10/visit	
Behavioral health treatment in home or other non-institutional facility setting	$50/visit		Not covered	
Office-based opioid treatment	$0 for the first 3 visits, then $10/visit		$0 for the first 3 visits, then $10/visit	
Partial hospitalization program	$750/episode		Not covered	
Psychological testing	$0		Not covered	
Inpatient services				
Physician inpatient services	$0		Not covered	
Hospital services	$1,000/admission		Not covered	
Residential care	$1,000/admission		Not covered	

Notes

1 Evidence of Coverage (EOC):
The Evidence of Coverage (EOC) describes the benefits, limitations, and exclusions that apply to coverage under this benefit plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.
Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):
Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before Blue Shield pays for Covered Services under the benefit plan.
If this benefit plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (□) in the Benefits chart above.

3 Using Shield Signature Level 1 and Shield Signature Level II Participating Providers:
Shield Signature Level I and Shield Signature Level II Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.
Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Shield Signature Level I and Shield Signature Level II Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Shield Signature Level I or Shield Signature Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):
Under Shield Signature Level I Participating Providers, *your payment after you reach the calendar year OOPM.*
Under Shield Signature Level II Participating Providers, you will continue to be responsible for Copayments or Coinsurance for Covered Services and for all expenses for Non-Covered Services.
Family coverage has an individual OOPM within the family OOPM. This means that the OOPM will be met for an individual 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 Copayment in addition to an allergy serum Copayment 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 under the Shield Signature Level 1 provider network. If you receive both Preventive Health Services and other Covered Services during the physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.
DC101617 GF

Shield Signature Coverage

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

Obtaining Medical Care

Your interest in the Shield Signature plan is truly appreciated. Blue Shield has served Californians for over 60 years, and we look forward to serving your health care coverage needs.

By choosing Shield Signature you have the opportunity to be an active participant in your own health care. We'll help you make a personal commitment to maintain and, where possible, improve your health. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

You will have two Benefit options called "Levels" for medical care. The choice you make at the time you need medical care will determine your out-of-pocket costs.

Shield Signature Level I provides a full service of coverage through our HMO network.

Shield Signature Level II offers you the option of receiving selected PPO Network Participating Provider Outpatient Professional Services Provided in an Office Setting.

Shield Signature Level I – HMO Covered Services

Shield Signature Level I is the "HMO" level of Benefits. Using it provides you with the highest level of Benefits — i.e., full Shield Signature Benefits at the lowest out-of-pocket cost to you. You will be covered under Shield Signature Level I only when care is provided by (1) your Primary Care Physician , (2) any provider authorized by your Primary Care Physician or (3) a Mental Health Service Administrator (MHSA) Participating Provider, or (4) any provider for Emergency Services as defined in this booklet Benefits section. You will only be responsible for the Shield Signature Level I Calendar Year Out-of-Pocket Maximum and Copayments.

To determine whether a Shield Signature Level I provider is a Participating or Preferred Provider; consult the Blue Shield HMO Physician and Hospital Directory. You may also verify this information by accessing Blue Shield's Internet site located at http://www.blueshieldca.com, or by calling Member Services at the telephone number provided on the back page of this booklet. Note: A Shield Signature Level I Participating Provider's status may change. It is your obligation to verify whether the provider you choose is a Shield Signature Participating or Preferred Provider; in case there have been any changes since your directory was published.

Shield Signature Level II – Selected PPO Network Participating Provider Outpatient Professional Services Provided in an Office Setting

Shield Signature Benefits under Shield Signature Level II provide coverage for selected PPO Network Participating Provider/MHSA Non-Participating Provider outpatient professional services provided in an office setting which are detailed in this booklet's Summary of Benefits Referral or authorization by your Primary Care Physician is not required and there are no deductibles or copayment maximums. For services received by a MHSA Non-Participating Provider the Member is responsible for any amount over the Allowable Amount.

Note: Coverage under Shield Signature Level II is only for selected PPO Network/MHSA Non-Participating Provider Outpatient Services. All Inpatient care including Hospitalization, Skilled Nursing Care and services which cannot be provided in an Outpatient medical office are not covered. Such services must be

obtained through your HMO Medical Group/IPA and Primary Care Physician or MHSA Participating Provider except for Covered Emergency and Urgent Care as described in this booklet.

To determine whether a provider is a Shield Signature Level II PPO Network /MHSA Non-Participating Provider, consult the Blue Shield Physician Directory. You may also verify this information by accessing Blue Shield's Internet site located at http://www.blueshieldca.com, or by calling Member Services at the telephone number provided on the back page of this booklet. Note: A Shield Signature Level II Preferred Provider's status may change. It is your obligation to verify whether the provider you choose is a Preferred Provider; in case there have been any changes since your directory was published.

Note: Benefits for Services for Mental Health are provided under Level I for MHSA Participating Providers and Level II for MHSA Non-Participating Providers.

Please review this booklet, which summarizes the general provisions and operation of your Shield Signature coverage. If you have any questions regarding the information, you may contact us through our Member Services Department at the number listed on your Shield Signature identification card.

Shield Signature Level I – HMO Covered Services

Choice of Primary Care Physician

Selecting a Primary Care Physician

A close Physician-patient relationship helps to ensure you receive the best medical care. Each Member is therefore required to select a Primary Care Physician at the time of enrollment. This decision is an important one because your Primary Care Physician is responsible for providing primary care and coordinating or arranging for referral to other health care Services as necessary. More specifically, your Primary Care Physician will:

1. Help you decide on actions to maintain and improve your total health.
2. Coordinate and direct all of your medical care needs.
3. Work with your Medical Group/IPA to arrange your referrals to specialty Physicians, Hospitals and all other health Services, including requesting any prior authorization you will need.
4. Authorize Emergency Services when appropriate.
5. Prescribe any lab tests, X-rays and other medical Services you require.
6. If you request it, assist you in obtaining prior approval from the Mental Health Service Administrator (MHSA) for Inpatient Mental Health Services*; and

   *See the Mental Health Services paragraphs in the Obtaining Medical Care section for information.
7. Assist you in applying for admission into a Hospice Program through a Participating Hospice Agency when necessary.

To ensure access to services, each Member must select a Primary Care Physician who is located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If you do not select a current Blue Shield HMO Primary Care Physician at the time of enrollment, Blue Shield will designate a Primary Care Physician for you and notify you. This designation will remain in effect until you advise Blue Shield of your selection of a different Primary Care Physician . To select a Primary Care Physician , contact the Blue Shield Member Services Department at the number provided on the back page of this booklet, Monday through Friday, between 7 a.m. and 7 p.m.

A Primary Care Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption but always within 60 days from the date of birth or placement for adoption. You may designate a pediatrician as the Primary Care Physician for your child. The Primary Care Physician selected for the month of birth must be in the same Medical Group or IPA as the mother's Primary Care Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Primary Care Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If you do not select a Primary Care Physician within 60 days following the birth or placement for adoption, Shield Signature will designate a Primary Care Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Primary Care Physician for the child after the month of birth or placement for adoption, see the section below on "Changing Primary Care Physician s". If your child is ill during the first month of coverage, be sure to read the information about changing Primary Care Physician s during a course of treatment or hospitalization.

Remember that if you want your child covered beyond the 60 days from the date of birth or placement for adoption, you must submit a written application as explained in the Eligibility section of this Evidence of Coverage and Disclosure Form.

Role of the Medical Group or IPA

Most Blue Shield Primary Care Physician s contract with Medical Groups or IPAs to share administrative and authorization responsibilities with them. (Of note, some Primary Care Physician s contract directly with Blue Shield.) Your Primary Care Physician coordinates with your designated Medical Group/IPA to direct all of your medical care needs and refer you to specialists or hospitals within your designated Medical Group/IPA unless because of your health condition, care is unavailable within the Medical Group/IPA.

Your designated Medical Group/IPA (or Blue Shield when noted on your identification card) ensures that a full panel of specialists is available to provide your health care needs and helps your Primary Care Physician manage the utilization of your Shield Signature benefits by ensuring that referrals are directed to providers who are contracted with them. Medical Groups/IPAs also have admitting arrangements with hospitals contracted with Blue Shield in their area and some have special arrangements that designate a specific hospital as "in network." Your designated Medical Group/IPA works with your Primary Care Physician to authorize services and ensure that that service is performed by their in network provider.

The name of your Primary Care Physician and your designated Medical Group/IPA (or, "Blue Shield Administered") is listed on your identification card. The Blue Shield HMO Member Services Department can answer any questions you may have about changing the Medical Group/IPA designated for your Primary Care Physician and whether the change would affect your ability to receive services from a particular specialist or hospital.

Changing Primary Care Physician s or Designated Medical Group or IPA

You or your Dependent may change Primary Care Physician s or designated Medical Group/IPA by calling the Blue Shield Member Services Department at the number provided on the back page of this booklet. Some Primary Care Physician s are affiliated with more than one Medical Group/IPA. If you change to a Medical Group/IPA with no affiliation to your Primary Care Physician , you must select a new Primary Care Physician affiliated with the new Medical Group/IPA and transition any specialty care you are receiving to specialists affiliated with the new Medical Group/IPA. The change will be effective the first day of the month following notice of approval by Blue Shield.

Once your Primary Care Physician change is effective, all care must be provided or arranged by your new Primary Care Physician , except for OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Primary Care Physician . Once your Medical Group/IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new Medical Group/IPA, even if you remain with the same Primary Care Physician . Blue Shield Member Services will assist you with the timing and choice of a new Primary Care Physician or Medical Group/IPA.

Voluntary Medical Group/IPA changes are not permitted during the third trimester of pregnancy or while confined to a Hospital. The effective date of your new Medical Group/IPA will be the first of the month following discharge from the Hospital, or when pregnant, following the completion of post-partum care.

Additionally, changing your Primary Care Physician or designated Medical Group/IPA during a course of treatment may interrupt your health care. For this reason, while obtaining HMO (Shield Signature Level I) Benefits, the effective date of your new Primary Care Physician or designated Medical Group/IPA, when requested during a course of treatment, will be the first of the month following the date it is medically appropriate to transfer your care to your new Primary Care Physician or designated Medical Group/IPA, as determined by Blue Shield.

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

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

Continuity of Care by a Terminated Provider

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

Continuity of Care for New Members by Non-Contracting Providers

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

Relationship with Your Primary Care Physician

Your Primary Care Physician seeks to provide Medically Necessary and appropriate professional Services to you in a manner compatible with your wishes. If your Primary Care Physician recommends procedures or treatments, which you refuse, or you and your Primary Care Physician fail to establish a satisfactory relationship, you may select a different Primary Care Physician . Member Services can assist you with this selection.

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

Obtaining Medical Care

(For both levels, for all Mental Health Services see the Mental Health Services paragraphs later in this Section)

Shield Signature Level I: Use of Primary Care Physician

To receive Shield Signature Level I Benefits, you must obtain or arrange for health care through your Primary Care Physician including preventive Services, routine health problems, consultation with Shield Signature Specialists, and admission into a Hospice Program through a Participating Hospice Agency, Urgent Services and hospitalization.

You should cancel any scheduled appointment at least 24 hours in advance when reasonably possible. This policy applies to appointments with or arranged by your Primary Care Physician or the Mental Health Service Administrator (MHSA) and self-arranged appointments for OB/GYN Services. Because your Physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the physician. Some offices

may advise you that a fee (not to exceed your Co-payment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

All Services, except those meeting the Emergency and Urgent Services requirements below, must have prior approval by the Primary Care Physician , Medical Group/IPA to receive the highest level of Benefits under Shield Signature Level I.

Obstetrical/Gynecological (ob/gyn) Physician Services

(Benefit is Provided Only under Shield Signature Level I)

Under Shield Signature Level I, a female Member may arrange for obstetrical and/or gynecological (OB/GYN) Services by an obstetrician/gynecologist or family practice Physician who is her designated Primary Care Physician . A referral from your Primary Care Physician or from the affiliated Medical Group or IPA is not needed. However, the obstetrician/gynecologist or family practice must be in the same Medical Group/IPA as her Primary Care Physician .

Obstetrical and gynecological Services are defined as:

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

It is important to note that services by an OB/GYN or family practice Physician outside of the Primary Care Physician 's Medical Group/IPA without authorization will not be covered under Shield Signature Level I. Before making the appointment, the Member should call the Member Services Department at the telephone number listed on your identification card. to confirm that the OB/GYN or family practice Physician is in the same Medical Group/IPA as her Primary Care Physician .

Referral to Specialty Services

To receive specialty Services (including X-rays and laboratory tests) under Shield Signature Level I, you must have the specialty Services provided or arranged by your Primary Care Physician . You will generally be referred to a Shield Signature Specialist or Non-Physician Health Care Practitioner in the same Medical Group or IPA as your Primary Care Physician , but you can be referred outside the Medical Group or IPA if the type of specialist or Non-Physician Health Care Practitioner needed is not available within your Primary Care Physician 's Medical Group or IPA. For Mental Health Services, see the Shield Signature Level I Mental Health Services paragraphs in the Obtaining Medical Care section for information regarding how to access care. Your Primary Care Physician will request any necessary prior authorization from your Medical Group/IPA. The Shield Signature Specialist or Non-Physician Health Care Practitioner will provide a report to your Primary Care Physician .

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, or if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Primary Care Physician to refer you to another Physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from your Primary Care Physician , the second opinion will be provided by a Physician within the same Medical Group/IPA as your Primary Care Physician . If you are requesting a second opinion about care received from a specialist, the second opinion may be provided by any Shield Signature Specialist of the same or equivalent specialty. All second opinion consultations must be authorized under Level I. Your Primary Care Physician may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to

Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Member Services Department telephone number listed on your identification card. In referring you for specialty Services, your Primary Care Physician will discuss with you what treatment options are best for you. If the Primary Care Physician determines that specialty Services are Medically Necessary, your Primary Care Physician will notify Blue Shield, request necessary authorization, and designate the particular specialist from whom you will receive the specialty Services.

When no HMO Participating Provider is available to perform the needed service, the Primary Care Physician will refer you to a non-HMO Provider after obtaining authorization. This authorization procedure is handled for you by your Primary Care Physician .

Referral by a Primary Care Physician , however, does not guarantee coverage for referral services. The eligibility provisions, exclusions, and limitations for the particular Services under the Shield Signature will still apply.

Emergency Services

If you obtain Emergency Services, you should notify your Primary Care Physician within 24 hours after care is received unless it was not reasonably possible to communicate with the Primary Care Physician within this time limit. In such case, notice should be given as soon as possible.

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

An emergency means an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

If you receive non-authorized Services in a situation that was not a situation in which a reasonable person would believe that an emergency condition existed, your Services will not be covered under Shield Signature Level I.

Inpatient, Home Health Care, Hospice Program and Other Services under Shield Signature Level I

The Primary Care Physician is responsible for obtaining prior authorization before you are admitted to the Hospital or a Skilled Nursing Facility or receive home health care and certain other Services or before you can be admitted into a Hospice Program through a Participating Hospice Agency under Shield Signature Level I. If the Primary Care Physician determines that you should receive any of these Services, he or she will request authorization. If Blue Shield determines that the requested Service is Medically Necessary, then your Primary Care Physician will arrange for your admission to the Hospital or Skilled Nursing Facility, including Subacute Care admissions, or to a Hospice Program through a Participating Hospice Agency, as well as for the provision of home health care and other Services. Note: For Hospital admissions for mastectomies or lymph node dissections, the length of Hospital stays will be determined solely by the Member's Physician in consultation with the Member. For information regarding length of stay for maternity or maternity related Services, see Shield Signature Level I Pregnancy and Maternity Care Benefits in this booklet's Benefits section, for information relative to the Newborns' and Mothers' Health Protection Act.

NurseHelp 24/7 & LifeReferrals 24/7

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

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

If your physician's office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) Or you can call Member Services at telephone number listed on your identification card. NurseHelp 24/7 and LifeReferrals 24/7 programs provide Members with no charge, confidential telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

These programs include:

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

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

Mental Health and Substance Use Disorder Services

Blue Shield contracts with a Mental Health Service Administrator (MHSA) to underwrite and deliver all Mental Health and Substance Use Disorder Services through a unique network of MHSA Participating Providers. All non-emergency Mental Health and Substance Use Disorder Hospital admissions and Other Outpatient Mental Health and Substance Use Disorder Services must be arranged through and authorized by the MHSA. Members are not required to coordinate Mental Health and Substance Use Disorder Services through their Primary Care Physician .

Shield Signature Level I: MHSA Participating Providers

For Shield Signature Level I, all Mental Health and Substance Use Disorder Services must be provided by an MHSA Participating Provider, apart from the exceptions noted in the next paragraph. Information regarding MHSA Participating Providers is available online at www.blueshieldca.com. Members, or their Primary Care Physician , may also contact the MHSA directly at 1-877-263-9952 to obtain this information.

Mental Health and Substance Use Disorder Services received from an MHSA Non-Participating Provider will not be covered at Level I except as an Emergency or Urgent Service or when no MHSA Participating Provider is available to perform the needed services and the MHSA refers the Member to an MHSA Non-Participating Provider and authorizes the services. Mental Health and Substance Use Disorder Services received from a health professional who is an MHSA Non-Participating Provider at a facility that is an MHSA Participating Provider will also be covered.

For coverage at Level I, all non-emergency Mental Health and Substance Use Disorder inpatient Hospital admissions including Residential Care, and Other Outpatient Mental Health and Substance Use Disorder Services must be prior authorized by the MHSA. For prior authorization of Mental Health and Substance Use Disorder Services, the MHSA Participating Provider should contact the MHSA at 1-877-263-9952 at least five business days prior to the admission. The MHSA will render a decision on all requests for prior authorization of services as follows:

1) for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;

2) for other services, within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to

the provider and Member within two business days of the decision.

If prior authorization is not obtained for an inpatient Mental Health and Substance Use Disorder Hospital admission or for any Other Outpatient Mental Health and Substance Use Disorder Services and the services provided to the member are determined not to be a Benefit of the plan, or were not medically necessary, coverage will be denied.

Prior authorization is not required for an emergency Mental Health and Substance Use Disorder Hospital admission.

Psychosocial Support through LifeReferrals 24/7

Notwithstanding the Benefits provided under Mental Health Services in this booklet's Benefits section, the Member also may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

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

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

Shield Signature Level I Urgent Services While Traveling

Shield Signature provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside your Primary Care Physician Service Area.

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

Out-of-Area Follow-up Care is defined as non-emergent Medically Necessary out-of-area Services to evaluate the Member's progress after an initial Emergency or Urgent Service.

(Urgent care) While in your Primary Care Physician Service Area

If you require urgent care for a condition that could reasonably be treated in your Primary Care Physician 's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), You may go directly to an urgent care clinic in your Primary Care Physician Service Area.

Outside of California

Shield Signature provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard Program, described herein, which can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Shield Signature Level I: Follow-up Services

Shield Signature Level I Out-of-Area Follow-up Care is covered and may be provided through the BlueCard® Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. To receive Shield Signature Level I Services, Blue Shield may direct the patient to receive the addi-

tional follow-up Services from the Primary Care Physician .

When a BlueCard Program provider is available, Shield Signature Level I Services should be obtained from a Participating Provider, when possible.

Within California

If you are temporarily traveling within California, but are outside of your Primary Care Physician Service Area, if possible you should call Blue Shield Member Services the telephone number listed on your identification card for assistance in receiving Urgent Services through a Blue Shield of California Provider. You may also locate a Blue Shield Provider by visiting our web site at http://www.blueshieldca.com. However, you are not required to use a Blue Shield of California Participating Provider to receive Urgent Services; you may use any provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Benefits will be determined in accordance with the requirements of Shield Signature coverage, subject to the applicable Copayments.

Follow-up care is also covered through a Blue Shield of California Participating Provider and may also be received from any provider. However, when outside your Primary Care Physician Service Area authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the Primary Care Physician .

If services are not received from a Blue Shield of California Participating Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for Urgent Services obtained outside of your Primary Care Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Primary Care Physician within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's Allowed Charges.

Claims for Emergency and Out-of-Area Urgent Services

1. Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the emergency service record for payment to Blue Shield, within 1 year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, Blue Shield will not pay for those emergency services, unless the claim was submitted as soon as reasonably possible as determined by Blue Shield. If the services are not preauthorized, Blue Shield will review the claim retrospectively for coverage. If Blue Shield determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been prospectively authorized, the services will not be covered under Shield Signature Level I and Blue Shield will notify the Member of that determination. Blue Shield will notify the Member of its determination within 30 days from receipt of the claim.

2. Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating BlueCard Program provider you must submit a complete claim with the Urgent Service record for payment to Blue Shield, within 1 year after the first provision of Urgent Services for which payment is requested. If the claim is not submitted within this period, the Blue Shield will not pay for those Urgent Services, unless the claim was submitted as soon as reasonably possible as determined by Blue Shield The services will be reviewed retrospectively to determine whether the services were Urgent Services. If Blue Shield determines that the services would not have been authorized, and therefore, are not covered, it will notify the Member of that determination. Blue Shield will notify the Member of its determination within 30 days from receipt of the claim.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Plan Providers:

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

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

Deductible

Calendar Year Deductible

There is no Calendar Year Deductible under Shield Signature Level I.

No Member Maximum Lifetime Benefits

There is no maximum lifetime limit on the aggregate payments by the plan for Shield Signature Level I covered Services provided under the plan.

No Annual Dollar Limit on Essential Benefits

Shield Signature Level I - HMO contains no annual dollar limits on essential benefits as defined by federal law.

Payment

The Member's Copayment amounts, applicable Copayment maximum amounts for Covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on Benefit and Copayment maximums and restrictions.

Complete Benefit descriptions may be found in this booklet's Benefits section. Shield Signature exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Shield Signature Level I (HMO Level of Benefits) Calendar Year Out-of-Pocket Maximum

Your Calendar Year Out-of-Pocket Maximum for covered Services is shown in the Summary of Benefits. Once a Member's maximum responsibility has been met*, Blue Shield will pay 100% of Allowed Charges for that Member's covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*,Blue Shield will pay 100% of Allowed Charges for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as described below.

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

Note that Copayments and charges for Services not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Note: It is the Member's responsibility to maintain accurate records of their Copayments and to determine and notify Blue Shield when the Calendar Year Out-of-Pocket Maximum has been reached.

You must notify Blue Shield Member Services when you feel that your Calendar Year Out-of-Pocket Maximum has been reached. At that time, you must submit complete and accurate records to Blue Shield substantiating your Copayment expenditures for the period in question. Member Services addresses and telephone numbers may be found on the last page of this booklet.

Reimbursement under Payment of Providers — Shield Signature Level I

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

If you want to know more about this payment system, contact Member Services at the number listed on your Shield Signature identification card or talk to your Shield Signature Provider.

Shield Signature Service Area

Shield Signature's Service Area is identified in the Blue Shield HMO Physician and Hospital Directory. You and your eligible Dependents must live or work in the Shield Signature Service Area identified in those documents to enroll in this plan and to maintain eligibility in Shield Signature.

Shield Signature Level I Benefits

The Benefits available to you under the Shield Signature are listed in this section, subject to the applicable Copayment responsibilities.

As set forth in the Exclusions and Limitations section, the Services and supplies described here are covered only if they are Medically Necessary as determined by the Medical Group/IPA or by Blue Shield If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.

Subject to the terms, conditions, exclusions (including Medical Necessity), limitations, Copayments, and other requirements contained in this Evidence of Coverage and Disclosure Form or the Group Health Service Contract, and to any conditions or limitations set forth in the benefit descriptions below, and to the Shield Signature Level I Exclusions and Limitations set forth in this booklet, Benefits are provided for the following health care Services under Shield Signature. The Copayments are listed in the Summary of Benefits. Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Allergy Testing and Treatment Benefits

Benefits are provided for office visits for the purpose of allergy testing and treatment, including injectables and serum.

Ambulance Benefits

Shield Signature will pay for ambulance Services as follows:

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

Ambulatory Surgery Center Benefits

(Benefits are provided only under Shield Signature Level I)

Benefits are provided for Ambulatory Surgery Center Benefits on an Outpatient facility basis at an Ambulatory Surgery Center.

Note: Outpatient ambulatory surgery Services may also be obtained from a Hospital or an Ambulatory Surgery Center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) in this booklet's Benefits section.

Benefits are provided for Medically Necessary Services in connection with Reconstructive Surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in function or appearance. In accordance with the Women's Health and Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and Reconstructive Surgery are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Surgery must be authorized as described herein. Benefits will be provided in accordance with guidelines established by the Blue Shield and developed in conjunction with plastic and reconstructive surgeons.

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

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

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

Bariatric Surgery Benefits

(Benefits are provided only under Shield Signature Level I)

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

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

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

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

Clinical Trial for Treatment of Cancer or Life Threatening Conditions Benefits

(Benefit is Provided Only under Shield Signature Level I)

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition where the clinical trial has a therapeutic intent and when prior authorized through the Member's Primary Care Physician , and:

1. the Member's Primary Care Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the Member;or

2. the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

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

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

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

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other life-threatening condition, and is limited to a trial that is:

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

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Diabetes Care Benefits

Diabetic Equipment (Benefit is provided only under Shield Signature Level I)

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

a. blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary sup plies;

c. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the *Outpatient Prescription Drug Benefits Supplement* if selected as an optional Benefit by the County.

Diabetes Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management, training, education and medical nutrition therapy when directed or prescribed by the Member's Primary Care Physician . These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetic educator.

Dialysis Centers Benefits

(Benefits are provided only under Shield Signature Level I)

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

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

Durable Medical Equipment Benefits

(Benefit is provided only under Shield Signature Level I)

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

Medically Necessary Durable Medical Equipment is covered as described in this section, except as noted below:

1) rental charges in excess of the purchase cost;

2) replacement of DME except when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See *the Outpatient Prescription Drug Benefits Supplement* if selected as an optional Benefit by the County for benefits for asthma inhalers and inhaler spacers);

3) breast pump rental or purchase when obtained from a non-Plan Provider;

4) for repair or replacement due to loss or misuse;

5) for environmental control equipment, generators, self- help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and

6) for backup or alternate items.

Note: See Shield Signature Level I Diabetes Care Benefits in this booklet's Benefits section for devices, equipment, and supplies for the management and treatment of diabetes.

If you are enrolled in a Shield Signature Level I Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency. For information see Shield Signature Level I Hospice Program Benefits in this booklet's Benefits section.

Emergency Room Benefits

1. Emergency Services. Members who reasonably believe that they have an emergency medical or Mental Health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the Primary Care Physician or the MHSA by phone within 24 hours of the commencement of the emergency Services, or as soon as it is medically possible for the Member to provide notice. When all these requirements are met, the Services will be covered under Shield Signature Level I, subject to the applicable Copayment. The Services will be reviewed retrospectively by Blue Shield to determine whether the Services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition. If Blue Shield determines they were not emergency services as described above, the Member will be notified of that determination.

   Emergency Services Copayment does not apply if a Member is admitted directly to the Hospital as an Inpatient from the emergency room.

2. Continuing or Follow-up Treatment.

   (This Benefit is provided only under Shield Signature Level I.)

   If you receive Emergency Services from a Hospital which is a non-Shield Signature Hospital, follow-up care must be authorized by Blue Shield or it may not be covered. If, once your Emergency medical condition is stabilized, and your treating health care provider at the non-Shield Signature Hospital believes that you require additional Medically Necessary Hospital Services, the non-Shield Signature Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital Services by the non-Shield Signature Hospital. If Blue Shield determines that you may be safely transferred to a Hospital that is contracted with Blue Shield and you refuse to consent to the transfer, the non-Shield Signature Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for Services provided to you once your Emergency condition is stable. Also, if the non-Shield Signature Hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Shield Signature Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Shield Signature Hospital, you should contact Blue Shield at the telephone number on your identification card. Blue Shield will provide benefits for care in a Hospital only for as long as the Member's medical condition prevents transfer to a Shield Signature Hospital in the Member's Service Area, as approved by the Medical Group/IPA or by Blue Shield. Unauthorized continuing or follow-up care after the initial emergency has been treated in a Hospital, or by a provider, is not a covered service under Shield Signature.

Eye Examination Benefit

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

Note: An annual self-referred eye examination will not be covered under your Blue Shield Access+ HMO Plan if the County provides supplemental Benefits for vision care through the Blue Shield Vision Plan. Please refer to your Blue

Shield Vision Plan Supplement for specific information about covered eye examinations.

The Plan provides payment for the following service:

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

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

Reimbursement Provision

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

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

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

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

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

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

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

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

Limitations and Exclusions

This vision Benefit does not cover corrective lenses, frames for eye glasses, contact lenses or the fitting of contact lenses; eye exercises; any other routine eye refractions; subnormal vision aids; vision training; any eye examination required by the County as a condition of employment; medical or surgical treatment of the eyes; Services performed by a close relative or by a person who ordinarily resides in your home; Services incident to any injury arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, or similar legislation. However, if Blue Shield provides payment for such Services, it shall be entitled to establish a lien for such other Benefits up to the amount paid by Blue Shield for treatment of the injury or disease; Services required by any government agency or program, federal, state or subdivision thereof; or Services for which no charge is made.

Family Planning Benefits

(This Benefit is provided only under Shield Signature Level I.)]

1) Family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives (Benefits provided only under Level I); and
2) vasectomy.

No benefits are payable for the following services:

1) Infertility Services. Infertility Services, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose and treat the cause of Infertility, including any services related to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service).

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

Home Health Care Benefits

(This Benefit is provided only under Shield Signature Level I.)

Benefits are provided for home health care services when ordered and authorized through the Member's Primary Care Physician .

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled services are covered up to four visits per day, two hours per visit up to the Calendar Year visit maximum. The visit maximum includes all home health visits by any of the following professional providers:

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

Intermittent and part-time visits by a home health agency to provide services from a Home Health Aide are covered up to four hours per visit.

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

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

This Benefit does not include medications or injectables covered under the Home Infusion/Home Injectable Therapy Benefit or under the Supplemental Benefit for Outpatient Prescription Drugs if selected as an optional Benefit by the County.

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

(Note: See Shield Signature Level I Hospice Program Benefits in this booklet's Benefits section for information about when a Member is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.)

Note: For information concerning diabetes self-management training, see Shield Signature Level I Diabetes Care Benefits in this booklet's Benefits section.

Home Infusion/Home Injectable Therapy Benefits

(This Benefit is provided only under Shield Signature Level I.)

Benefits are provided for home infusion and injectable medication therapy. Services include home infusion agency Skilled Nursing visits, infusion therapy provided in infusion suites associated with a home infusion agency, parenteral nutrition services, enteral nutritional services and as-

sociated supplements, medical supplies used during a covered visit, medications injected or administered intravenously and related laboratory services when prescribed by the Primary Care Physician and prior authorized, and when provided by a home infusion agency. Services related to hemophilia are described separately.

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

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the Non-Participating home infusion agency and Blue Shield. Shift care and private duty nursing must be prior authorized by Blue Shield. When services are authorized, they are covered under Level II.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. (Note: most Participating home health care and home infusion agencies are not Participating Hemophilia Infusion Providers.) A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. Members may also verify this information by calling Customer Service at the telephone number provided on the back page of this Evidence of Coverage and Disclosure Form.

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

Following evaluation by the Member's Primary Care Physician , a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once authorized by Blue Shield, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non- emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the *Emergency Room Benefits* section.)

Included in this Benefit is the blood factor product for in-home infusion by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home except for services in infusion suites managed by a Participating Hemophilia Infusion Provider, and services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other Benefits described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

No Benefits are provided for:

1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2) services from a hemophilia treatment center or any provider not authorized by Blue Shield; or,
3) self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under *Outpatient Prescription Drug Benefits Supplement* if selected as an optional Benefit by the County, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

Hospice Program Benefits

(This Benefit is provided only under Shield Signature Level I.)

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

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver and the Family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Hospice Agency.

1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.
2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:
    a) Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;
    b) Home Health Aide services to provide personal care (supervised by a registered nurse);
    c) homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);
    d) bereavement services for the immediate surviving Family members for a period of at least one year following the death of the Member;
    e) medical social services including the utilization of appropriate community resources;
    f) counseling/spiritual services for the Member and Family;
    g) dietary counseling;
    h) medical direction provided by a licensed Physician acting as a consultant to the interdisciplinary Hospice team and to the Member's Primary Care Physician with regard to pain and symptom management and as a liaison to community physicians;
    i) physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;
    j) respiratory therapy;
    k) volunteer services.
3) Drugs, DME, and supplies.
4) Continuous home care when Medically Necessary to achieve palliation or management of acute medical symptoms including the following:
    a) eight to 24 hours per day of continuous Skilled Nursing care (eight-hour minimum);
    b) homemaker or Home Health Aide services up to 24 hours per day to supplement skilled nursing care.
5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.
6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

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

DEFINITIONS

Bereavement Services – Services available to the immediate surviving family members for a period of at least 1 year after the death of the Member. These Services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

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

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

Homemaker Services – Services that assist in the maintenance of a safe and healthy environment and Services to enable the Member to carry out the treatment plan.

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

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

Interdisciplinary Team – the Hospice care team that includes, but is not limited to, the Member and the Member's family, a Physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction – Services provided by a licensed Physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Member's Primary Care Physician , as requested, with regard to pain and symptom management, and liaison with Physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period Of Care – the time when the Primary Care Physician recertifies that the Member still needs and remains eligible for Hospice care even if the Member lives longer than 1 year. A Period of Care starts the day the Member begins to receive Hos-

pice care and ends when the 90 or 60 day period has ended.

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

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

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

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

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

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of 1 year or less, if the disease follows its natural course.

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

Hospital Benefits (Facility Services)

(This Benefit is provided only under Shield Signature Level I.)

(Other than bariatric surgery Services which are described under the Bariatric Surgery Benefits section.)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

1) Semi-private room and board unless a private room is Medically Necessary.
2) General nursing care and special duty nursing.
3) Meals and special diets.
4) Intensive care services and units.
5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.
6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield.
8) Drugs and oxygen.
9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.
10) Hospital ancillary services, including diagnos-

tic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.

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

12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.

13) Subacute Care.

14) Medical social services and discharge planning.

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

16) Inpatient substance Use Disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance Use Disorder detoxification is authorized through the Member's Primary Care Physician .

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

1) Dialysis services.

2) Outpatient Care.

3) Surgery.

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

5) Routine newborn circumcision within 18 months of birth.

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

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

1) Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;

2) Surgery to reform or reshape skin or bone;

3) Surgery to excise or reduce skin or connec tive tissue that is loose, wrinkled, sagging, or excessive on any part of the body;

4) Hair transplantation; and

5) Upper eyelid blepharoplasty without docu mented significant visual impairment or symptomatology.

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

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

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

1) treatment of tumors of the gums;

2) treatment of damage to natural teeth caused solely by an Accidental Injury is limited to palliative services necessary for the initial medical stabilization of the Member as determined by Blue Shield;

3) non-surgical treatment (e.g. splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

*Note: There is a visit maximum as shown in the Summary of Benefits per person Calendar Year maximum for all Physical Ther-

apy Covered Services performed on an Outpatient basis (except for Physical Therapy provided under Home Health Care Benefits) under Level II.

4) surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5) treatment of maxilla and mandible (Jaw Joints and Jaw Bones);
6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;
7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair; or
8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck.
9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

No Benefits are provided for:

1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;
2) dental implants (endosteal, subperiosteal or transosteal);
3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and
5) fluoride treatments except when used with radiation therapy to the oral cavity.

Shield Signature Level I (HMO) Mental Health and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services and Substance Use Disorder for Blue Shield Members within California. All non-emergency inpatient Mental Health and Substance Use Disorder Services, including Residential Care, and Non-Routine Outpatient Mental Health and Substance Use Disorder Services must be prior authorized by the MHSA.

Office Visits for Mental Health and Substance Use Disorder Services

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

Other Outpatient Mental Health and Substance Use Disorder Services

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

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

   BHT is covered when prescribed by a Plan Physician or licensed psychologist and provided under a treatment plan developed by an MHSA Participating Provider. BHT must be

obtained from MHSA Participating Providers.

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

2) Electroconvulsive Therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.
3) Intensive Outpatient Program – an outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
4) Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment
5) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.
6) Psychological Testing – testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.
7) Transcranial Magnetic Stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

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

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

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

Orthotics Benefits

(This Benefit is provided only under Shield Signature Level I.)

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

1) shoes only when permanently attached to such appliances;
2) special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
3) knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
4) functional foot orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
5) initial fitting and adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

No Benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet not listed above. No Benefits are provided for backup or alternate items, or replacement due to loss or misuse.

See the *Diabetes Care Benefits* in the Shield Signature Benefits section for devices, equipment, and supplies for the management and treatment of diabetes.

Outpatient X-ray, Pathology and Laboratory Benefits

Benefits are provided for X-ray services, diagnostic testing, clinical pathology, and laboratory services.

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

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

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

PKU Related Formulas and Special Food Products Benefits

(This Benefit is provided only under Shield Signature Level I.)

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

Pregnancy and Maternity Care Benefits

(This Benefit is provided only under Shield Signature Level I.)

Benefits are provided for maternity services, including the following:

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

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

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

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

Preventive Health Benefits

Preventive Health Services are only covered when provided or arranged by the Member's Primary Care Physician .

Preventive Health Services include primary preventive medical and laboratory services for early detection of disease as specifically listed below:

1) evidence-based items, drugs or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule

/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

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

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

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

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

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

Professional (Physician) Benefits

(Other than Bariatric Surgery Benefits and Mental Health Benefits which are described elsewhere in this booklet's Benefits section.)

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

1) Physician office visits for examination, diagnosis, and treatment of a medical condition, disease or injury.

2) Specialist office visits for second medical opinion or other consultation and treatment;

3) Mammography and Papanicolaou's tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

4) Preoperative treatment;

5) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;

6) Outpatient surgical procedures.

7) Outpatient routine newborn circumcision within 18 months of birth;

8) Office administered Injectable medications approved by the Food and Drug Administration (FDA) as prescribed or authorized by the Primary Care Physician

9) Outpatient radiation therapy and chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10) Diagnostic audiometry examination.

11) Physician visits to the home.

12) Inpatient medical and surgical Physician services when Hospital or Skilled Nursing Facility services are also covered.

13) Routine newborn care in the Hospital including physical examination of the infant and counseling with the mother concerning the infant during the Hospital stay;

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

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

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

A Plan Physician may offer extended-hour and urgent care services on a walk-in basis in a non-Hospital setting such as the Physician's office or an urgent care center. Services received from a Plan Physician at an extended-hour facility will be reimbursed as a Physician office visit. A list of urgent care providers may be found online at www.blueshieldca.com or by calling Customer Service

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

Covered laboratory and X-ray services provided in conjunction with the professional services listed above are described under the *Outpatient X-ray, Pathology and Laboratory Benefits* section.

Preventive Health Benefits, Mental Health and Substance Use Disorder Benefits, Hospice Program Benefits, and Reconstructive Surgery Benefits are described elsewhere under *Principal Benefits and Coverages (Covered Services).*

Prosthetic Appliances Benefits

(This Benefit is provided only under Shield Signature Level I.)

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

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

Routine maintenance is not covered. No Benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided above). No Benefits are provided for backup or alternate items.

For surgically implanted and other prosthetic de

vices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see the *Surgery Benefits* section.

Reconstructive Surgery Benefits

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

create a normal appearance only when it offers more than a minimal improvement in appearance.

In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas.

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

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

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

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

See Shield Signature Level I *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitation services rendered in the home.

Note: See Shield Signature Level I Home Health Care Benefits in this booklets Benefits section for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

Skilled Nursing Facility Benefits

(Benefit is provided only under Shield Signature Level I)

Subject to all of the Inpatient Hospital Services provisions, Medically Necessary skilled nursing Services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. Note: For information concerning Hospice Program Benefits see Shield Signature Level I Hospice Program Benefits in this booklet's Benefits section.

Speech Therapy Benefits (Rehabilitation and Habilitative Services)

Benefits are provided for Medically Necessary Outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist/pathologist or other appropriately licensed or certified Health Care Provider, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

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

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

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

Transplant Benefits

(This Benefit is provided only under Shield Signature Level I.) .

Transplant benefits include coverage for donation-related services for a living donor (including a potential donor), or a transplant organ bank.

Donor services must be directly related to a covered transplant and must be prior authorized by Blue Shield. Donation-related services include harvesting of the organ, tissue, or bone marrow and treatment of medical complications for a period of 90 days following the evaluation or harvest service.

Tissue and Kidney Transplant

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient. Benefits also include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special Transplant

(This Benefit is provided only under Shield Signature Level I.)

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

Failure to obtain prior written authorization and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this Benefit:

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

Urgent Services Benefits

To receive urgent care within your Primary Care Physician Service Area, call your Primary Care Physician 's office or follow instructions given by your assigned Medical Group/IPA in accordance with the Obtaining Medical Care section.

When outside the Primary Care Physician Service Area, Members may receive care for Urgent Services as follows:

Inside California

For Urgent Services within California but outside the Member's Primary Care Physician Service Area, if possible, the Member should contact Blue Shield Member Services at the number provided on the back page of this booklet in accordance with the Obtaining Medical Care section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Participating Provider. Members may also locate a Participating Provider by visiting Blue Shield's internet site at http://www.blueshieldca.com. You are not required to use a Blue Shield of California Plan Provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Outside California or the United States

When temporarily traveling outside California, Members should, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. If Urgent Services are not avail-

able through a BlueCard Program participating provider, and you received Services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. See Claims for Emergency and Out-of-Area Urgent Services in the Obtaining Medical Care section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

For Shield Signature Level I services, up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. When a BlueCard Program participating provider is available, you should obtain out of area Urgent or follow-up Services from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. (See preceding paragraph for what to do if a participating provider is not available.) Authorization by Blue Shield is required for more than two follow-up outpatient visits. To receive Shield Signature Level I services, Blue Shield may direct the member to receive the additional follow-up care from the Primary Care Physician .

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the Blue Cross Blue Shield Global™ (BCBS Global™) Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient hospital care, contact the BCBS Global™ Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.
When you receive services from a physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the How to Use Your Health Plan section. See *BlueCard Program* in the How to Use Your Health Plan section for additional information.

Members before traveling abroad may call their local Member Services office for the most current listing of providers and to obtain a copy of the Blue Cross Blue Shield Global™ Network brochure that provides helpful information on receiving covered Services in a foreign country or they can visit Blue Shield's internet site at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide". However, a Member is not required to receive Urgent Services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

Shield Signature Level II – PPO Benefits

Benefits under Shield Signature Level II provides coverage for selected Outpatient benefits through our PPO network which are detailed in this booklet's Summary of Benefits in the front section of this booklet. Referral or authorization by your Primary Care Physician is not required and there are no deductibles or copayment maximums. Covered Services do not require prior authorization requirements of the Benefits Management Program. However, you will not be required to pay any difference between the Participating Provider's actual charges and Blue Shield's Allowable Amount, except as set forth in the section on Reductions – Third Party Liability.

Note: Coverage under Shield Signature Level II is only for selected Outpatient Services. All Inpatient care including Hospitalization, Skilled Nursing Care and services which cannot be provided in a medical office are not covered. Such services must be obtained through your HMO Medical Group/IPA and Primary Care Physician except for Covered Emergency and Urgent Care as described in this booklet.

Continuity of Care by a Terminated Provider

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

Financial Responsibility for Continuity of Care Services

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

Shield Signature Level II: Use of Blue Shield PPO Network Participating Providers

Under Shield Signature Level II, you may choose to receive specified Outpatient covered medical Services as listed in this booklet Summary of Benefits, including second medical opinions, from any Blue Shield PPO Network Participating Provider without referral or authorization by your Primary Care Physician .

Emergency Services

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available or seek immediate care from the nearest Hospital.

An emergency means an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

If you receive non-authorized Services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, your Services will not be covered.

Claims for Emergency and Out-of-Area Urgent Services

Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record

for payment to the Plan, within one year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered under Level I, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. The services will be covered under Level II, subject to the applicable deductibles, Copayments and requirements of the Plan. In the event covered medical transportation services are obtained in such an emergency situation, the Blue Shield Health Plan shall pay the medical transportation provider directly.

No Member Maximum Lifetime Benefits

There is no maximum lifetime limit on the aggregate payments by the plan for Shield Signature Level II covered Services provided under the plan.

No Annual Dollar Limit on Essential Benefits

There is no annual dollar limits on Essential Benefits under Shield Signature Level II.

Limitation of Liability

(For Shield Signature Level II Benefits)

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of Shield Signature will be provided for covered Services received anywhere in the world for emergency care of an illness or injury.

Benefits will also be provided for covered Services received outside of the United States through the BlueCard Worldwide Network. If you need urgent care while out of the country, call either the toll-free BlueCard Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should call Blue Shield of California at the Member Services telephone number indicated on the back of the Member's identification card. For inpatient hospital care at participating hospitals, show your I.D. card to the hospital staff upon arrival. You are responsible for the usual out-of-pocket expenses (non-covered charges, and copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for inpatient hospitalization, if you do not use the BlueCard Worldwide Network, you will have to pay the entire bill for your medical care and submit a claim form (with a copy of the bill) to Blue Shield of California.

Before traveling abroad, call your local Member Services office for the most current listing of participating Hospitals worldwide or you can go online at www.bcbs.com and select the "Find a Doctor or Hospital" tab.

Reimbursement Under Shield Signature Level II

Payment of Providers — Shield Signature Level II

Shield Signature Level II Services are those covered Outpatient Services received from Blue Shield Participating Providers. Please see the Payment section, under Shield Signature Level II, for payment parameters.

Blue Shield contracts with Hospitals and Physicians to provide Services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact Member Services at the number provided on the back page of this booklet.

Shield Signature Level II (PPO Network) Benefits

Allergy Testing and Treatment Benefits

Benefits are provided for office visits for the purpose of allergy testing and treatment, including injectables and serum.

Ambulance Benefits

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

Diabetes Care Benefits

Diabetes Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management, training, education and medical nutrition therapy when directed or prescribed by the Member's Primary Care Physician . These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetic educator.

Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services and emergency room follow-up services (e.g., suture removal, wound check, etc.) should be authorized by Blue Shield or obtained through the Member's Primary Care Physician .

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

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

Eye Examination Benefit

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

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

The Plan provides payment for the following service:

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

cated, as in presence of trauma or severe inflammation.

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

Reimbursement Provision

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

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

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

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

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

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

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

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

Limitations and Exclusions

This vision Benefit does not cover corrective lenses, frames for eye glasses, contact lenses or the fitting of contact lenses; eye exercises; any other routine eye refractions; subnormal vision aids; vision training; any eye examination required by the County as a condition of employment; medical or surgical treatment of the eyes; Services performed by a close relative or by a person who ordinarily resides in your home; Services incident to any injury arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, or similar legislation. However, if Blue Shield provides payment for such Services, it shall be entitled to establish a lien for such other Benefits up to the amount paid by Blue Shield for treatment of the injury or disease; Services required by any government agency or program, federal, state or subdivision thereof; or Services for which no charge is made.

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

Professional Outpatient Services provided for conditions of the teeth, gums, or jaw joints and jaw bones, including adjacent tissues, are a Benefit only to the extent that these Services are:

1. Provided for the treatment of tumors of the gums if provided Outpatient in a Provider's office;
2. The treatment of damage to natural teeth caused solely by an accidental injury is limited to Medically Necessary Services if provided Outpatient in a Provider's office until the Services result in initial, palliative stabilization of the Member as determined by Blue Shield;

   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodon-

tia and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.

3. Medically Necessary non-surgical Outpatient in a Provider's office treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
4. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones) if provided Outpatient in a Provider's office;

This Benefit does not include:

1. Services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;

2) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;

3) dental implants (endosteal, subperiosteal or transosteal);

4) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

5) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and

6) fluoride treatments except when used with radiation therapy to the oral cavity.

See the Shield Signature Level II Principal Limitations, Exceptions, Exclusions and Reductions section for additional services that are not covered.

Shield Signature Level II Mental Health and Substance Use Disorder (MHSA Non-Participating) Benefits

Benefits are provided for services by MHSA Non-Participating Providers for Outpatient Professional Services provided in an office setting for Mental Health and Substance Use Disorder Conditions.

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

Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit description below, and to the Shield Signature Exclusions and Limitations set forth in this booklet.

Office Visits for Outpatient Mental Health Services

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

Behavioral Health Services

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

1. Behavioral Health Treatment (BHT) – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.
2. Outpatient office visits for BHT is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by the MHSA. BHT delivered in the home or other non-institutional setting must be obtained from MHSA Participating Providers.
3. Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

Outpatient X-ray, Pathology and Laboratory Benefits

Laboratory, X-ray, Major Diagnostic Services and clinical laboratory tests and Services if provided Outpatient in a Provider's office.

Preventive Health Benefits

Preventive health services, as defined, are covered.

Professional (Physician) Benefits

1. Physician Office Visits. Office visits for examination, diagnosis, and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations.,
2. Outpatient chemotherapy and radiation therapy, diabetic counseling, audiometry examinations, when performed by a Physician or by an audiologist at the request of a Physician if provided Outpatient in a Provider's office.

   Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors if provided Outpatient in a Provider's office.
3. Injectable medications approved by the Food and Drug Administration (FDA) provided in a Provider's Office are covered for the Medically Necessary treatment of medical conditions when prescribed or authorized by the Primary Care Physician or as described herein. Insulin will be covered if the County provides supplemental benefits for prescription drugs through the supplemental Benefit for Outpatient Prescription Drugs.

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

Rehabilitation/Habilitative Services include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy are covered pursuant to a written treatment plan, and when rendered in the Provider's office.

Benefits for Outpatient Speech Therapy provided in a Provider's office as described in Shield Signature Level II Speech Therapy Benefits in this booklet's Benefits section.

Speech Therapy Benefits (Rehabilitation and Habilitative Services)

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

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

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

Urgent Care

Outside California or the United States

When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest Blue-Card Program participating provider. When a Blue-Card Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-Blue-Card participating provider. If you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services. See Claims for Emergency and Out-of-Area Urgent Services in the Obtaining Medical Care section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the Blue Cross Blue Shield Global™ (BCBS Global™) Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient hospital care, contact the BCBS Global™Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.
When you receive services from a Physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the Obtaining Medical Care section. See *BlueCard Program* in the Obtaining Medical Care section for additional information.

Members before traveling abroad may call their local Member Services office for the most current listing of providers or they can go on line at www.bcbs.com and select "Find a Doctor or Hospital' and "Blue Cross Blue Shield Global™".". However, a Member is not required to receive Urgent Services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

1) routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
2) for hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot, except as specifically provided under Shield Signature Level I Orthotics Benefits and Diabetes Care Benefits in this booklet's Benefits section;
4) inpatient treatment in a pain management center to treat or cure chronic pain, except as may be provided through a Shield Signature Level I Participating Hospice Agency or through a palliative care program offered by Blue Shield;
5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under Shield Signature Level I Hospice Program Benefits;
6) services in connection with private duty nursing, except as provided under Shield Signature Level I Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
7) prescription and non-prescription food and nutritional supplements, except as provided under Shield Signature Level I Home Infusion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;
8) hearing aids;
9) eye exams and refractions, (except as specifically provided under Eye Examination Benefit), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Shield Signature Level I Prosthetic Appliances Benefits in this booklet's Benefits section, and video-assisted visual aids or video magnification equipment for any purpose;
10) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);
11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
12) for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under Shield Signature Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services) in this booklet's Benefits section;
13) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory

conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Shield Signature Level I Hospital Benefits (Facility Services) and Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits in this booklet's Benefits section;

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

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

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

17) For or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Shield Signature Level I Medically Necessary treatment of medical complications;

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

19) services incident to bariatric surgery services, except as specifically provided under Shield Signature Level I Bariatric Surgery Benefits;

20) home testing devices and monitoring equipment except as specifically provided in Shield Signature Level I Durable Medical Equipment Benefits;

21) genetic testing except as described in Shield Signature Level I sections on Outpatient X-ray, Pathology and Laboratory Benefits;

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

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

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

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

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

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

28) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclu-

sion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

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

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

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

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

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

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

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

36) for spinal manipulation and adjustment, except as specifically provided under Shield Signature Professional (Physician) Benefits in the Plan Benefits section;

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

38) for inpatient and Non-Routine Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA.

39) drugs dispensed by a Physician or Physician's office for outpatient use; and

40) services not specifically listed as a Benefit. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.

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

The following Limitations, Exceptions, Exclusions and Reductions apply only to Shield Signature Level II Coverage

1. All services provided by a Non-Preferred or Participating Provider except for Covered Urgent Care and Emergency Care;

2. All hospitalization and skilled nursing services;
3. Inpatient and home visits physician services;
4. All services performed in an Ambulatory Surgery Center;
5. Bariatric Surgery;
6. Clinical Trials for Cancer benefits;
7. Diabetic Care devices, equipment and supplies;
8. Dialysis Center services;
9. Durable Medical Equipment;
10. Family Planning and Infertility services;
11. Home Health Services;
12. Home Infusion/Home Injectable Therapy Benefits;
13. Hospice care;
14. Laboratory, x-ray and diagnostic services performed outside of a Physicians and Specialist's office;
15. Maternity Care and Delivery Services;
16. Inpatient, Partial Hospitalization, Psychological Testing, Intensive Outpatient Care and Outpatient ECT Services, and Psychosocial Support through LifeReferrals 24/7 Mental Health services;
17. Internet Consultations;
18. Orthotics;
19. Outpatient Hospital Services including chemotherapy and renal dialysis;
20. PKU related formulas and Special Food Products;
21. Prosthetic Appliances;
22. Rehabilitation Services provided under Home Health Care, Hospital, Inpatient unit of a Hospital and a Skilled Nursing Facility
23. Speech Therapy Services provided under Home Health Care, Hospital, Inpatient unit of a Hospital and a Skilled Nursing Facility;
24. Transplant Benefits – Cornea, Kidney or Skin
25. Transplants – Special;
26. MBL, MUGA, PET and SPECT diagnostic Services.

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

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements

Emergency Services

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

BlueCard Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard Service Area. When you receive Covered Services within the geographic area served by a Host Blue, Blue Shield

will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

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

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

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

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

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

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

Non-participating Providers Outside of California

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

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

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

Blue Shield Global Core

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

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

Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

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

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

Submitting a Blue Shield Global Core Claim

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

Special Cases: Value-Based Programs

Blue Shield Value-Based Programs

You may have access to Covered Services from providers that participate in a Blue Shield Value-Based Program. Blue Shield Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.
If you receive covered services under a Blue Shield Value-Based Program, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement.

BlueCard® Program

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

Utilization Management

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

Medical Necessity Exclusion

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

Limitations for Duplicate Coverage

Medicare Eligible Members

1) Blue Shield will provide benefits before Medicare in the following situations:
    a) When the Member is eligible for Medicare due to age, if the subscriber is actively

working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).

b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).

c) When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

2) Blue Shield will provide benefits after Medicare in the following situations:

a) When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).

b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).

c) When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

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

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

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

Members Covered by Another Government Agency

If the Member is entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and this Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowed Charges).

Contact Customer Service for any questions about how Blue Shield coordinates group plan benefits in the above situations.

Exception for Other Coverage

A Plan Provider may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under Shield Signature.

Claims Review

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

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

If a claim is unpaid at the time of a Member's death or if the Member is not legally capable of accepting it, payment will be made to the Member's estate or

any relative or person who may legally accept on the Member's behalf

Reductions - Third Party Liability

If another person or entity, through an act or omission, causes a Member to suffer an injury or illness, and if Blue Shield paid Benefits for that injury or illness, the Member must agree to the provisions listed below. In addition, if the Member is injured and no other person is responsible but the Member receives (or is entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, the Member must agree to the following provisions.

1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.
2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (a) because the Member does not receive the full amount of damages that the Member claimed or (2) because the Member had to pay attorneys' fees.
4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

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

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

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

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

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

Coordination of Benefits

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

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

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

Conditions of Coverage

Eligibility and Enrollment

Coverage is Non-transferable

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

To enroll and continue enrollment, a Subscriber must be an eligible Retiree and meet all of the eligibility requirements for coverage established by the County of San Bernardino. If you are a Retiree that meets County eligibility rules and reside in the Plan Service Area, you are eligible for coverage as a Subscriber the first day of the month following your qualifying event. Your spouse or Domestic Partner and all Dependent children who live or work in the Plan Service Area are eligible for coverage at the same time.

A qualifying event can be any of the following:

a) You retire from the County of San Bernardino;
b) You are a retiree or Dependent and you separate from your current employer;

c) You are a retiree or Dependent and your COBRA or Cal-COBRA coverage ends due to exhaustion of the maximum time allowed;

d) You are a retiree or Dependent and you relocate into or out of a network service area;

e) You are a retiree or Dependent, covered under your spouse or domestic partner's plan and she/he loses that insurance;

f) You are a retiree and become eligible for Medicare;

g) You are a retiree, covered under your spouse or domestic partner's plan and you get divorced or you terminate the domestic partnership.

A Retiree or the Retiree's Dependents may enroll when initially eligible or during the County's annual Open Enrollment Period. Under certain circumstances, a Retiree and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, a date 12 months from the date a written request for enrollment is made, the County's annual Open Enrollment period, or a Special Enrollment Period, a Retiree or Dependent may not enroll in the health program offered by the County. Please see the definition of Late Enrollee and Special Enrollment Period in the *Definitions* section for details on these rights. For additional information on enrollment periods, please contact the County or Blue Shield.

Dependent children of the Retiree, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be eligible immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days*, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption.

*To continue coverage of a newborn or a child placed for adoption beyond the first 31 days without lapse in coverage, an application must be submitted to and received by Blue Shield within 31 days from the date of birth or placement of a child for adoption.

If both partners in a marriage or Domestic Partnership are eligible Retirees and Subscribers, then they are both eligible for Dependent benefits. Their children may be eligible and may be enrolled as a Dependent of both parents. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

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

The County must meet specified eligibility, participation and contribution requirements subject to the Group contract terms, to be eligible for this group health plan. If the County fails to meet these requirements, this coverage will terminate. See the *Termination of Benefits* section of this Evidence of Coverage and Disclosure Form for further information. Retirees will receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

Subject to the requirements described under the Continuation of Group Coverage provision in this Evidence of Coverage and Disclosure Form, if applicable, a Retiree and his or her Dependents will be eligible to continue group coverage under this health plan when coverage would otherwise terminate.

Effective Date of Coverage

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

Dependents may be enrolled within 60 days of the Retiree's eligibility date to have the same effective date of coverage as the Retiree. If the Retiree or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the County's next Open Enrollment Period. Other than approved retroactive adjustments, Blue Shield will not consider applications for earlier effective dates unless the Retiree or Dependent qualifies for a Special Enrollment Period.

In general, if the Retiree or Dependents qualify for a Special Enrollment Period, and the Premium payment is delivered or postmarked within the first 15

days of the month, coverage will be effective on the first day of the month after receipt of payment. If the Premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Retiree qualifies for a Special Enrollment Period as a result of a birth, adoption, guardianship, marriage or Domestic Partnership and enrollment is requested by the Retiree within 60 days of the event, the effective date of enrollment will be as follows:

1) For the case of a birth, adoption, placement for adoption, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption or court order of guardianship.
2) For marriage or Domestic Partnership the coverage effective date shall be the first day of the month following the date the request for special enrollment is received.

Premiums (Dues)

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

All Premiums required for coverage for the Subscriber and Dependents will be paid by the County to Blue Shield. Any amount the Subscriber must contribute is set by the County. The County will receive notice of changes in Premiums at least 60 days prior to the change. The County will notify the Subscriber immediately.

Grace Period

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

Shield Signature Changes

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

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

No change in Shield Signature Benefits nor waiver of any of its provisions shall be valid without the approval of Blue Shield.

The benefits of Shield Signature, including but not limited to Covered Services, Copayment, and annual Out-of-Pocket Maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days' written notice of any such change.

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

Renewal of Group Health Service Contract

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

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

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

Termination of Benefits (Cancellation and Rescission of Coverage)

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive Benefits of this health plan following termination of a Member's coverage.

Cancellation at Member Request

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

Cancellation of Member's Enrollment by Blue Shield

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

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

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

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

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

See the Cancellation and Rescission provision for termination for fraud or intentional misrepresentations of material fact.

Cancellation by the County

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

Cancellation for the County's Non-Payment of Premium

Blue Shield may cancel this health plan for non-payment of Premium. If the County fails to pay the required Premium when due, coverage will terminate upon expiration of the 45-day grace period following notice of termination for nonpayment of premium. The County will be liable for all Premium accrued while this coverage continues in force including those accrued during the 45-day grace period and 30-day notic of intent period. Blue Shield will mail the County a Cancellation Notice (or Notice Confirming Termination of Coverage). The County must provide enrolled Retirees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the County, or with respect to coverage of Retirees or Dependents, for fraud or intentional misrepresentation of material fact by the Retiree, Dependent, or their representative. A rescission voids the Contract

retroactively as if it was never effective; Blue Shield will provide written notice to the County prior to any rescission.

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

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

Date Coverage Ends

Subject to the County's eligibility and enrollment rules; coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the County Group Health Service Contract is discontinued, (2) the last day of the month in which the Subscriber no longer meets the eligibility requirement, as established by the County, unless a different date has been agreed to between Blue Shield and the County, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the County (see Cancellation for Non-Payment of Premium – Notices), or (4) the last day of the month in which the Subscriber and Dependents become ineligible for coverage, except as provided below.

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

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 60 days following the Dependent's birth or placement for adoption, Benefits under this health plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the County is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The County is solely responsible for notifying their Retiree of the availability and duration of family leaves.

Reinstatement

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

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under Shield Signature and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend the Benefits of Shield Signature, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on

which a replacement carrier provides coverage to the Member.

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

Group Continuation Coverage

Please examine your options carefully before declining this coverage.

A Member can continue his or her coverage under this group Health Plan when the County is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The County should be contacted for more information.

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

A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

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

1) With respect to the Subscriber:
   a) the termination of employment (other than by reason of gross misconduct); or
   b) the reduction of hours of employment to less than the number of hours required for eligibility.
2) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the County is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
   a) the death of the Subscriber; or
   b) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
   c) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
   d) the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or
   e) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
   f) a Dependent child's loss of Dependent status under Shield Signature.

   Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.
3) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the County's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1) With respect to COBRA enrollees:

   The Member is responsible for notifying the County of divorce, legal separation, or a child's loss of Dependent status under Shield Signature, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under Shield Signature because of a Qualifying Event.

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

   When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under Shield Signature.

   The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

2) With respect to Cal-COBRA enrollees:

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

   The County is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

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

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

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

Duration and Extension of Group Continuation Coverage

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

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

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

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

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

Notification Requirements

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

Payment of Premiums

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

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

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

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

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Member's coverage under Shield Signature would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as Premiums are timely paid.

Termination of Group Continuation Coverage

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

1) discontinuance of this group health service contract (if the County continues to provide any group benefit plan for Retirees, the Member may be able to continue coverage with another plan);
2) failure to timely and fully pay the amount of required Premiums to the COBRA administrator or the County or to Blue Shield as applicable. Coverage will end as of the end of the period for which Premiums were paid;

3) the Member becomes covered under another group health plan;
4) the Member becomes entitled to Medicare;
5) the Member commits fraud or deception in the use of the Services of Shield Signature.

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

Continuation of Group Coverage for Members on Military Leave

CONTINUATION OF GROUP COVERAGE IS AVAILABLE FOR MEMBERS ON MILITARY LEAVE IF THE COUNTY IS SUBJECT TO THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA). MEMBERS WHO ARE PLANNING TO ENTER THE ARMED FORCES SHOULD CONTACT THE COUNTY FOR INFORMATION ABOUT THEIR RIGHTS UNDER THE USERRA. THE COUNTY IS RESPONSIBLE TO ENSURE COMPLIANCE WITH THIS ACT AND OTHER STATE AND FEDERAL LAWS REGARDING LEAVES OF ABSENCE INCLUDING THE CALIFORNIA FAMILY RIGHTS ACT, THE FAMILY AND MEDICAL LEAVE ACT, AND LABOR CODE REQUIREMENTS FOR MEDICAL DISABILITY.

Other Provisions

Plan Service Area

The geographic area served by this Plan is defined as the Plan Service Area. Subscribers and Dependents must live or work within the prescribed Plan Service Area to enroll in this Plan and to maintain eligibility in this Plan. For specific information on the boundaries of the Plan Service Area members may call Customer Service at the number provided on the back page of this Evidence of Coverage and Disclosure Form.

Liability of Subscribers in the Event of Non-Payment by Blue Shield

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

If services are provided by a non-Plan provider, the Member is responsible for all amounts Blue Shield does not pay.

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

Right of Recovery

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

Independent Contractors

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

Non-Assignability

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield. Possession of a Blue Shield ID card confers no right to services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber who has been accepted by the County and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

Plan Providers are paid directly by Blue Shield or the Medical Group/IPA.

If the Member receives services from a non-Plan provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the non-Plan provider. The Member or the provider of service may not request that the payment be made directly to the provider of service.

Plan Interpretation

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

Public Policy Participation Procedure

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

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

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

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

Please follow the following procedure:

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

Confidentiality of Personal and Health Information

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

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this Evidence of Coverage and Disclosure Form, or by accessing Blue

Shield's internet site at www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Access to Information

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

Grievance Process

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

Medical Services

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

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

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

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service.

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

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

Mental Health and Substance Use Disorder Services

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

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

1-877-263-9952

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

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

If the grievance involves an MHSA Non-Participating Provider, the Member should contact the Blue Shield Customer Service Department as shown on the back page of this Evidence of Coverage and Disclosure Form.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE NOTE: If the County's group 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 the Member's claim have been completed and the claim has not been approved. Additionally, the Member and the Member's plan may have other voluntary alternative dispute resolution options, such as mediation.

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to sub-

mit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If the Member has a grievance against their health plan, he or she should first telephone the health plan at **1-855-256-9404** and use the 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 the Member. If the Member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the health plan, or a grievance that has remained unresolved for more than 30 days, the Member may call the Department for assistance. The Member may also be eligible for an Independent Medical Review (IMR). If the Member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, **(www.hmohelp.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

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

Customer Service

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

For all Mental Health and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and Substance Use Disorder Services, MHSA Participating Providers, or Mental Health and Substance Use Disorder Benefits. Members may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952
Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

Definitions

When the following terms are capitalized in this Evidence of Coverage and Disclosure Form, they will have the meaning set forth below:

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

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

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

1) For a Participating Provider, the amount that the Provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.

2) For a Non-Participating Provider who provides Emergency Services, anywhere within or outside of the United States:

   a) For physicians and Hospitals – the amount is the Reasonable & Customary Charge; or

   b) All other providers – the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield have agreed upon some other amount.

3. For a Non-Participating Provider in California, (including an Other Provider), who provides services (other than Emergency Services): the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or

4. For a provider outside of California (within or outside of the United States), that has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for Covered Service(s) rendered.

5. For a Non-Participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield plan) who provides services (other than Emergency Services): the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

Allowed Charges — the amount an HMO Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-HMO Plan Providers (except physicians rendering Emergency Services, hospitals which are not Participating Providers rendering any Services, and non-contracting dialysis centers rendering any Services when authorized by Blue Shield will be paid based on the – Reasonable & Customary Charge as defined).

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

Ambulatory Surgery Center — an Outpatient surgery facility which:

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

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

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

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

Benefits (Covered Services) — those services which a Member is entitled to receive pursuant to the terms of the group health service contract.

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

Blue Shield of California – a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this Evidence of Coverage and Disclosure Form, as Blue Shield.

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

Close Relative — the spouse, Domestic Partner, childen, brothers, sisters, or parents of a Subscriber or Dependent.

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

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

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

County – shortened name for the County of San Bernardino

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

Creditable Coverage —

1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2) The Medicare Program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as MediCal in California).
4) Any other publicly sponsored program of medical, Hospital or surgical care, provided in this state or elsewhere.
5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq.
6) A medical care program of the Indian Health Service or of a tribal organization.
7) A state health benefits high risk pool.
8) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.
9) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
10) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).
11) Any other Creditable Coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other

forms of self care and/or supervisory care by a Physician) or care furnished to a Member who is mentally or physically disabled, and

1) Who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or

2) when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible — the Calendar Year amount which the Member must pay for specific Covered Services that are a benefit of Shield Signature before the Member becomes entitled to receive any benefit payments from Shield Signature for those Services.

Dependent —

1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.

2) A Dependent Domestic Partner is an individual is meets the definition of Domestic Partner as defined in this Agreement.

3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

   a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

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

   c) thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:

      i) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

      ii) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

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

Domestic Partner — an individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

Durable Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, Hospital beds, respirators and other items

that Blue Shield determines are Durable Medical Equipment.

Emergency Medical Condition (including a psychiatric emergency) — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

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

"Post-Stabilization Care" means Medically Necessary services received after the treating physician determines the emergency medical condition is stabilized.

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury or condition at issue. Services which require approval by the federal government or any agency thereof or by any state government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature.

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued for health coverage binding both Blue Shield and the County that establishes the Benefits that Subscribers and Dependents are entitled to receive from Shield Signature.

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

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psycholo-

gist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

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

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

HMO Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the Level I Benefits ("HMO Plan" level of benefits) and for Mental Health and Substance Use Disorder Services, an MHSA Participating Provider.

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

Hospital — an entity which is:

1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and which provides 24-hour a day nursing service by registered nurses; or
2) a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

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

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

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

Infertility —

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

Intensive Outpatient Care Program — an outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

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 Retiree 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 60 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the annual date a written request for coverage is made or at the County's next Open Enrollment Period.

An eligible Retiree or Dependent may qualify for a Special Enrollment Period.

Medical Group — an organization of Physicians who are generally located in the same facility and provide Benefits to Members.

Medical Necessity (Medically Necessary) —

Benefits are provided only for services which are medically necessary.

1) Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional stan-

dards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are:

a) consistent with Blue Shield medical policy; and,

b) consistent with the symptoms or diagnosis; and,

c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; and,

d) furnished at the most appropriate level which can be provided safely and effectively to the patient.

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

3) Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

   Inpatient services which are not Medically Necessary include hospitalization:

   a) for diagnostic studies that could have been provided on an Outpatient basis;

   b) for medical observation or evaluation;

   c) for personal comfort;

   d) in a pain management center to treat or cure chronic pain; or

   e) for inpatient Rehabilitation that can be provided on an outpatient basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Providers —

1) Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; licensed acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2) Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and outpatient clinics not MD-owned; portable X-ray companies; independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

Out-of-Area Follow-up Care — non-emergent Medically Necessary out-of-area services to evaluate the Member's progress after an initial Emergency or Urgent Service.

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

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

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

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

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

Participating Hospice or Participating Hospice Agency – an entity which: 1) provides Hospice services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health

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

Participating (Participating Provider) – refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

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

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

Primary Care Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with one of the contracted Independent Practice Associations, Medical Groups, or Blue Shield as a Primary Care Physician to provide primary care to Members and to refer, authorize, supervise, and coordinate the provision of all Benefits to Members in accordance with the contract.

Primary Care Physician Service Area — that geographic area served by the Member's Primary Care Physician 's Medical Group or IPA.

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

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine. For Benefits, the term Physician also includes clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist podiatrist, audiologist, licensed marriage and family therapist, and registered physical therapist.

Plan Hospital — a Hospital licensed under applicable state law contracting specifically with Blue Shield to provide Benefits to Members under the Plan.

Plan Non-Physician Health Care Practitioner – a health care professional who is not a physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals, or Blue Shield to provide covered Services to Members when referred by a Primary Care Physician . For all Mental Health and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Plan Service Area — that geographic area served by a Blue Shield Plan.

Plan Specialist — a Physician other than a Primary Care Physician , psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide Covered Services to Members according to an authorized referral by a Primary Care Physician . For all Mental Health and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Premiums (Dues) — the monthly prepayment that is made to Shield Signature on behalf of each Member by the County.

Preventive Health Services — primary preventive medical services, including related laboratory services, for early detection of disease as specifically described in the Principal Benefits and Coverages section of this Evidence of Coverage and Disclosure Form.

Provider Incentive — An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the

provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

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

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

Reasonable & Customary Charge —

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

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

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

Rehabilitation — Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care — services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for acute inpatient care.

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

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

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

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

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

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

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

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

1) The eligible Employee or Dependent meets all of the following requirements:
   a. The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time he was offered enrollment under this Plan;
   b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that, if he was covered under another employer health plan or had other health insurance coverage, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee;
   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment; or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
   d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2) A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
3) For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of up to 12 months, unless he or she meets the criteria specified in paragraphs 1 or 2 above; or
4) For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
5) For Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or

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

Special Food Products — a food product which is both of the following:

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

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

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

Subscriber — an individual who satisfies the eligibility requirements of the contract, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Shield Signature membership under the terms of the contract.

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

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

Terminal Disease or Terminal Illness (Terminally Ill) – a medical condition resulting in a life expectancy of one year or less, if the disease follows its natural course.

Total Disability (or Totally Disabled) —

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

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

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

This combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of Shield Signature. Should you have any questions, please call the Blue Shield Member Services Department at the number listed on the last page of this booklet.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

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

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

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

សេវាកម្មភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

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

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

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Summary of Benefits

Member Calendar Year Brand Drug Deductible	Deductible Responsibility	
	Participating Pharmacy	**Non-Participating Pharmacy**
Per Member There is no Brand Drug deductible requirement	None	Not covered

Benefit	Member Copayment	
	Participating Pharmacy[1]	**Non-Participating Pharmacy**
Retail Prescriptions		
Contraceptive Drugs and Devices[2]	$0	Not covered
Formulary Generic Drugs	$10	Not covered
Formulary Brand Drugs	$30	Not covered
Non-Formulary Brand Drugs	$50	Not covered
Mail Service Prescriptions		
Contraceptive Drugs and Devices[2]	$0	Not covered
Formulary Generic Drugs	$20	Not covered
Formulary Brand Drugs	$60	Not covered
Non-Formulary Brand Drugs	$100	Not covered
Specialty Pharmacies		
Specialty Drugs[3]		Not covered
Formulary Generic Drugs	$10	Not covered
Formulary Brand Drugs	$30	Not covered
Non-Formulary Brand Drugs	$50	Not covered

1. Coinsurance is calculated based on the contracted rate.

2. Contraceptive Drugs and Devices covered under the Outpatient Prescription Drug Benefit are not subject to the Member Calendar Year Brand Drug Deductible. If a brand contraceptive is selected when a generic equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

3. Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the EOC. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated.

4. Includes orally administered Anticancer Medications.

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

Outpatient Prescription Drug Benefit

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

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

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

Your plan may cover Non-Formulary Drugs at a higher Copayment or Coinsurance. Some Drugs and most Specialty Drugs require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process* section. You, your Physician or Health Care Provider may request prior authorization from Blue Shield.

Some drugs have specific quantity limits as described in *Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill.*

Outpatient Drug Formulary

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

The Drug Formulary is described in the chart below. Your Copayment or Coinsurance will vary based on the drug tier.

Drug Formulary	Description
Formulary Generic Drugs	Most Generic Drugs and low cost Preferred Brands
Formulary Brand Drugs	1. Non-preferred Generic Drugs or; 2. Preferred Brand Name Drugs or; 3. Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
Non-Formulary Brand Drugs	1. Non-preferred Brand Name Drugs or; 2. Recommended by P&T committee based on drug safety, efficacy and cost or; 3. Generally have a preferred and often less costly therapeutic alternative at a lower tier.
Specialty Drugs	1. Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2. Self administration requires training, clinical monitoring or; 3. Drug was manufactured using biotechnology or; 4. Plan cost (net of rebates) is >$600

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

You must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs under the Outpatient Prescription Drug benefit. You can locate a Participating Pharmacy by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service. If you obtain Drugs without a Blue Shield Identification Card, Blue Shield will deny your claim, unless it is for a covered emergency.

Blue Shield negotiates contracted rates with Participating Pharmacies for covered Drugs. If your plan has a Brand Drug Deductible, you are responsible for paying the full contracted rate for Brand Drugs until you meet the Member Calendar Year Brand Drug Deductible.

You must pay the applicable Copayment or Coinsurance for each prescription Drug when you obtain it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than your Copayment or Coinsurance, you only pay the contracted rate.

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 Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

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

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

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

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

When you obtain Drugs from a Non-Participating Pharmacy:

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

  Blue Shield of California
  Argus Health Systems, Inc.
  P.O. Box 419019,
  Dept. 191
  Kansas City, MO 64141

- You will be reimbursed as shown on the Summary of Benefits, based on the price you paid for the Drugs.

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

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

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

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

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

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

Obtaining Specialty Drugs through the Specialty Drug Program

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

Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or upon your request, at an associated retail store for pickup. Exceptions for access at other Participating Pharmacies are available under limited circumstances. See the section on *Prior Authorization/Exception Request Process*. If a Participating Pharmacy is not reasonably accessible, you may obtain Specialty Drugs from a Non-Participating Pharmacy (see *Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*).

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

Go to http://www.blueshieldca.com for a complete list of Specialty Drugs. Most Specialty Drugs require prior authorization for Medical Necessity by Blue Shield, as described in the *Prior Authorization/Exception Request Process* section.

Prior Authorization/Exception Request Process

Some Drugs and Drug quantities require prior approval for Medical Necessity before they are eligible for coverage under the Outpatient Prescription Drug Benefit. This process is called prior authorization. Some Formulary, Non-Formulary, compound Drugs, and most Specialty Drugs require prior authorization. Blue Shield limits Drugs to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy. Drugs exceeding the maximum allowable quantity require prior authorization. Additionally, some Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance.

Blue Shield covers compounded medication(s) when:

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

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

You, your Physician or Health Care Provider may request prior authorization or exception request by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, we will provide prior authorization approval or denial, based upon Medical Necessity, within two business days.

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

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

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

   If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug. You can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service.

3. You may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.

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

5. You may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

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

1. Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional (Physician) Benefits* and *Hospital Benefits (Facility Services)* sections of your EOC.

2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of your EOC.

3. Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC) including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug.

4. Drugs for which you are not legally obligated to pay, or for which no charge is made.

5. Drugs that are considered to be experimental or investigational.

6. Medical devices or supplies except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits,* and the *Orthotics Benefits* sections of your EOC.

7. Blood or blood products. See the *Hospital Benefits* section of your EOC.

8. Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.

9. Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of your EOC.

10. Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, Hospice Program Benefits,* or *Family Planning Benefits* sections of your EOC.

11. All Drugs for the treatment of infertility.

12. Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases prior authorization by Blue Shield is required.

13. Contraceptive drugs or devices which do not meet all of the following requirements:
    - Are FDA-approved
    - Are ordered by a Physician or Health Care Provider
    - Are generally purchased at an outpatient pharmacy, and
    - Are self-administered.

    Other contraceptive methods may be covered under the *Family Planning Benefits* section of your EOC.
14. Compounded medication(s) which do not meet all of the following requirements:
    - The compounded medication(s) include at least one Drug
    - There are no FDA-approved, commercially available, medically appropriate alternatives
    - The compounded medication is self-administered, and
    - Medical literature supports its use for the diagnosis.
15. Replacement of lost, stolen or destroyed Drugs.
16. If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the Hospice Program Benefits section of your EOC.
17. Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to:
    - Antibiotics prescribed to treat infection,
    - Drugs prescribed to treat pain, or
    - Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
18. Except for a covered emergency, Drugs obtained from a pharmacy:
    - Not licensed by the State Board of Pharmacy, or
    - Included on a government exclusion list.
19. Immunizations and vaccinations solely for the purpose of travel.
20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Definitions

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

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

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

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

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

Formulary — a list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

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

Network Specialty Pharmacy – select Participating Pharmacies contracted by Blue Shield to provide covered Specialty

Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs.

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

Non-Formulary Drugs — Drugs that Blue Shield's Pharmacy and Therapeutics Committee has determined do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment or Coinsurance.

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

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

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

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.

Handy Numbers

If your Family has more than one Blue Shield POS Primary Care Physician , list each Family member's name with the name of his or her Physician.

Family Member _____

Primary Care Physician _____

Phone Number _____

Family Member _____

Primary Care Physician _____

Phone Number _____

Family Member _____

Primary Care Physician _____

Phone Number _____

Important Numbers:

Hospital _____

Pharmacy _____

Police Department _____

Ambulance _____

Poison Control Center _____

Fire Department _____

General Emergency _____*911*_____

POS Customer Service
Department (See back page of this Evidence of Coverage and Disclosure Form) ____

For Mental Health Services and information, call the MHSA at 1-877-263-9952.

Contacting Blue Shield of California

For information contact your appropriate Blue Shield of California location.

Members may call Customer Service toll free at 1-855-256-9404

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

For prior authorization:

Please call the Customer Service telephone number listed above.

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

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

Please refer to the *Benefits Management Program* section of this Evidence of Coverage and Disclosure Form for additional information on prior authorization.

Please direct correspondence to:

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