PPO Savings Plus Plan

Blue Shield Combined Evidence of Coverage and Disclosure Form

Agile Software Corporation

Group Number: 975751-000/001/002/003/CBA/CB1/CB2/CB3

Effective Date: July 1, 2005
Combined Evidence of Coverage and Disclosure Form

Agile Software Corporation
PPO Savings Plus Plan
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NOTICE
This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan.

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

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

PLEASE NOTE
Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health Plan at Blue Shield’s Customer Service telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.
This Plan is intended to qualify as a “high deductible health plan” for the purposes of qualifying for a health savings account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Although Blue Shield believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, Blue Shield will make efforts to amend this Plan, if necessary, to meet the requirements of a qualified plan. If Blue Shield determines that the amendment necessitates a change in the Plan provisions, Blue Shield will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

Important Information Regarding HSAs

The Shield Spectrum PPO Savings Plus Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow you, if you are eligible, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this Plan.

If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

NOTICE: Blue Shield does not provide tax advice. If you intend to purchase this Plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.
The Blue Shield PPO Health Plan

Subscriber Bill of Rights

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

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.

2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.

3. Receive information about your rights and responsibilities.

4. Receive information about your PPO Health Plan, the Services we offer you, the Physicians and other practitioners available to care for you.

5. Have reasonable access to appropriate medical services.

6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.

7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.


10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.

11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.

12. Communicate with and receive information from Customer Service in a language you can understand.

13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

14. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.

15. Voice complaints or grievances about the PPO Health Plan or the care provided to you.

16. Participate in establishing Public Policy of the Blue Shield PPO, as outlined in your Evidence of Coverage or Health Service Agreement.
The Blue Shield PPO Health Plan

Subscriber Responsibilities

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

1. Carefully read all Blue Shield PPO materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield PPO membership as explained in the Evidence of Coverage or Health Service Agreement.

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

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

4. 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.

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

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

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

8. Offer suggestions to improve the Blue Shield PPO Plan.

9. 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.

10. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.

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

12. Pay your Dues, Copayments and charges for non-covered services on time.

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

14. Follow the provisions of the Blue Shield Benefits Management Program.
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This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

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

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

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**NOTICE**

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

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

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**IMPORTANT**

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

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

Benefits may be modified during the term of this Plan as specifically provided under the terms of the group contract or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.
### SUMMARY OF BENEFITS
Shield Spectrum PPO Savings Plus Plan

#### DEDUCTIBLE

<table>
<thead>
<tr>
<th>Individual Coverage Calendar Year Deductible</th>
<th>For Illness/Accidental Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Calendar Year Deductible does not apply to:</td>
<td>$2,250</td>
</tr>
<tr>
<td>the following Preventive Care Benefits:</td>
<td></td>
</tr>
<tr>
<td>mammography, Papanicolaou's Test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer screening tests, colorectal cancer screening, and the Annual Health Appraisal Exam; however, other covered Services received during or in conjunction with an Annual Health Appraisal Exam Participating Physician office visit are subject to the Calendar Year Deductible;</td>
<td></td>
</tr>
<tr>
<td>the following Well Baby Care Benefits:</td>
<td></td>
</tr>
<tr>
<td>office visits, tuberculin tests, or immunizations; however, other covered Services received during or in conjunction with a Well Baby Care Participating Physician office visit are subject to the Calendar Year Deductible.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Coverage Calendar Year Deductible</th>
<th>For Illness/Accidental Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Calendar Year Deductible does not apply to:</td>
<td>$4,500 per Family¹</td>
</tr>
<tr>
<td>the following Preventive Care Benefits:</td>
<td></td>
</tr>
<tr>
<td>mammography, Papanicolaou's Test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer screening tests, colorectal cancer screening, and the Annual Health Appraisal Exam; however, other covered Services received during or in conjunction with an Annual Health Appraisal Exam Participating Physician office visit are subject to the Calendar Year Deductible;</td>
<td></td>
</tr>
<tr>
<td>the following Well Baby Care Benefits:</td>
<td></td>
</tr>
<tr>
<td>office visits, tuberculin tests, or immunizations; however, other covered Services received during or in conjunction with a Well Baby Care Participating Physician office visit are subject to the Calendar Year Deductible.</td>
<td></td>
</tr>
</tbody>
</table>

#### REDUCED PAYMENTS

<table>
<thead>
<tr>
<th>Reduced Payments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to the Benefits Management Program for any Reduced Payments which may apply.</td>
<td></td>
</tr>
</tbody>
</table>

¹ Before benefits will be provided for covered Services to any and all covered Persons, the Calendar Year Family Coverage deductible must be satisfied for those Services to which it applies. This deductible must be made up of charges covered by the plan and must be satisfied once during each Calendar Year. For those Services to which the Family Coverage deductible applies, charges Incurred by one or all of the covered Persons in combination will be used to calculate the Calendar Year Family Coverage deductible.
### SUMMARY OF BENEFITS
Shield Spectrum PPO Savings Plus Plan

#### BLUE SHIELD’S PAYMENT PERCENTAGE

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Participating Physicians</th>
<th>Non-Participating Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (except as otherwise stated in the Payment section and except for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility &amp; Office Mental Health Services for other than Severe Mental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illnesses or Serious Emotional Disturbances of a Child &amp; for substance abuse care,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and for Hospice Program Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating Physicians</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Non-Participating Physicians</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Hospitals (except for Mental Health &amp; substance abuse Services, for Skilled Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities Services, and for Hospice Program Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Hospitals —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Hospitals —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>50%*</td>
<td></td>
</tr>
<tr>
<td>(*Payment not to exceed $300 per Person per day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Care Services Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Home Medical Equipment suppliers, individual certified orthotists, prosthettists, and prosthetist-orthotists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating Alternate Care Services Providers</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Non-Participating Alternate Care Services Providers</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Note: There is a per Person, per Calendar Year Benefit maximum of $2,000 for all covered Orthoses Services, except those Services covered under the Diabetes Care Benefit, Participating and Non-Participating Providers combined.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SUMMARY OF BENEFITS**  
Shield Spectrum PPO Savings Plus Plan

<table>
<thead>
<tr>
<th>Blue Shield’s Payment Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facilities Services —</strong></td>
<td></td>
</tr>
<tr>
<td>Provided by a Skilled Nursing Facility Unit of a Hospital —</td>
<td></td>
</tr>
<tr>
<td>Preferred Hospital</td>
<td>80%</td>
</tr>
</tbody>
</table>
| Non-Preferred Hospital | 50%*  
(*Payment not to exceed $300 per Person per day) |  |
| Provided by a free-standing Skilled Nursing Facility — |  |
| | 80% |
| **Ambulatory Surgery Centers —** |  |
| Participating Ambulatory Surgery Center | 80% |
| Non-Participating Ambulatory Surgery Center | 50%*  
(*Payment not to exceed $300 per Person per day) |  |
| NOTE: Outpatient ambulatory surgery Services may also be obtained from a Hospital. Ambulatory surgery Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified in the Hospital section of this Summary of Benefits. |  |
| **Other Providers** | 80% |
### SUMMARY OF BENEFITS
Shield Spectrum PPO Savings Plus Plan

<table>
<thead>
<tr>
<th>BLUE SHIELD’S PAYMENT PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Physician Office Visit Copayments in conjunction with:</td>
</tr>
<tr>
<td>an Annual Health Appraisal Examination or with Well Baby Care</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Home Health Care and Home Infusion Agencies² —</td>
</tr>
<tr>
<td>Participating Home Health Care and Home Infusion agencies</td>
</tr>
<tr>
<td>Non-Participating Home Health Care and Home Infusion agencies</td>
</tr>
<tr>
<td>Hospice Program Services —</td>
</tr>
<tr>
<td>Participating Hospice Agency —</td>
</tr>
<tr>
<td>Continuous Home Care provided during a Period of Crisis</td>
</tr>
<tr>
<td>General Inpatient care</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
</tr>
<tr>
<td>Routine home care</td>
</tr>
<tr>
<td>Pre-hospice consultative visit</td>
</tr>
<tr>
<td>Non-Participating Hospice Agency⁴ —</td>
</tr>
</tbody>
</table>

¹ Copayments for these Participating Physician office visits are not subject to the Calendar Year Deductible but do apply towards the Calendar Year maximum out-of-pocket responsibility. These Copayment amounts apply only to charges for office visits with Participating Physicians in conjunction with the covered Services listed. Other covered Services received during or in connection with these office visits are paid at 80% of the Allowable Amount.

² All benefits for home health care, home infusion and home injectable treatment must be prior authorized by Blue Shield.

³ No benefits are provided for Home Health Care benefits and Home Infusion Therapy benefits by Non-Participating Providers except as may be prior authorized by Blue Shield. If prior authorized by Blue Shield, Non-Participating Providers will be reimbursed at a rate determined by the agency and Blue Shield and the Subscriber Copayment will be 20% of the determined rate.

⁴ Covered Hospice Services received from Non-Participating Hospice Agencies must be prior authorized by Blue Shield. If Blue Shield prior authorizes Hospice Services from a Non-Participating Hospice Agency, those Hospice Services will be reimbursed at the Participating Hospice Agency level.
### SUMMARY OF BENEFITS
Shield Spectrum PPO Savings Plus Plan

### SUBSCRIBER COPAYMENTS FOR OFFICE VISITS AND EMERGENCY ROOM VISITS

<table>
<thead>
<tr>
<th>For Participating Physician Office Visits in conjunction with:</th>
<th>$35 per Visit per Person¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>an Annual Health Appraisal Examination or with Well Baby Care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Emergency Room Copayment</th>
<th>Hospital Outpatient Emergency Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>After your Calendar Year Deductible has been satisfied, you will be responsible for a $50 Copayment for each Hospital Outpatient emergency room visit. The emergency room Copayment does apply towards the Calendar Year maximum out-of-pocket responsibility. This emergency room Copayment is waived if you are admitted directly to the Hospital as an Inpatient.</td>
<td>$50 per Visit plus 20%</td>
</tr>
</tbody>
</table>

### CALENDAR YEAR MAXIMUM OUT-OF-POCKET RESPONSIBILITY

<table>
<thead>
<tr>
<th>The Calendar Year maximum out-of-pocket responsibility for covered Services rendered by any combination of Preferred Providers (Physician Members, Preferred Hospitals, and Participating Providers), Non-Preferred Providers, MHSA Participating Providers, MHSA Non-Participating Providers and Other Providers.</th>
<th>$3,000 per Calendar Year for Individual Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5,500 per Calendar Year for Family Coverage</td>
</tr>
</tbody>
</table>

¹ Copayments for these Participating Physician office visits are not subject to the Calendar Year Deductible but do apply towards the Calendar Year maximum out-of-pocket responsibility. These Copayment amounts apply only to charges for office visits with Participating Physicians in conjunction with the covered Services listed. Other covered Services received during or in connection with these office visits are paid at 80% of the Allowable Amount.
### SUMMARY OF BENEFITS

**Shield Spectrum PPO Savings Plus Plan**

<table>
<thead>
<tr>
<th>MENTAL HEALTH &amp; SUBSTANCE ABUSE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health Services —</strong></td>
</tr>
<tr>
<td>Note: Unless selected as an optional benefit by your employer, no benefits are provided for Inpatient substance abuse services except for Inpatient substance abuse detoxification which is covered as any other medical benefit shown in this Summary. All Inpatient Mental Health Services (except for Emergency &amp; Urgent Services) must be prior authorized by the MHSA.</td>
</tr>
<tr>
<td><strong>Physician Services —</strong></td>
</tr>
<tr>
<td>MHSA Participating Physicians¹</td>
</tr>
<tr>
<td>MHSA Non-Participating Physicians</td>
</tr>
<tr>
<td><strong>Hospital Services —</strong></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td>MHSA Participating Hospitals — Emergency and Non-Emergency</td>
</tr>
<tr>
<td>MHSA Non-Participating Hospitals —</td>
</tr>
<tr>
<td>Emergency</td>
</tr>
<tr>
<td>Non-Emergency</td>
</tr>
<tr>
<td>(*Payment not to exceed $300 per Person per day)</td>
</tr>
<tr>
<td><strong>Partial Hospitalization Services —</strong></td>
</tr>
<tr>
<td>MHSA Participating Hospitals</td>
</tr>
<tr>
<td>MHSA Non-Participating Hospitals</td>
</tr>
<tr>
<td>(*Payment not to exceed $300 per Person per day)</td>
</tr>
</tbody>
</table>

¹ An MHSA (Mental Health Services Administrator) Participating Provider is a Provider who participates in the MHSA Mental Health Provider Network. An MHSA Non-Participating Provider is a Provider who does not participate in the MHSA Provider Network. See MHSA Participating Provider and MHSA Non-Participating Provider definitions in the Definitions section for more information.
### SUMMARY OF BENEFITS
Shield Spectrum PPO Savings Plus Plan

#### MENTAL HEALTH & SUBSTANCE ABUSE SERVICES (CONTINUED)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>MHSA Participating Providers</th>
<th>MHSA Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility &amp; Office Mental Health Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the Outpatient department of a Hospital (includes Intensive Outpatient Care):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Participating Providers –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient visits and Intensive Outpatient Care</td>
<td>80%*</td>
<td></td>
</tr>
<tr>
<td>MHSA Non-Participating Providers –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient visits and Intensive Outpatient Care</td>
<td>50%*</td>
<td></td>
</tr>
<tr>
<td>In the Office:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Participating Providers –</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>MHSA Non-Participating Providers –</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Copayment includes both Outpatient Facility and Professional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility &amp; Office Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child &amp; for substance abuse care —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to a combined Benefit maximum of 20 visits for each Person in a Calendar Year. No benefits are provided for Outpatient or out-of-Hospital Mental Health Services &amp; substance abuse care from MHSA Non-Participating Providers, except for the initial visit¹.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Participating Providers –</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>MHSA Non-Participating Providers –</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>(except for the initial visit¹)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological testing —</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHSA Participating Providers –</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>MHSA Non-Participating Providers –</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Lifepath Advisers Psychosocial Support</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

¹ Note: The initial Mental Health Services or substance abuse care visit to determine the condition and diagnosis of the Person will be paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbance of a Child.

Note: These Summary of Benefits pages represent only a brief description of the Plan’s Benefits. Please read this booklet carefully for a complete description of provisions, Benefits and exclusions of the Plan.
WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including Plan deductibles and Co-payments, as well as some medical expenses not covered by your health Plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

HOW A HEALTH SAVINGS ACCOUNT WORKS

An HSA is very similar to the flexible spending accounts currently offered by some employers. If you qualify for and set up an HSA with a qualified institution, the money deposited will be tax-deductible and can be used tax-free to reimburse you for many medical expenses. So, instead of using taxed income for medical care as you satisfy your deductible, you may use 100% of every dollar invested (plus interest). And, as with an Individual Retirement Account, any amounts you do not use (or withdraw with penalty) can grow. Your principal and your returns may be rolled over from year to year to provide you with tax-deferred savings for future medical or other uses.

Please note that Blue Shield does not offer HSAs itself, and only offers high deductible health plans.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA SHIELD SPECTRUM PPO SAVINGS PLAN

Benefits of this Plan differ substantially from traditional Blue Shield of California plans. If you have questions about your Benefits, contact Blue Shield of California before Hospital or medical Services are received.

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

You are responsible for following the Blue Shield of California Benefits Management Program including:

1. Assuring that the Physician or Hospital you choose is a Preferred Provider. (See the Definitions section for more information.)

2. Obtaining, or assuring that your Physician obtains, Preservice Benefit Determination and Certification to determine if contemplated services are covered.

3. Obtaining, or assuring that your Physician obtains, Blue Shield of California approval 5 working days before Hospital admission for all non-emergency Inpatient Hospital Services.

4. Notifying Blue Shield of California (or MHSA in the case of mental health or substance abuse Services) within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.

5. Assuring that you obtain Blue Shield of California's recommendation regarding surgical procedures to be performed on an Outpatient basis.

6. Obtaining approval from Blue Shield of California (or MHSA in the case of mental health or substance abuse Services) for any proposed treatment plan for home care, Home Medical Equipment, home infusion therapy, Speech Therapy or Rehabilitation.

7. Obtaining prior approval from the Mental Health Services Administrator (MHSA) for all Non-Emergency Inpatient Mental Health and substance abuse Services. (See the following Blue Shield of California Preferred Providers section for information.)
8. Obtaining prior approval for admission into an approved Hospice Program as specified under the Hospice Program Services in the Covered Services Section.

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

NOTE: Blue Shield or the MHSA will render a decision on all requests for pre-service review, prior authorization and pre-admission review within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Person or when the Person is experiencing severe pain, Blue Shield will respond within 72 hours from receipt of the request.

BLUE SHIELD OF CALIFORNIA PREFERRED PROVIDERS

The Blue Shield of California Preferred Plan is specifically designed for you to use Blue Shield of California Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other providers. Preferred Providers are listed in the Preferred Provider directories. You may also verify this information by accessing Blue Shield’s Internet site located at http://www.mylifepath.com, or by calling Customer Service at the telephone number provided at the back of this booklet. It is your obligation to be sure that the Physician, Hospital, or Alternate Care Services Provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider directory was published.

Blue Shield of California Preferred Providers agree to accept Blue Shield of California's payment, plus your payment of any applicable deductible and Copayment, or amounts in excess of Benefit dollar maximums specified, as payment-in-full for covered Services. This is not true of Non-Preferred Providers.

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

If emergency care is needed in a Non-Preferred Hospital, payment will be made up to the Hospital's billed charge for covered Services, less any applicable deductible or Copayment. You are responsible for notifying Blue Shield of California within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

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

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

It is your responsibility to ensure that the Provider you select for Mental Health and substance abuse Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. Additionally, Subscribers may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-263-7178.

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

**YOUR BLUE SHIELD OF CALIFORNIA SHIELD SPECTRUM PPO SAVINGS PLAN AND HOW TO USE IT**

**THE BLUE SHIELD OF CALIFORNIA PREFERRED PLAN**

You are now part of the Blue Shield of California team along with Physicians, Hospitals, and other healthcare professionals working together toward a common goal — quality medical care at reasonable costs. This Plan differs substantially from traditional Blue Shield of California plans. Greater responsibility is placed on you, the Subscriber, as a result.

To take full advantage of your Blue Shield of California Preferred Plan, and avoid unnecessary liability, it is very important for you to know how your Plan works, what Blue Shield of California and its Preferred Providers are doing, and what you, the Subscriber, will have to do.

**BLUE SHIELD OF CALIFORNIA’S PREFERRED PROVIDERS**

All Blue Shield of California Physician Members are Blue Shield of California Preferred Providers. So are selected Hospitals in your community.

Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

Blue Shield of California Preferred Providers are working to hold down the costs of health care while maintaining quality care. They agree to accept Blue Shield of California's payment, plus any deductibles or Copayments you may be responsible for under the terms of your Plan, as payment-in-full for covered Services.

**Using Preferred Providers Saves You Money; Using Non-Preferred Providers Can Cost You Money**

When you receive covered Services from a Preferred Provider, Blue Shield of California pays the provider directly, and, except for any deductibles or Copayments that may apply, you have no further financial responsibility.

When you use a Non-Preferred Provider, you are responsible for any difference between Blue Shield of California's payment (as described in this Evidence of Coverage and Disclosure Form booklet) and the billed amount. Non-Preferred Providers have not agreed to accept Blue Shield of California's payment determination as payment-in-full. In addition, what Blue Shield of California will pay for covered Services performed by a Non-Preferred Provider will usually be considerably less than the amount billed. The additional cost to you could be substantial. It makes sense to select a Preferred Provider.
How to Make Your Blue Shield of California Preferred Plan Work for You

First, read your Summary of Benefits and Evidence of Coverage and Disclosure Form booklet carefully.

Your booklet tells you which services are covered by your health Plan and which are excluded. It also spells out your responsibility for any Co-payments and deductibles. These are important facts for your health care budget.

HOW TO RECEIVE SERVICES

Remember, it is to your advantage to use the Blue Shield of California Preferred Providers for Services covered by your Plan. When you use a Non-Preferred Provider, the Blue Shield of California payment may be substantially less than the billed charge. (The exception to this is the use of Non-Preferred Hospitals for Emergency Services. Further details are contained elsewhere in this Evidence of Coverage and Disclosure Form booklet.) You will be responsible for that portion of the Non-Preferred Provider's bill over and above the amount Blue Shield of California pays. Directories of the Preferred Providers in your immediate area have been provided to you. Extra copies are available from Blue Shield of California. If you do not have the copies you need, you should call Blue Shield of California at the number listed on the last page of this booklet.

Persons 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.

Your Blue Shield of California I.D. Card is Your Passport to Service

When you need health care, present your Blue Shield of California I.D. card to your Physician, Hospital, or other licensed healthcare provider. You should verify that the provider is a Preferred Provider, in case there have been any changes since your Preferred Provider directory was published.

Your I.D. card has your Subscriber and group numbers on it. Be sure to include these numbers on all claims you submit to Blue Shield of California.

YOU MAY NEVER HAVE TO FILL OUT A CLAIM FORM…

Hospitals and Blue Shield of California Preferred Providers usually bill Blue Shield of California directly.

…but if you do need to fill out a claim — it’s easy.

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

You may call Blue Shield of California Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Blue Shield of California claim form.

Be sure to send in a claim for all covered Services even if you have not yet met your Calendar Year Deductible. Blue Shield of California will keep track of the deductible for you. Blue Shield of California uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

Requests for payment from any source must be submitted to Blue Shield within 1 year after the month Services were provided. Blue Shield will notify you of its determination within 30 days after receipt of the claim.
DEFINITIONS

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

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

**Activities of Daily Living (ADL)** — the self-care and mobility skills required for independence in normal everyday living. This does not include recreational or sports activities.

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

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

2. For a non-participating provider anywhere within or outside of the United States who provides emergency services, the provider’s billed charge for covered Services, unless the provider and Blue Shield have agreed upon some other amount; or

3. For a non-participating provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or

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

5. For a non-participating provider (i.e., that does not contract with a local Blue Cross or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that Blue Shield would have allowed for a Participating Provider performing the same services in California.

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

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

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

**Calendar Year Deductible** — the initial amount an Individual or Family must pay in a Calendar Year for certain covered Services before becoming eligible to receive certain benefits.

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

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

**Copayment** — the amount that a Person is required to pay for certain Services after meeting any applicable deductible.
Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

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 on-site medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

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

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the 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.

Dependent —

1. a Subscriber's legally married spouse who is not covered for Benefits as a Subscriber and is not legally separated from the Subscriber; or

2. a Subscriber's Domestic Partner, who is not covered for benefits as a Subscriber; or

3. a Subscriber's or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including any stepchild or child placed for adoption or any other child for whom the Subscriber or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) who is: (a) less than 19 years of age; or (b) less than 25 years of age, if a full-time student and proof of student status is submitted to and received by Blue Shield unless a child of a court appointed legal guardian.

Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student; and (c) not covered for Benefits as a Subscriber; and (d) primarily dependent upon the Subscriber or Domestic Partner for support and maintenance, or is dependent upon the Subscriber or Domestic Partner for medical support by reason of a court order;

and who has been enrolled and accepted by Blue Shield of California as a Dependent and has

*Note: For Subscribers enrolled under sections 002 and CB2, the Dependent child is less than 25 years of age without the full-time student status requirement.

For Subscribers enrolled under sections 003 and CB3, the Dependent child is less than 26 years of age without the full-time student status requirement.
maintained membership under the terms of the contract.

4. * If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), and the Dependent child is Totally Disabled (Physically Handicapped or Mentally Retarded), Benefits for such Dependent will be continued upon the following conditions:

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

   b. the Subscriber or Domestic Partner submits to Blue Shield a Physician's written certification of Total Disability within 31 days from the date of the Employer's or Blue Shield's request; and

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

      (1) within 6 months after the month when the Dependent would otherwise have been terminated; and

      (2) annually thereafter on the same month when certification was made in accordance with item (1) above.

In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

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*Note: For Subscribers enrolled under sections 002 and CB2, the Dependent child is less than 25 years of age without the full-time student status requirement.

For Subscribers enrolled under sections 003 and CB3, the Dependent child is less than 26 years of age without the full-time student status requirement.  

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

1. Both partners are (a) 18 years of age or older and (b) of the same sex or different sex;

2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same principal residence;

3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

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

**Dues** — the monthly prepayment that is made to the Plan on behalf of each Person by the Contratholder.

**Emergency Services** — Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part.

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

Employer (Contractholder) — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

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

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

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

Family — the Subscriber and all enrolled Dependents.

Family Coverage — Coverage provided for 2 or more Persons, as defined herein.

Group Health Service Contract (Contract) — the contract issued by the Plan to the contractholder that establishes the services that Subscribers and Dependents are entitled to receive from the Plan.

Home 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. Home Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, and other items that Blue Shield of California determines are Home Medical Equipment.

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

Hospital —

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

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

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

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

Individual (Self-only) Coverage — Coverage provided for only one Subscriber, as defined herein.

Infertility — either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of Infertility, or (2) because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or (3) be-
cause of the inability to conceive a pregnancy after six cycles of artificial insemination. These initial six cycles are not a benefit of this Plan.

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

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

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

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

2. The employer offers multiple health benefit plans and the eligible Employee elects this Plan during an open enrollment period; or

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

4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, as well as a six (6) month Pre-existing Condition exclusion, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Dependents who have lost or will lose their no share-of-cost Medi-Cal coverage and who request enrollment within 31 days after notification of this loss of coverage; or  

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

**Mental Health Services** — see definition of Psychiatric Care.

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

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

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

**Mentally Retarded (or Mental Retardation)** — only those Persons, not psychotic, who are so Mentally Retarded from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control, and care for their own welfare, or for the welfare of others, or for the welfare of the community.

**Non-Participating Home Health Care and Home Infusion Agency** — an agency which has not contracted with Blue Shield and whose services are not covered unless prior authorized by Blue Shield.

**Non-Participating/Non-Preferred Providers** — any provider who has not contracted with Blue Shield to accept Blue Shield’s payment, plus any applicable deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services.

NOTE: this definition does not apply to Mental Health and substance abuse Services. For Non-Participating/Non-Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Non-Participating Provider definition above.

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

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

**Other Providers** —

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

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

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

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

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

**Participating Ambulatory Surgery Center** — a licensed Ambulatory Surgery facility which has contracted with Blue Shield of California to provide surgical services on an Outpatient basis and accept reimbursement at negotiated rates.

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

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

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

**Participating Provider** — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, or a Home Health Care and Home Infusion agency that has contracted with Blue Shield of California to furnish Services and to accept Blue Shield of California’s payment, plus applicable deductibles and Copayments, as payment in full for covered Services, except as provided under the Payment and Subscriber Copayment provision in this booklet.

**NOTE:** this definition does not apply to Mental Health and substance abuse Services or Hospice Program Services. For Participating Providers for Mental Health and substance abuse Services and Hospice Program Services, see the Mental Health Services Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definitions above.

**Person** — either a Subscriber or Dependent.

**Physical Handicap** — a physical or mental impairment that results in anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

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

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

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

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

**Pre-existing Condition** — an illness, injury or condition (including Total Disability) which existed during the 6 months prior to the enrollment date of coverage if, during that time, any medical advice, diagnosis, care or treatment was recommended or received from a licensed health practitioner.

**Preferred Hospital** — a Hospital under contract to Blue Shield which has agreed to furnish services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by Blue Shield.

NOTE: for Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Participating Provider definition above.

**Preferred Provider** — a Physician Member, a Preferred Hospital, or a Participating Provider. NOTE: for Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Participating Provider definition above.

**Prosthesis** — an artificial part, appliance or device used to replace a missing part of the body.

**Psychiatric Care (Mental Health Services)** — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist, for diagnosis or treatment of a mental or emotional disorder or the mental or emotional problems associated with an illness, injury, or any other condition.

**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.

**Rehabilitation** — Inpatient or Outpatient care furnished primarily to restore an individual’s ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. Rehabilitation services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

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

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders *(other than a primary substance use disorder or developmental disorder)*, that results in behavior inappropriate for the child’s age according to expected developmental norms, and

2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

   (a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home
or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;

(b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

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

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizoaffective 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 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.

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

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

2. Used in place of normal food products, such as grocery store foods, used by the general population.

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

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

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

Total Disability (or Totally Disabled) —

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

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

ELIGIBILITY

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

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your De-
pendents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer’s next open enrollment period and shall be subject to a six-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

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

You may add newly acquired Dependents and yourself to the Plan by submitting a written application on forms furnished by Blue Shield of California within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;
2. to add a spouse after marriage, or add a Domestic Partner after establishing a domestic partnership;
3. to add yourself and spouse following birth of a newborn or placement of a child for adoption;
4. to add yourself and spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

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

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

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are Physically Handicapped or Mentally Retarded, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of Mental Retardation or Physical Handicap within 31 days of the request for information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee 6 months later and annually thereafter.

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

**Effective Date of Coverage**

Your coverage will become effective at 12:01 a.m. Pacific Time on the eligibility date established by your Employer. You become eligible when you submit a written application on the form furnished by Blue Shield, and completed health statement when required by your Employer, within 31 days of that date. If you enroll during the initial enrollment period, you will become eligible on your eligibility date.
If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date of request for enrollment or at the Employer’s next open enrollment period and shall be subject to a six-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

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

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

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

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

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

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption is effective the date the Subscriber, spouse or Domestic Partner has the right to control the child’s health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield prior to 31 days from the date of birth or placement for adoption of such Dependent. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet.
If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

If you or your Dependents voluntarily discontinu-ued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer’s next open enrollment period.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your Employer;

1. you and all your Dependents who were validly covered under the previous group health plan on the date of discontinuance, will be eligible under this Plan except that,

2. if you or your Dependents were enrolled in the previous group health plan for less than 6 months and were Totally Disabled on the date of discontinuance of the previous group health plan and were entitled to an extension of benefits under Section 1399.62 of the California Health and Safety Code or Section 10128.2 of the California Insurance Code, you or your Dependents will not be entitled to any benefits under this Plan for services or expenses directly related to any condition which caused such Total Disability for a period not to exceed 6 months. Blue Shield will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan’s Pre-existing Condition exclusion.

1. non-payment of Dues (see “Termination of Benefits” and “Reinstatement, Cancellation and Rescission Provisions”);

2. fraud, misrepresentations or omissions;

3. failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;

4. termination of plan type by Blue Shield;

5. Employer moves out of the service area;

6. association membership ceases.

All groups will renew subject to the above.

**PREPAYMENT FEE**

The monthly Dues for you and your Dependents are indicated in your employer’s group contract. The initial Dues are payable on the effective date of this health Plan, and subsequent Dues are payable on the same date of each succeeding month. Dues are payable in full on each transmittal date and must be made for all Subscribers and Depend-ents.

All Dues required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this health Plan up to the date immediately before the next transmittal date, but not after.

**PLAN CHANGES**

The Benefits of this Plan are subject to change following at least 30 days' written notice by Blue Shield. Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

**MEDICAL NECESSITY**

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

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished under gen-
erally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:

a. consistent with Blue Shield of California medical policy;

b. consistent with the symptoms or diagnosis;

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

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

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

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

b. for medical observation or evaluation;

c. for personal comfort;

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

e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.

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

**Utilization Review**

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

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

To request a copy of the document describing this Utilization Review process, call the Customer Service Department at the number listed in the back of this booklet.

**Second Medical Opinion Policy**

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

Remember that the second opinion visit is subject to all Plan contract Benefit limitations and exclusions. Additionally, please see the section on “Your Blue Shield of California Shield Spectrum PPO Savings Plan and How to Use It” regarding advantages of selecting a Preferred Physician for these services.

**Health Education and Health Promotion Services**

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

**Lifepath Advisers**

Blue Shield of California's Lifepath Advisers provides Persons with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychoso-
cial issues. Persons may obtain these Services by calling 1-866-543-3728, a 24-hour, toll-free telephone number. There is no charge for these Services.

Lifepath Advisers includes a nurseline (see Principal Benefits & Coverages, the Preventive Care Benefits section) and a psychosocial support feature (see Principal Benefits & Coverages, the Mental Health and Substance Abuse Services section).

**BLUE SHIELD ONLINE**

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

**BENEFITS MANAGEMENT PROGRAM**

Blue Shield has established the Benefits Management Program to assist you, your Dependents or provider in identifying the most appropriate and cost-effective course of treatment for which Benefits will be provided under this health Plan and for determining whether the services are Medically Necessary. However, you, your Dependents and provider make the final decision concerning treatment. The Benefits Management Program includes preservice review; prior authorization for certain services, preadmission review (except for emergency admissions), emergency admission notification (for emergency admissions), Hospital Inpatient utilization review; discharge planning; and care management if determined to be applicable and appropriate by Blue Shield. In some cases, the Benefits Management Program requires you to contact Blue Shield and/or follow Blue Shield’s recommendations. If you fail to follow the Benefits Management Program, some services may not be covered. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefits Management Program also apply to your Dependents.

Blue Shield requires preservice review for selected Inpatient and Outpatient services, supplies and Home Medical Equipment; prior authorization for all home health care, home infusion/home injectable services, and PKU related formulas and Special Food Products; prior authorization for admission into an approved Hospice Program; prior authorization for certain radiology procedures; preadmission review for all Inpatient Hospital and Skilled Nursing Facility services (except for Emergency Services) and notification for Inpatient Emergency Services. In these situations, you or your provider need to call Blue Shield as described in the following sections.

By obtaining preservice review or prior authorization for certain services or preadmission review prior to receiving services, you and your provider will know: (1) whether Blue Shield considers the proposed treatment Medically Necessary, (2) if Plan Benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by Blue Shield. You and your provider are informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

**PRESERVICE REVIEW**

Before services are provided, you and your provider can learn whether a procedure or treatment program is covered by calling Blue Shield at 1-800-343-1691.

Examples of services for which Blue Shield of California recommends that you or your provider contact Blue Shield are:

1. Home Medical Equipment, such as motorized wheelchairs, insulin infusion pumps, and CPAP (Continuous Positive Air Pressure) machines;

2. Surgery which may be considered to be Cosmetic in nature rather than Reconstructive (e.g., eyelid surgery, rhinoplasty or breast reduction) and those Reconstructive Surgeries which may result in only minimal improve-
ment. Reconstructive Surgeries which may result in only minimal improvement in function or appearance, Cosmetic Surgeries and reimplantation of breast implants originally provided for cosmetic augmentation are not covered. The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the Principal Benefits and Coverages section;

3. Arthroscopic surgery of the temporomandibular joint (TMJ).

Note: It is to your advantage to contact Blue Shield for Preservice Review to determine whether services are Medically Necessary and whether they are covered Services under your Plan.

PRIOR AUTHORIZATION

Before services are provided, you or your provider can determine whether a procedure or treatment program is covered and may also receive a recommendation for an alternative Service.

Blue Shield requires prior authorization for the following services:

1. Select injectable drugs administered in the physician office setting.*

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

You and your Physician may call 1-800-343-1691 for information on specific injectables requiring prior authorization and to obtain prior authorization for these drugs.

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

2. Home Health Care, Home Infusion/Injectable Care and PKU related formulas and Special Food Products.

   Call 1-800-343-1691 for prior authorization for these services.

   Failure to receive prior authorization or to follow the recommendations of Blue Shield for Home Health Care and Home Infusion/Injectable Care services may result in non-payment if the service is determined not to be a covered Service.

   Failure to receive prior authorization or to follow the recommendations of Blue Shield for covered, Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a reduction in the covered amount. Blue Shield will cover only 50% of any amount remaining after the Allowable Amount is reduced by applicable deductibles and/or Copayments required by this Plan. You will be responsible for both the non-covered 50% and for applicable deductibles and/or Copayments. Your 50% responsibility will not be included in the calculation of the Calendar Year maximum out-of-pocket responsibility.

3. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis:

   CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, Bone Densitometry testing and any cardiac diagnostic procedure utilizing Nuclear Medicine.

   Call 1-888-642-2583 for prior authorization for these services.

   Failure to receive prior authorization for these services or to follow the recommendations of
Blue Shield will result in Reduced Payment amounts per procedure and non-payment for procedures which are determined not to be covered Services.

♦ When covered Services are not authorized in advance, Blue Shield will cover only 50% of any amount remaining after the Allowable Amount is reduced by applicable deductible and/or Copayments. You will be responsible for both the non-covered 50% and for applicable deductible and/or Copayments. Your 50% responsibility will not be included in the calculation of the Calendar Year maximum out-of-pocket responsibility;

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

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

4. Admission into an approved Hospice Program as specified under Hospice Program Services in the Covered Services section.

Call 1-800-343-1691 for information on requesting admission to a Hospice Program.

Failure to receive prior authorization for hospice services or to follow the recommendations of Blue Shield will result in non-payment of services by Blue Shield.

5. Clinical Trial for Cancer.

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

Call 1-800-343-1691 for prior authorization for these services.

Failure to receive prior authorization for a clinical trial for cancer will result in non-payment of services by Blue Shield.

6. All Inpatient Mental Health and substance abuse Services (including Psychiatric Partial Hospitalization/partial Hospital Services), except for Emergency Services, must be prior authorized by the Mental Health Services Administrator (MHSA).

For Inpatient Mental Health or substance abuse Services, except for Emergency Services, failure to obtain prior authorization as described will result in the following reductions in coverage:

♦ *$250 of the Allowable Amount per Hospital admission for Inpatient Care for diagnosis or treatment of Mental Health conditions will not be covered;

♦ *$1,000 of the Allowable Amount per Hospital admission for the diagnosis or treatment of substance abuse, if your Plan provides Inpatient Benefits for the treatment of substance abuse, will not be covered.

*Only one $250 or $1,000 Reduction in Coverage will apply per Hospital admission for failure to notify or to follow a recommendation of the MHSA.

For an admission for Emergency Mental Health or substance abuse Services, the MHSA should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, as soon as it is reasonably possible to do so, or the Subscriber may be responsible for the Reduction in Coverage as described above.
For prior authorization of Inpatient Mental Health and substance abuse Services, call the MHSA at 1-877-263-7178.

Note: Blue Shield or the MHSA will render a decision on all requests for pre-service review, prior authorization and pre-admission review within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Person or when the Person is experiencing severe pain, Blue Shield will respond within 72 hours from receipt of the request.

Preadmission Review – Hospital and Skilled Nursing Facility Admissions
(Other than for Hospital admissions for Mental Health and substance abuse Services, which are described under the prior authorization paragraphs of this section.)

Preadmission Review must be used for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are Hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care. Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician must contact Blue Shield’s Medical Management Unit at 1-800-343-1691 at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Medical Management will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this health Plan that the services be performed on an Outpatient basis.

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

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

Failure to contact Medical Management as described above or failure to follow the recommendations of Medical Management will result in the following reductions in coverage:

♦ $250 of the Allowable Amount per Hospital or Skilled Nursing Facility admission, except for Hospital admissions for Inpatient Care for diagnosis or treatment of substance abuse, will not be covered.

♦ $1,000 of the Allowable Amount per Hospital admission for the diagnosis or treatment of substance abuse, other than Inpatient substance abuse medical detoxification, if your Plan provides Inpatient Benefits for treatment of substance abuse, will not be covered.

Failure to contact Blue Shield for Hospital, Skilled Nursing Facility or Psychiatric Care admissions, described above, may also result in non-payment if Blue Shield determines that the admission is not a covered Service.
EMERGENCY ADMISSION NOTIFICATION

If you are admitted for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the first $250 of the Allowable Amount for the Emergency Services may not be covered.

HOSPITAL INPATIENT UTILIZATION REVIEW

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

DISCHARGE PLANNING

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

CARE MANAGEMENT

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

DEDUCTIBLES

1. **INDIVIDUAL COVERAGE DEDUCTIBLE (APPLICABLE TO 1 PERSON COVERAGE) — CALENDAR YEAR INDIVIDUAL DEDUCTIBLE, $2,250**

After the Calendar Year Individual Coverage deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services. This deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the deductible. The Individual Coverage deductible must be satisfied once during each Calendar Year.

2. **FAMILY COVERAGE DEDUCTIBLE (APPLICABLE TO 2 OR MORE PERSON COVERAGE) — CALENDAR YEAR FAMILY DEDUCTIBLE, $4,500**

The Calendar Year Family Coverage deductible must be satisfied for those Services to which it applies before Benefits will be provided for covered Services to any and all covered Persons. This deductible must be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. Charges in excess of the Allowable Amount do not apply toward the deductible. For those Services to which the Family Coverage deductible applies, charges Incurred by one or all of the covered Persons in combination
will be used to calculate the Calendar Year Family Coverage deductible.

These Calendar Year Deductibles will count towards the Calendar Year maximum out-of-pocket responsibility.

Services Not Subject to the Deductible

The Calendar Year Deductible applies to all covered Services Incurred during a Calendar Year except:

a. annual physical examination from Participating Physicians;

b. office visits from Participating Physicians in conjunction with a Health Appraisal Exam or Well Baby Care;

c. lab and X-ray associated with an annual physical exam from Participating Physicians;

d. colorectal cancer screening;

e. immunizations and vaccinations from Participating Physicians;

f. tuberculin tests from Participating Physicians;

g. Preventive Care Benefits annual routine mammography and routine Papanicolaou’s test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

h. venereal disease tests;

i. eye and ear screening for Dependent children through age 18;

j. screening for blood lead levels for Dependent children as prescribed by a Doctor of Medicine;

k. Well Baby routine Inpatient care/exam from Participating Physicians.

However, other covered Services received during or in connection with a Participating Physician Office Visit in conjunction with the Health Appraisal Exam or Well Baby Care are subject to the Calendar Year Deductible.

Refer to the Preventive Care and Well Baby Care Benefits sections for complete deductible provisions for Services in conjunction with these office visits.

Prior Carrier Deductible Credit

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

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

Reduced Payments for Failure to Use the Benefits Management Program

A Reduction in Coverage of $250 may apply in addition to the applicable Calendar Year Deductible. This Reduction in Coverage will be applicable to Hospital Inpatient charges when a Subscriber or Dependent fails to follow the procedures described under the Preadmission Review section of the Benefits Management Program.

If this Plan provides Benefits for Hospital admissions for diagnosis or treatment of substance abuse, the $250 Reduction in Coverage will be increased to $1,000 if you fail to notify Blue Shield.

Only one $250 or $1,000 Reduction in Coverage will apply to each Hospital admission for failure to follow the Benefits Management Program notification requirements or recommendations.

Failure to receive prior authorization for the radiological procedures listed in the Benefits Management Program section or to follow the recommendations of Blue Shield will result in Reduced Payment amounts per procedure and may result in non-payment for procedures which are determined not to be covered services.
♦ For covered Services that are not authorized in advance, Blue Shield will cover only 50% of any amount remaining after the Allowable Amount is reduced by applicable deductible and/or Copayments required by this Plan. You will be responsible for both the non-covered 50% and for applicable deductible and/or Copayments. Your 50% responsibility will not be included in the calculation of the Calendar Year maximum out-of-pocket responsibility;

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

Failure to receive prior authorization or to follow the recommendations of Blue Shield for covered, Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a reduction in the covered amount. Blue Shield will cover only 50% of any amount remaining after the Allowable Amount is reduced by applicable deductible and/or Copayments required by this Plan. You will be responsible for both the non-covered 50% and for applicable deductibles and/or Copayments. Your 50% responsibility will not be included in the calculation of the Calendar Year maximum out-of-pocket responsibility.

**Maximum Aggregate Payment Amount**

The maximum aggregate of benefits payable is $6,000,000. The maximum aggregate payment amount is determined by totaling all covered Benefits provided to you whether you are a Subscriber or a Dependent while covered under this Plan, or while covered under any prior or subsequent health plan with Blue Shield of California or any of its affiliated companies. Benefits in excess of this amount are not covered under this Plan.

**Payment**

(Other than Mental Health and substance abuse Services, which are described in the Mental Health and Substance Abuse Services section.)

**Blue Shield Payment and Subscriber Copayment Responsibilities for Covered Services**

Subject to all requirements of the Benefits Management Program and Mental Health Services/substance abuse care as shown in the Summary of Benefits, and after all applicable deductibles have been satisfied, benefits are provided for covered Services as follows:

**Physician Services**

(Other than Participating Physician Office Visits for an Annual Routine Physical Exam and Well Baby Care.)

1. Services rendered by a Participating Provider are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

2. The following covered Professional Services received from a Participating Provider are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of this amount:
   - Emergency Services,
   - Outpatient X-Ray and Lab,
   - Diabetes Care, except for Diabetes Self-Management,
   - Transplant Benefits,
   - Injectable contraceptives when administered by a Participating Physician as described under the family planning and consultation services Benefit in the Preventive Care Benefits section*.

   *Copayment for injectable contraceptives is in addition to the office visit Copayment as noted in items 1. and 2. above.

3. Services rendered by a Non-Participating Physician are paid at 50% of the Allowable Amount. Subscribers are responsible for the
remaining 50% of the Allowable Amount, as well as any charges above the Allowable Amount. (See Principal Benefits and Coverages for services which are not covered when rendered by Non-Preferred Providers.) Note: Emergency Room Services from Non-Preferred Providers are paid at 80% of the Allowable Amount.

Payment for covered Services is limited to the lesser of the Benefit maximum for Services specified under the Covered Services section of this booklet or the applicable payment for the Services specified above.

Preferred Physicians have agreed to accept Blue Shield's payment, plus applicable deductibles and Copayments, as payment-in-full for covered Services. Subscribers are not responsible to Preferred Physicians for payment of covered Services, except for applicable deductibles, Copayments, or amounts in excess of specified maximums and except as provided under the Exception for Other Coverage provision.

If the Subscriber or Dependent recovers from a third party the reasonable value of Services rendered by a Preferred Physician who rendered such Services is not required to accept the amount paid by Blue Shield as payment-in-full, but may collect from the Subscriber or Dependent the difference, if any, between the amount paid by Blue Shield and the amount collected by the Subscriber or Dependent for such Services.

A Physician Member or other Participating Physician may seek reimbursement from other third party payors for the balance of its reasonable charges for Services rendered under this Plan.

Covered Services received during or in connection with the Participating Physician Office Visit are paid at 80% of the Allowable Amount.

Hospital Services
(Other than Services provided by a Skilled Nursing Facility Unit of a Hospital, which are described under the Skilled Nursing Facilities Benefits Section.)

1. Rendered by a Preferred Hospital:

   For all covered Services, Benefits are paid at 80% of the lesser of billed charges or the negotiated rate. Subscribers are responsible for the remaining 20%.

2. The following covered Services received from a Participating Provider are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of this amount:

   - Emergency Services,
   - Outpatient X-Ray and Lab,
   - Diabetes Care, except for Diabetes Self-Management,
   - Transplant Benefits.

3. Rendered by a Non-Preferred Hospital:

   a. For Emergency Services or for covered Services not available in a Preferred Hospital, subject to Blue Shield's Preadmission Review and other applicable requirements, Benefits are paid at 80% of billed charges. Subscribers are responsible for the remaining 20% of billed charges.

   If a covered Person is admitted for Emergency Services, he or she should be transferred to a Preferred Hospital as soon as he or she is stable, unless the continued stay in the Non-Preferred Hospital will be less than 24 hours. The covered Person or the attending Doctor of Medicine must notify Blue Shield of California within 24 hours or by the end of the first business day following the admission for Emergency Services, or as soon as it is reasonably possible to do so, and make ar-

Participating Physician Office Visits for An Annual Routine Physical Exam and Well Baby Care

Participating Physicians office visits in conjunction with an annual routine physical exam or Well Baby Care are paid at 100% of the Allowable Amount, less the Copayment shown on the Summary of Benefits.
rangements for the transfer to a Preferred Hospital.

b. For non-Emergency Inpatient and Outpatient Services, Benefits are paid at 50% of the Allowable Amount of no more than $600 per Person per day. Subscribers are responsible for the remaining 50% of the $600, as well as all charges in excess of $600.

Benefits for covered Services are substantially reduced when Services are provided by a Non-Preferred Hospital. To avoid these payment limitations, it is to the Person's advantage to use Preferred Hospitals. Preferred Hospitals accept Blue Shield of California's negotiated amount plus the applicable deductibles and Copayment amounts as payment-in-full for covered Services.

The Person's Copayment for Non-Preferred Hospital Inpatient Services does apply toward the Calendar Year maximum out-of-pocket responsibility.

Services provided in the emergency room of a Hospital for treatment of illness or injury are covered, subject to an additional Copayment of $50 per visit after the Plan deductible has been satisfied. The emergency room Copayment does apply towards the Calendar Year maximum out-of-pocket responsibility. This emergency room Copayment is waived if you are admitted directly to the Hospital as an Inpatient.

**Skilled Nursing Facilities Services**

Skilled Nursing Facility charges for covered Services are paid as follows:

1. **Skilled Nursing Services Rendered by a Skilled Nursing Facility Unit of a Hospital:**

   a. **Preferred Hospitals** – For covered Services rendered in a Skilled Nursing Facility Unit of a Preferred Hospital, Benefits will be paid at 80% of the lesser of billed charges or the negotiated rate. Subscribers are responsible for the remaining 20%.

   b. **Non-Preferred Hospitals** – For covered Services rendered in a Skilled Nursing Facility Unit of a Non-Preferred Hospital, Benefits will be paid at 50% of the Allowable Amount of no more than $600 per Person per day. Subscribers are responsible for the remaining 50% of the $600, as well as all charges in excess of $600.

2. **Skilled Nursing Services Rendered by a Free-Standing Skilled Nursing Facility:**

   For covered Services rendered in a free-standing Skilled Nursing Facility, Benefits will be paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20%, as well as any charges above the Allowable Amount.

   Benefits are provided for confinement in a Skilled Nursing Facility up to a Benefit maximum of 100 days per Person per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

**Services by Alternate Care Services Providers**

Alternate Care Service Providers include Home Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

1. Services rendered by Participating Alternate Care Services Providers are paid at 80% of the Allowable Amount.* Subscribers are responsible for the remaining 20% of the Allowable Amount.

2. Services rendered by Non-Participating Alternate Care Services Providers are paid at 50% of the Allowable Amount.* Subscribers are responsible for the remaining 50% of the Allowable Amount, as well as any charges above the Allowable Amount.

*Note: for all Services covered under the Orthoses Benefit, Subscribers have a combined $2,000 per Person, per Calendar Year Benefit maximum. This maximum does not apply to Services covered under the Prosthetic Appliances...
and Home Medical Equipment Benefits or the Diabetes Care Benefit.

**Services by Participating Home Health Care and Home Infusion Agencies and PKU Related Formulas and Special Food Products**

1. Services rendered by Participating Home Health Care and Home Infusion agencies are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

2. Services rendered by Non-Participating Home Health Care and Home Infusion agencies are not covered, unless prior authorized by Blue Shield.*

   *If prior authorized by Blue Shield, Non-Participating Providers will be reimbursed at a rate determined by the agency and Blue Shield and the Subscriber Copayment will be 20% of the determined rate.

3. Benefits for Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) are paid at 80% of billed charges. Subscribers are responsible for the remaining 20%. These enteral formulas and Special Food Products must be prior authorized by Blue Shield.

**Services by Ambulatory Surgery Centers**

1. Services rendered by Participating Ambulatory Surgery Centers are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

2. Services rendered by Non-Participating Ambulatory Surgery Centers are paid at 50% of the Allowable Amount of no more than $600 per Person per day. Subscribers are responsible for the remaining 50% of the Allowable Amount, as well as any charges above the Allowable Amount. (See Covered Services for services which are not covered when rendered by Non-Participating Providers.)

**Services by Hospice Agencies**

1. Services rendered by Participating Hospice Agencies are paid as follows:

   a. Continuous Home Care provided during a Period of Crisis is paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

   b. General Inpatient care is paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

   c. Inpatient Respite Care is paid at 100% of the Allowable Amount.

   d. Routine home care is paid at 100% of the Allowable Amount.

   e. Pre-hospice consultative visit is paid at 100% of the Allowable Amount.

2. Services rendered by Non-Participating Hospice Agencies are not covered, unless prior authorized by Blue Shield.

   If Blue Shield prior authorizes Hospice Services from a Non-Participating Hospice Agency, those Hospice Services will be reimbursed at the Participating Hospice Agency level, as described in item 1. above at the payment rates negotiated between Blue Shield and the Non-Participating Hospice Agency.
Note: All Hospice Program Services must be prior authorized by Blue Shield. See Hospice Program Services in the Covered Services section for a complete description of covered Hospice Services and Hospice Program requirements.

**Outpatient Prescription Drugs**

Outpatient prescription drugs are subject to the Calendar Year Deductible. Once the Calendar Year Deductible has been satisfied:

1. Outpatient prescription drugs obtained at a Participating Pharmacy are paid at 80% of the Blue Shield pharmacy contracted rate. Subscribers are responsible for the remaining 20% of the Blue Shield pharmacy contracted rate.*

2. Outpatient prescription drugs obtained at a Non-Participating Pharmacy are paid at 80% of the lesser of the price actually paid for the drugs or the reasonable charge (as determined by Blue Shield of California). Subscribers are responsible for the remaining 20%.*

3. Outpatient prescription drugs obtained through the mail service prescription drug program are paid at 80% of the Blue Shield pharmacy contracted rate. Subscribers are responsible for the remaining 20% of the Blue Shield pharmacy contracted rate.*

*The submission of a prescription drug claim is required for reimbursement of all outpatient prescription drugs. See the Covered Services section for claims submission information.

**Services by Other Providers**

Other Providers are paid at 80% of the lesser of billed charges or the Allowable Amount. Subscribers are responsible for all remaining amounts.

Services by Other Providers are Benefits only to the extent that such Services are covered under the Plan.

**Radiological Procedures**

The radiological procedures which are listed in the Benefits Management Program section require prior authorization by Blue Shield. Failure to obtain this authorization will result in the Service being paid at a reduced amount or may result in non-payment for procedures which are determined not to be covered Services.

See the Benefits Management Program section for complete information.

**Out-of-Area Program: The BlueCard® Program**

Benefits will be provided, according to paragraphs (1.), (2.), and (3.) below, for covered Services received outside of California within the United States. Blue Shield of California calculates the Subscriber's copayment as a percentage of the Allowable Amount, as defined in this booklet. When covered Services are received in another state, the Subscriber's copayment will be based on the local Blue Cross Blue Shield plan's arrangement with its providers.

1. Covered Services received from a provider who has contracted with the local Blue Cross Blue Shield plan are paid at the Preferred level. Subscribers are responsible for the remaining Copayment.

2. Non-emergency covered Services received from providers who have not contracted with the local Blue Cross Blue Shield plan are paid at the Non-Preferred level of Blue Shield's Allowable Amount. Subscribers are responsible for the remaining Copayment as well as any charges in excess of Blue Shield's Allowable Amount.

3. Emergency Services received from providers who have not contracted with the local Blue Cross Blue Shield plan are paid at the Preferred level of billed charges. Subscribers are responsible for the remaining Copayment.

If you do not see a participating provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a
claim form (with a copy of the bill) to Blue Shield of California for payment. Blue Shield will notify you of its determination within 30 days after receipt of the claim. Blue Shield will pay you at the Non-Preferred Provider benefit level. Remember, your copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield of California and the amount billed.

**Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Subscriber's responsibility and are not included in out-of-pocket calculations.**

To receive the maximum benefits of your plan, please follow the procedure below.

When you require covered Services while traveling outside of California:

1. call *BlueCard Access*® at **1-800-810-BLUE (2583)** to locate Physicians and Hospitals that participate with the local Blue Cross Blue Shield plan;

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

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

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

Preadmission review is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Preservice review is required for selected Inpatient and Outpatient Services, supplies and home medical equipment. To receive preadmission or preservice review from Blue Shield of California, the out-of-area provider should call 1-800-343-1691.

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

**Care for Covered Urgent Care and Emergency Services Outside the United States**

Benefits will also be provided for covered Services received outside of the United States 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 1-800-343-1691. 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, deductibles, and Copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for hospitalization, if you do not use the BlueCard Program 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 Customer Service office for the most current listing of participating Hospitals world-wide and to obtain a copy of the BlueCard Program Worldwide Network brochure that provides helpful information on receiving covered services in a foreign country or you can visit Blue Shield’s Internet site at http://www.mylifepath.com.

Calculation of your deductibles, Copayments and maximum out-of-pocket responsibilities under the BlueCard Program:
When you obtain health care services through the BlueCard Program outside the geographic area Blue Shield of California serves, the amount you pay for covered services is calculated on the lower of:

1. The billed charges for your covered services, or
2. The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Blue") passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The negotiated price may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Subscriber liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, Blue Shield of California would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

**Calendar Year Maximum Out-of-Pocket Responsibility**

1. **Individual Coverage**
   (applicable to 1 Person coverage) —

   The maximum out-of-pocket responsibility required each Calendar Year for covered Services is $3,000.

2. **Family Coverage**
   (applicable to 2 or more Person coverage) —

   The maximum out-of-pocket responsibility required each Calendar Year for covered Services is $5,500 per Family. This $5,500 Family maximum out-of-pocket responsibility will be satisfied by the Subscriber and all of his covered Dependents collectively.

Once the Individual Coverage or Family Coverage maximum out-of-pocket responsibility has been met, Blue Shield will pay 100% of the Allowable Amount for the Individual’s or Family’s covered Services for the remainder of that Calendar Year.

Charges for Services which are not covered, charges by Non-Preferred Providers and MHSA Non-Participating Providers in excess of the amount covered by the Plan, such as Physician charges above the Allowable Amount, and Reduced Payments Incurred under the Benefit Management Program are the Subscriber's responsibility and are not included in the Calendar Year maximum out-of-pocket responsibility calculations.

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

**Preferred Provider Benefit Features**

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

Providers do not receive financial incentives or bonuses from Blue Shield of California.

This Plan is most effective and advantageous when the Services of Participating Physicians and Participating Hospitals are used. You receive the maximum Benefits of the Plan when you select these providers.

You are responsible for a lower Copayment percentage when Preferred Providers are seen. Preferred Providers include Preferred Physicians, Participating Alternate Care Services Providers and Participating Ambulatory Surgery Centers.

Participating Providers and Preferred Providers have agreed to accept Blue Shield's payment, plus applicable deductibles and Copayments as payment-in-full for covered Services, except as provided under the Exception for Other Coverage provision and for amounts in excess of specified Benefit maximums. You are not liable to these providers for any amounts payable by Blue Shield for covered Services. Blue Shield payment for Services by Non-Preferred Providers generally will be less than payments for the same Services when provided by a Participating Provider, and could result in substantial additional out-of-pocket expense. You are responsible for all balances when Services are rendered by a Non-Preferred Provider.

You and your Dependent must determine if your Physician, Hospital, or other provider is a Participating or Preferred Provider. Participating or Preferred Providers are paid directly by Blue Shield.

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

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

CONTINUITY OF CARE BY A TERMINATED PROVIDER

Persons 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 Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

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

PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES)

(Other than Mental Health and substance abuse Services, which are described in the Mental Health and Substance Abuse Services section.)
Benefits are provided for the following Medically Necessary covered Services, subject to applicable deductibles, Copayments and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provision. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet.

**Hospital Benefits**

(Other than Mental Health Services and substance abuse care and Hospice Program Services and Skilled Nursing Facilities Benefits, which are described in subsequent sections.)

**Inpatient Services for Treatment of Illness or Injury**

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

2. Use of operating room and specialized treatment rooms.

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

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

5. Rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.

6. Drugs and oxygen.

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

8. X-ray examination and laboratory tests.


10. Professional surface ambulance transportation required after admission.

11. Use of medical appliances and equipment.

12. Subacute Care.

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

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

**Outpatient Services for Treatment of Illness or Injury**

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

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

3. Rehabilitation.

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

5. Services provided in the emergency room of a
Hospital for treatment of illness or injury are
covered, subject to an additional Copayment
of $50 per visit after the Plan deductible has
been satisfied. The emergency room Copay-
ment does apply towards the Calendar Year
maximum out-of-pocket responsibility. This
emergency room Copayment is waived if you
are admitted directly to the Hospital as an In-
patient.

6. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine new-
born circumcisions are circumcisions performed
within 31 days of birth unrelated to illness or in-
jury. Routine circumcisions after this time period
are covered for sick babies when authorized by
Blue Shield.

**SKILLED NURSING FACILITIES BENEFITS**
(Other than Hospice Program Services, which
are described in a subsequent section.)

Benefits are provided for confinement in a Skilled
Nursing Facility up to a Benefit maximum of 100
days per Person per Calendar Year, except that
room and board charges in excess of the facility's
established semi-private room rate are excluded.

**SURGICAL BENEFITS**

When surgery is performed for the treatment of
an illness or injury, benefits are provided for:

1. Surgeons (M.D. or D.O.);
2. Assistant surgeons;
3. Anesthesiologists;
4. Consultants — during and after an operation;
5. Podiatrists.

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

**Ambulatory Surgical Benefits**

The Hospital and surgical Benefits of this Plan are
provided whenever care is rendered in a freestand-
ing ambulatory facility (including a Physician's
office) or a short stay surgical unit, or Outpatient
unit of a Hospital, when those Services are med i-
cally necessary as determined by Blue Shield.
Ambulatory surgery Services means surgery which
does not require admission to a Hospital (or simi-
lar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are
covered when performed in an ambulatory sur-
gery center. For the purposes of this Benefit, rou-
tine newborn circumcisions are circumcisions
performed within 31 days of birth unrelated to
illness or injury. Routine circumcisions after this
time period are covered for sick babies when au-
thorized by Blue Shield.

Outpatient Services including general anesthesia
and associated facility charges in connection with
dental procedures are covered when performed in
an ambulatory surgery center because of an un-
derlying medical condition or clinical status and
the Person is under the age of seven or develop-
mentally disabled regardless of age or when the
Person’s health is compromised and for whom
general anesthesia is medically necessary regard-
less of age. Excludes dental procedures and ser-
vice[s] of a dentist or oral surgeon.

**MEDICAL BENEFITS**
(Other than Preventive Care, Mental Health
and substance abuse care and Hospice Pro-
gram Services, which are described in a subse-
quent section.)

Benefits are provided for Services of Physicians
for treatment of illness or injury, and for treat-
ment of physical complications of a mastectomy,
including lymphedemas, as indicated below.
1. Visits to the office, home, Hospital or Skilled Nursing Facility, beginning with the first visit;

2. Extra time spent when a Physician is detained to treat a Person in critical condition;

3. Services of consultants;

4. Necessary preoperative treatment;

5. Radiotherapy, radium therapy, radioisotope therapy and X-ray therapy for treatment of benign and malignant diseases;

6. Treatment of burns;

7. Services in connection with kidney dialysis;

8. Outpatient Rehabilitation Services;

9. Allergy testing and treatment;

10. Outpatient routine newborn circumcisions;*

   *For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by Blue Shield.

11. Asthma self-management training and education to enable a Person to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.

**PARTICIPATING PHYSICIAN OFFICE VISITS FOR AN ANNUAL PHYSICAL EXAM AND WELL BABY CARE**

Benefits are provided for Participating Physician office visits in conjunction with an annual physical examination and well baby care. Benefits for these office visits are paid at 100% of the Allowable Amount, minus the Copayment per visit shown on the Summary of Benefits page.

Covered Services received during or in connection with the Participating Physician office visit are paid at 80% of the Allowable Amount.

The Calendar Year Deductible does not apply to these office visits. Refer to the Preventive Care and Well Baby Care Benefits sections for complete deductible provisions for Services in conjunction with these office visits.

Benefits for Participating Physician office visits are also subject to the Benefit maximums specified in the Preventive Care provisions in this booklet. Subscribers are responsible for all charges in excess of the specified Benefit maximums.

Subscriber Copayments for Participating Physician office visits do apply towards the Calendar Year maximum out-of-pocket responsibility.

**PREVENTIVE CARE BENEFITS**

*Note: No benefits are provided for Preventive Care from Non-Preferred Providers.*

The Calendar Year Deductible only applies to family planning and consultation. It does not apply to the other Preventive Care Services listed as Benefits.

Benefits are provided for the following Services without illness or injury being present:

1. One annual mammography and Papanicolaou's Test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer screening test for screening purposes. The routine office visit associated with these tests is covered, subject to the Annual Health Appraisal Exam described below.

2. Family planning and consultation Services, including voluntary sterilization (tubal ligation and vasectomy), elective abortions, and injectable contraceptives when administered by a Participating Physician. No benefits are provided for contraceptives, except as provided in the Outpatient Prescription Drug Benefit. Physician office visits for diaphragm fittings are covered.

3. Colorectal Cancer Screening.

   For Subscribers and Dependents age 50 and older, Benefits are provided for:
a. flexible sigmoidoscopy every 5 years,
b. double contrast barium enema every 5 to 10 years,
c. colonoscopy every 10 years.

4. Osteoporosis Screening.

Benefits are provided for osteoporosis screening for Subscribers and Dependents age 65 and older or 60 and older if at increased risk.

5. For Subscribers and Dependents age 3 and over, Benefits are provided for one Health Appraisal Exam in a Calendar Year. The Subscriber will be responsible for the office visit Copayment shown in the Summary of Benefits for each Health Appraisal Examination. The Copayment is not included in the calculation of the Calendar Year Deductible but is counted toward the Calendar Year maximum out-of-pocket responsibility. No benefits are provided for Health Appraisal Examinations received from Non-Preferred Providers.

Annual Health Appraisal Exams include the following Services:

a. annual routine physical examination including:
   1) pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC);
   2) eye and ear screenings to determine the need for eye refractions or audiograms when provided to a Dependent child through 18 years of age.

b. routine laboratory Services based on Blue Shield’s Preventive Health Guidelines. These guidelines are derived from the US Preventive Services Task Force, Advisory Committee on Immunization Practices and Centers for Disease Control and Prevention recommendations. Except for routine Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests which are covered as indicated above, routine laboratory Services include but are not limited to:
   1) tuberculin test;
   2) screening for blood lead levels in children at risk for lead poisoning, as determined and prescribed by a Doctor of Medicine;
   3) venereal disease tests as recommended in Blue Shield’s Preventive Health Guidelines;
   4) fecal occult blood test (FOBT) for Subscribers and Dependents age 50 and older.

6. As part of Lifepath Advisers, Persons may call a registered nurse via 1-866-543-3728, a 24-hour, toll-free number to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

(Note: See the following section on Outpatient or Out-of-Hospital X-ray and Laboratory Benefits for information on coverage of genetic testing and diagnostic procedures.)

OUTPATIENT OR OUT-OF-HOSPITAL X-RAY AND LABORATORY BENEFITS

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

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

*Note: Certain radiological procedures require prior authorization by Blue Shield. See the Benefits Management Program section for complete information.*

**CHEMOTHERAPY BENEFITS**

Benefits are provided for Chemotherapy for cancer, when provided by a Physician in the Hospital, the Physician's office, or the Person's home. Benefits include catheterization, Physician visits, injectable drugs and solutions, and infusion devices and servicing. Oral chemotherapy drugs for self-administration are covered under Outpatient Prescription Drugs. High-dose chemotherapy (which requires collection and reinfusion of a patient's own blood products as a supportive measure) is a Benefit only when provided in connection with those certain bone marrow transplant procedures when authorized under the Special Transplant Benefits provision.

**ACUPUNCTURE BENEFITS**

Benefits are provided for acupuncture treatment by a Doctor of Medicine (M.D.) or a certificated acupuncturist up to a Benefit maximum of 20 visits for each Person during a Calendar Year. Benefits are limited to a maximum payment of $25 per visit.

**PROSTHETIC APPLIANCES AND HOME MEDICAL EQUIPMENT BENEFITS**

Benefits are provided for prosthetic appliances, e.g., artificial limbs and eyes and their fitting; Blom-Singer and artificial larynx prostheses for speech following a laryngectomy; for oxygen and its administration; rental of wheelchair, Hospital bed, and other Home Medical Equipment, except that no benefits are provided for rental charges in excess of the purchase cost.

*Note: For surgically and non-surgically implanted prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Reconstructive Surgery. Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.*

Benefits are provided for nebulizers, including face masks and tubing, and peak flow monitors for the management and treatment of asthma.

*Note: See the Outpatient Prescription Drugs Benefit for benefits for asthma inhalers and inhaler spacers.*

Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost effective appliance. Initial fitting and replacement after the expected life of the prosthesis is covered. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

*No benefits are provided for wigs for any reason, environmental control equipment, generators, self-help/educational devices, or any type of speech or language assistance devices (except as specifically provided), air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.*

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

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

**ORTHOSES BENEFITS**

Benefits are provided for orthotic appliances, including:

♦ shoes only when permanently attached to such appliances;

♦ 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;

♦ medically necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteo-arthritis;

♦ medically necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has occurred with a trial of strapping or an over-the-counter stabilizing device;

♦ initial fitting and replacement after the expected life of the orthosis is covered.

**DIABETES CARE**

Benefits are provided for the following diabetes care Services and supplies:

1. Devices, equipment and supplies for the management and treatment of diabetes when medically necessary.

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

   b. Insulin pumps and all related necessary supplies;

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

   d. visual aids, excluding eyewear, designed to assist the visually impaired with proper dosing of Insulin (excluding video-assisted visual aids);

2. Diabetes testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets).

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

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

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

There is a combined $2,000 per Person per Calendar Year maximum on all Orthotic devices covered under this Benefit. This maximum does not apply to Services covered under the Diabetes Care Benefit.
Note: See the Outpatient Prescription Drug Benefit section for coverage of pen delivery systems for the administration of insulin.

WELL BABY CARE BENEFITS

Note: No benefits are provided for Well Baby Care Benefits from Non-Preferred Providers.

Benefits are provided for Services of a Participating Physician for a newborn or Dependent child less than 3 years of age of the Subscriber or the covered spouse, including:

1. routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;
2. office visits;
3. tuberculin test;
4. immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC).

Subscribers will be responsible for a $35 Copayment per Participating Physician office visit. This Copayment will count toward the Calendar Year maximum out-of-pocket responsibility. The Copayment applies only to charges for Participating Physician office visits. Covered Services received during or in conjunction with the office visit will be subject to the appropriate Copayment percentage as described under the PAYMENT section.

For preventive care Benefits for covered individuals 3 years of age and over, refer to the Preventive Care Benefits paragraphs.

PREGNANCY BENEFITS

Benefits are provided for pregnancy and complications of pregnancy, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, and post-delivery care. (Note: See the Section on Outpatient or Out-of-Hospital X-ray and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Person qualifies for an extension of Benefits as described elsewhere in this booklet.

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

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

MEDICAL TREATMENT OF THE TEETH, GUMS, OR JAW JOINTS AND JAW BONES BENEFITS

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

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an accidental injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Person as determined by the Plan;
Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.

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

4. surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;

5. medically necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or

6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is medically necessary to correct a skeletal deformity.

No benefits are provided for:

1. services performed on the teeth, gums (other than tumors) 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, including treatment to alleviate TMJ;

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

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

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

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

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

RECONSTRUCTIVE SURGERY

Medically necessary Services in connection with Reconstructive Surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, surgically and non-surgically implanted prosthetic devices (including prosthetic bras) and Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy is covered. Any such Services must be received while the contract is in force with respect to the Person. Benefits will be provided in accordance with guidelines established by Blue Shield of California and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless determined by Blue Shield to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

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

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

**CHIROPRACTIC SERVICES**

Benefits are provided for any Medically Necessary Chiropractic Services rendered by a chiropractor. Benefits are limited to a maximum of 20 visits per Person per Calendar Year.

**OUTPATIENT REHABILITATION BENEFITS**

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan for as long as continued treatment is Medically Necessary and when rendered in the provider’s office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. Blue Shield reserves the right to periodically review the provider’s treatment plan and records. If Blue Shield determines that continued treatment is not Medically Necessary and not provided with the expectation that the patient has restorative potential pursuant to the treatment plan, Blue Shield will notify the Subscriber of this determination and benefits will not be provided for services rendered after the date of the written notification.

Note: See the *Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products* and the *Hospice Program Services* sections for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

**SPEECH THERAPY BENEFITS**

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

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

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

Except as specified above and as stated under the Home Health Care, Home Infusion Care Benefits and PKU Related Formulas and Special Food Products Benefit and the Hospice Program Services Benefit, no Outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See the *Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products* sections for information on coverage for Speech Therapy Services rendered in the home, including visit limits. See the *Inpatient Services for Treatment of Illness or Injury* section for information on Inpatient Benefits and the Hospice Program Services section.

**TRANSPLANT BENEFITS**

**Organ Transplants**

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants only to the extent that:
1. they are provided in connection with the transplant of a cornea, kidney, or skin; and
2. the recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank and will be charged against the maximum aggregate payment amount.

**Special Transplant Benefits**

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

Blue Shield of California reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding benefits based on (1) the medical circumstances of each Person, and (2) consistency between the treatment proposed and Blue Shield of California medical policy. **Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.**

The following procedures are eligible for coverage under this provision:

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

**HOME HEALTH CARE, HOME INFUSION CARE BENEFITS, AND PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS**

Benefits are provided for Services of a Participating Home Health Care or Home Infusion agency when medically necessary, ordered by the attending Physician, and included in a written treatment plan, **when prior authorized by Blue Shield.**

Benefits are provided only to a Person who is home-bound and would otherwise require hospitalization (except in the case of Benefits for enteral formulas and Special Food Products that are Medically Necessary for the treatment of phenylketonuria [PKU]). Benefits include visits for chemotherapy for cancer, catheterization, and associated drugs and supplies; parenteral and enteral nutritional Services and associated supplies and supplements used during a covered visit.

Benefits for home health care and home infusion care will be payable up to a maximum Benefit of 100 visits for each Person during a Calendar Year. For the purpose of this Benefit, a visit shall be considered a single visit of any length, except for visits from home health aides for whom a visit
of four hours or less shall be considered as one visit.

Note: See the Hospice Program Services section for Services provided when a Person is admitted into a Hospice Program through a Participating Hospice Agency.

Intermittent and part-time visits by a home health agency to provide skilled nursing Services up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers are payable subject to applicable deductibles and Copayments:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2., or 3. above;
5. Medical social Services provided by a licensed medical social worker for consultation and evaluation and Services of a nutritional counselor.

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

Home Infusion/Home Injectable Therapy Benefits

Benefits are provided for home infusion therapy and medical supplies used during a covered visit, including the cost of pharmaceuticals administered intravenously; and for medically necessary, FDA approved injectable medications, when prescribed by a Doctor of Medicine. All Services must be prior authorized by Blue Shield.

Certain injectable medications are subject to conditions and limitations applicable to other Benefits of this Plan. Insulin and insulin syringes are subject to the Outpatient Prescription Drug Benefit.

NOTE: Services rendered by Non-Participating Home Health Care and Home Infusion agencies are not covered, unless prior authorized by Blue Shield.

PKU Related Formulas and Special Food Products

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

Other Services: Physician, Hospital, ambulance, hemodialysis, Home Medical Equipment when prescribed and authorized by the attending Doctor of Medicine, medical supplies, drugs and medicines used during a covered visit, and related pharmaceutical and laboratory Services to the extent Benefits would have been provided had the Person remained in the Hospital will be provided as stated under Covered Services, and are not subject to the maximum Benefit provided under this section.

Hospice Program Services

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Person requests admission to and is formally admitted to an approved Hospice Program. The Person must have a Terminal Illness as determined by their Physician’s certification and the admission must receive prior approval from Blue Shield. (Note: Persons with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Persons can continue to receive covered Services that are not related to
the palliation and management of the Terminal Illness from the appropriate provider. **Note: hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.**

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

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Persons do not have to be enrolled in the Hospice Program to receive this Benefit).

2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.

3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.


5. Social Services/Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Person to the extent that these needs are not met by the Person’s other providers.


8. Short-term Inpatient care arrangements.

9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods Of Crisis as necessary to maintain a Person at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can’t be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods Of Crisis but the care provided during these periods must be predominantly nursing care.

12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

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

**DEFINITIONS:**

**BEREAVEMENT SERVICES** – services available to the immediate surviving family members for a period of at least one year after the death of the Person. 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 Person.

**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 Person and the performance of related tasks in the Person’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 Person 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 Person 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:

a) Considers the Person and the Person’s family in addition to the Person, as the unit of care.

b) Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Person and their family.

c) 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 Persons who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d) 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.

e) Provides for Bereavement Services following the Person’s death to assist the family to cope with social and emotional needs associated with the death.

f) Actively utilizes volunteers in the delivery of Hospice Services.

g) Provides Services in the Person’s home or primary place of residence to the extent appropriate based on the medical needs of the Person.

h) Is provided through a Participating Hospice.

INTERDISCIPLINARY TEAM – the hospice care team that includes, but is not limited to, the Person and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

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

PERIOD OF CARE – the time when the Participating Provider recertifies that the Person still needs and remains eligible for hospice care even if the Person lives longer than one year. A Period Of Care starts the day the Person begins to receive hospice care and ends when the 90 or 60-day period has ended.
PERIOD OF CRISIS – a period in which the Person 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 Person 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 Person only when necessary to relieve the family members or other persons caring for the Person.

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 Person’s provider to the Person and his family that pertain to the palliative, supportive services required by the Person with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing needs of the Person, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Person 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 Person 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 Person and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

TERMINAL DISEASE OR TERMINAL ILLNESS – a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

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

AMBULANCE BENEFITS

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

PODIATRIC SERVICES

Benefits are provided for office visits, surgical procedures, and other covered Services customarily provided by a licensed doctor of podiatric medicine.

CLINICAL TRIAL FOR CANCER

Benefits are provided for routine patient care for Persons who have been accepted into an approved clinical trial for cancer when prior authorized by Blue Shield, and:

1. the clinical trial has a therapeutic intent and the Person’s treating Physician determines that participation in the clinical trial has a meaningful potential to benefit the Person with a therapeutic intent; and
2. the Person’s treating Physician recommends participation in the clinical trial; and
3. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless
the protocol for the trial is not available through a Participating Provider.

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

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

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

An approved clinical trial is limited to a trial that is

1. Approved by one of the following:
   a. one of the National Institutes of Health;
   b. the federal Food and Drug Administration, in the form of an investigational new drug application;
   c. the United States Department of Defense;
   d. the United States Veterans’ Administration;
   or
2. Involves a drug that is exempt under federal regulations from a new drug application.

**OUTPATIENT PRESCRIPTION DRUGS**

Benefits are provided for medically necessary Outpatient prescription drugs, which meet all the requirements specified in this section, are prescribed by a Physician, and are obtained from a licensed pharmacy. Benefits are limited to medically necessary drugs which are approved by the Food and Drug Administration (FDA), and which require a prescription under Federal or California law. This benefit includes access to Blue Shield’s Participating Pharmacy Network. By presenting your Blue Shield ID card to a Participating Pharmacy you will pay Blue Shield’s contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see section “Obtaining Outpatient Prescription Drugs at a Participating Pharmacy” for more details.

Outpatient Prescription Drugs are subject to the Calendar Year Deductible.

Benefits are provided for:

1. Insulin, and disposable insulin needles and syringes;
2. Pen delivery systems for the administration of Insulin as determined by Blue Shield to be medically necessary;
3. Diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets);
4. Oral contraceptives and diaphragms, including drugs for emergency contraception;
5. Smoking cessation drugs which require a prescription – coverage limited to one 12-week course of treatment per lifetime;
6. Inhalers and inhaler spacers for the management and treatment of asthma.

Note: No prescription is necessary to purchase the items shown in (1), (2), and (3) above; however,
in order to be covered these items must be ordered by your Physician.

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

To obtain prescription drugs at a Participating Pharmacy, the Subscriber should present his Blue Shield of California Identification Card*

The Subscriber must first pay all charges for the prescription and submit a completed prescription drug claim form for reimbursement. Outpatient prescription drugs obtained at a Participating Pharmacy are paid at 80% of the Blue Shield pharmacy contracted rate after the Calendar Year Deductible amount has been satisfied.

*Note: If you do not present your Blue Shield Identification Card when obtaining drugs at a Participating Pharmacy, you will be reimbursed at 80% of the lesser of the price actually paid for the drugs or the reasonable charge (as determined by Blue Shield of California), which can make your Copayment significantly higher than if you had presented your card to a Participating Pharmacy.

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

To obtain prescription drugs at a Non-Participating Pharmacy, the Subscriber must first pay all charges for the prescription and submit a completed prescription drug claim form for reimbursement. Outpatient prescription drugs obtained at a Non-Participating Pharmacy are paid at 80% of the lesser of the price actually paid for the drugs or the reasonable charge (as determined by Blue Shield of California), after the Calendar Year Deductible amount has been satisfied.

Home Self-Administered Injectables, except for Insulin, are not available through the Mail Service Prescription Drug Program.

*You are responsible for payment of 100% of the Participating mail service Pharmacy contracted rate for the drug to the mail service pharmacy prior to your prescription being sent to you. To obtain the Participating Pharmacy contracted rate amount, please contact the mail service pharmacy at 1-800-544-6962.

Following the submission to Blue Shield of a prescription drug claim form for outpatient prescription drugs obtained through the mail service program, you will be reimbursed at 80% of the Blue Shield pharmacy contracted rate after the Calendar Year Deductible amount has been satisfied.

**Submitting a Claim**

The submission of a prescription drug claim is required for reimbursement of all outpatient prescription drugs. Each claim submission should contain your name, home address, group contract number, Subscriber number, the patient's name and your receipt(s) for the prescription drug(s) being claimed. Claim forms are provided upon request from the Blue Shield Service Center at the address and telephone number as listed at the back of this booklet.

Claims must be received within 1 year from the date of service to be considered for payment.
Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill

1. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply.

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

3. Prescriptions may be refilled at a frequency that is considered to be medically necessary.

Exclusions

No benefits are provided under the Outpatient Prescription Drugs Benefit for or on account of the following (please note, certain services excluded below may be covered under other benefits/ports of your Evidence of Coverage – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. any drugs provided or administered while the Subscriber is an Inpatient, or in a Physician’s office (see the Medical Benefits and Hospital Benefits sections of your Evidence of Coverage);

2. medical devices or supplies, except as specifically listed as covered herein (see the Prosthetic Appliances and Home Medical Equipment Benefits section and the Orthoses Benefits section of your Evidence of Coverage);

3. drugs for which the Subscriber is not legally obligated to pay, or for which no charge is made;

4. injectable drugs which are not self-administered in the home, including all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the Home Health Care, Home Infusion Care and PKU Related Formulas and Special Food Products, the Hospice Program Services and the family planning and consultation services Benefit under the Preventive Care Benefits sections of the health Plan;

5. blood or blood products (see the Hospital Benefits section of your Evidence of Coverage);

6. drugs that are considered Experimental or Investigational in nature;

7. drugs when prescribed for cosmetic purposes, such as those used to retard or reverse the effects of skin aging or to treat hair loss;

8. contraceptive devices (except diaphragms), injections or implants, except as specifically listed;

9. appetite suppressants and other weight loss medications*;

10. dietary or nutritional products (see the Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products section of your Evidence of Coverage);

11. drugs (except as specifically listed as covered under this Outpatient Prescription Drugs Benefit) which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;

12. drugs obtained from a Pharmacy not licensed by the National Association of Boards of Pharmacies, unless medically necessary for a covered Emergency.

*Call Customer Service for further information.

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

Definitions

Participating Pharmacy — a pharmacy which participates in the Blue Shield of California Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield of California Subscribers and Dependents.

To select a Participating Pharmacy, you may access this information at http://www.mylifepath.com or call the toll-free Customer Service number on your Blue Shield ID card.

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

Mental Health and Substance Abuse Services

Blue Shield of California’s Mental Health Services Administrator (MHSA) administers and delivers the Plan’s Mental Health and substance abuse benefits. Prior authorization is not required for Inpatient Mental Health and Substance Abuse Services when obtained outside of California. See the “Out-Of-Area Program: The BlueCard Program” section of this booklet for an explanation of how payment is made for out of state Services.

All Non-Emergency Inpatient Mental Health and substance abuse Services must be prior authorized by the MHSA. For prior authorization, Subscribers should contact the MHSA at 1-877-263-7178. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following Medically Necessary covered Mental Health and substance abuse Services, subject to applicable deductibles, Copayments and charges in excess of any Benefit maximums, Participating Provider provisions and Benefits Management Program provision. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet.

All Copayments will be calculated as described in detail in the Blue Shield Payment and Subscriber Copayment Responsibilities for Mental Health and Substance Abuse Benefits paragraphs of this section.

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

Mental Health and Substance Abuse Benefits

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

Note: for all Inpatient Hospital care or psychiatric Partial Hospitalization, except for Emergency Services, failure to contact the MHSA prior to obtaining Services will result in the Subscriber being responsible for a Reduction in Coverage of $250 per admission, as outlined in the “Pre-admission Review - Hospital Admissions” paragraphs of the Benefits Management Program section.

1. Inpatient Mental Health Services —

Benefits are provided for psychiatric Inpatient Services in connection with hospitalization or psychiatric Partial Hospitalization (day treatment) for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Person of any age and of Serious Emotional Disturbances of a Child). Residential care is not covered.
Hospital Facility Services:

Subscriber Copayments

Inpatient Services:
♦ MHSA Participating Hospital........20%
♦ MHSA Non-Participating Hospital
   Emergency..............................20%
   Non-Emergency......................50%
   of up to $600 per day and charges
   above $600 (Blue Shield payment
   not to exceed $300 per day)

Partial Hospitalization Services:
♦ MHSA Participating Hospital........20%
♦ MHSA Non-Participating Hospital........
   50% of up to $600 per day and charges
   above $600 (Blue Shield payment not to
   exceed $300 per day)

Professional (Physician) Services:
♦ MHSA Participating Provider ......20%
♦ MHSA Non-Participating Provider.... 50%
   and charges above the Allowable Amount

2. Outpatient Facility Care and Office Care
a. for Severe Mental Illnesses or Serious
   Emotional Disturbances of a Child —

Subscriber Copayments

Outpatient Visits & Intensive Outpa-
tient Care*:
♦ MHSA Participating Provider .....20%*
♦ MHSA Non-Participating Provider .... 50%
   and charges above the Allowable Amount*
   * Copayment includes both Outpatient
   Facility and Professional Services.

Office visits:
Subscriber Copayments
♦ MHSA Participating Provider...........20%
♦ MHSA Non-Participating Provider ....50%
   and charges above the Allowable Amount

b. for other than Severe Mental Illnesses or
   Serious Emotional Disturbances of a
   Child & for substance abuse care —

Subscriber Copayments
♦ MHSA Participating Provider ...... 50%*
♦ MHSA Non-Participating Provider ........
   ......................................... Not covered*
   * Except for the initial visit which will
   be paid as if the condition was a Se-
   vere Mental Illness or Serious Emo-
   tional Disturbance of a Child.

Outpatient or office Mental Health Services
and substance abuse care for other than Se-
vere Mental Illnesses or Serious Emotional
Disturbances of a Child are limited to a
combined Benefit maximum of 20 visits for
each Person per Calendar Year.

The initial Mental Health Services or sub-
stance abuse care visit to determine the con-
dition and diagnosis of the Person will be
paid as if the condition was a Severe Mental
Illness or a Serious Emotional Disturbance
of a Child.

If the outcome of the initial visit determines
that the condition is other than a Severe
Mental Illness or a Serious Emotional Dis-
turbance of a Child, the visit will count to-
wards the 20 visit Calendar Year maximum.

No benefits are provided for Outpatient or
office care from MHSA Non-Participating
Providers for Mental Health Services for
other than Severe Mental Illnesses or Seri-
ous Emotional Disturbances of a Child or
for treatment of substance abuse, except for
the initial visit.

3. Psychological testing

Subscriber Copayments
♦ MHSA Participating Provider........20%
♦ MHSA Non-Participating Provider ....50%
   and charges above the Allowable Amount
Psychological testing is a covered Benefit when provided to diagnose a mental illness.

No benefits are provided for:

1. telephone psychiatric consultations;
2. testing for intelligence or learning disabilities.

4. Psychosocial Support

   Subscriber Copayments

   .................................................No charge

Notwithstanding the Benefits provided elsewhere in this section, the Person also may call 1-866-543-3728 on an unlimited, 24-hour basis for confidential psychosocial support Services available through Lifepath Advisers. 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 per episode of major life events. An episode shall mean a single event, or multiple events which occur within a six-month period and are determined by a counselor to be related. Major life events include work related problems, marital and relationship issues, family problems, emotional and personal issues and death and dying issues. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and Substance Abuse Services.

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

BLUE SHIELD PAYMENT AND SUBSCRIBER COPAYMENT RESPONSIBILITIES FOR MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Subject to all requirements of the Benefits Management Program and Psychiatric Care/substance abuse as shown in the Summary of Benefits, and after all applicable deductibles have been satisfied, Benefits are provided for covered Services as follows:

Professional (Physician) Services

1. Inpatient Care (including psychiatric Partial Hospitalization)

   a. Services rendered by a MHSA Participating Physician for Mental Health Services are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

   b. Services rendered by a MHSA Non-Participating Physician for Mental Health Services are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount,*

   *Except for Emergency Services which will be paid at 80% of the Allowable Amount.

2. Outpatient Facility Care (including Intensive Outpatient Care)

   a. for Severe Mental Illnesses or Serious Emotional Disturbances of a Child —

      (1) Services rendered by a MHSA Participating Physician for Mental Health Services are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.*

      (2) Services rendered by a MHSA Non-Participating Physician for Mental Health Services are paid at 50% of the
Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount, as well as any charges above the Allowable Amount.* **

*Copayment includes both Outpatient Facility and Professional Services.

**Except for Emergency Services which will be paid at 80% of the Allowable Amount.

b. for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child —

(1) Services rendered by a MHSA Participating Physician for Mental Health Services and substance abuse are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount.*

(2) Services rendered by a MHSA Non-Participating Physician for Mental Health Services and substance abuse are not covered.*

*Except for the initial visit which will be paid as if the condition was a Severe Mental Illness or Serious Emotional Disturbance of a Child.

b. for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child —

(1) Services rendered by a MHSA Participating Physician for Mental Health Services and substance abuse are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount.*

(2) Services rendered by a MHSA Non-Participating Physician for Mental Health Services and substance abuse are not covered.*

*Except for the initial visit which will be paid at 80% of the Allowable Amount as described in a.(1) above.

MHSA Participating Physician office visits for a Severe Mental Illness or a Serious Emotional Disturbance of a Child are subject to the Calendar Year Deductible, but Subscriber Copayments for these office visits do apply towards the Subscriber’s Calendar Year maximum out-of-pocket responsibility.

b. for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child —

(1) Services rendered by a MHSA Participating Physician for Mental Health Services and substance abuse are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount.*

(2) Services rendered by a MHSA Non-Participating Physician for Mental Health Services and substance abuse are not covered.*

*Except for the initial visit which will be paid at as if the condition was a Severe Mental Illness or Serious Emotional Disturbance of a Child.

All Outpatient and office Services for Mental Health and substance abuse for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child are limited to a combined Benefit maximum of 20 visits per Person per Calendar Year.
If the outcome of the initial visit determines that the condition is other than a Severe Mental Illness or a Serious Emotional Disturbance of a Child, the visit will count towards the 20 visit Calendar Year maximum.

MHSA Participating Physician office visits are subject to the Calendar Year Deductible and Subscriber Copayments for these office visits do apply towards the Subscriber's Calendar Year maximum out-of-pocket responsibility.

4. Psychological testing

Psychological testing is a covered Benefit when provided to diagnose a mental illness.

a. Services rendered by an MHSA Participating Physician for psychological testing are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20% of the Allowable Amount.

b. Services rendered by an MHSA Non-Participating Physician for psychological testing are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50% of the Allowable Amount, as well as any charges above the Allowable Amount.

5. Psychosocial support

Psychosocial support Services through Lifepath Advisers are provided at no charge to the Person.

MHSA Participating Providers have agreed to accept Blue Shield's payment, plus applicable deductibles and Copayments, as payment-in-full for covered Mental Health and substance abuse Services. Subscribers are not responsible to MHSA Participating Providers for payment of covered Services, except for applicable deductibles, Copayments, or amounts in excess of specified maximums and except as provided under the Exception for Other Coverage provision.

If the Subscriber or Dependent recovers from a third party the reasonable value of Services rendered by a MHSA Participating Provider, that Provider who rendered such Services is not required to accept the amount paid by Blue Shield as payment-in-full, but may collect from the Subscriber or Dependent the difference, if any, between the amount paid by Blue Shield and the amount collected by the Subscriber or Dependent for such Services.

A MHSA Participating Provider may seek reimbursement from other third party payors for the balance of its reasonable costs for Services rendered under this Plan.

Hospital Facility Services

1. Inpatient Hospital Facility Services

a. Rendered by a MHSA Participating Hospital for Emergency and Non-Emergency Services:

   Inpatient Hospital facility Services from a MHSA Participating Hospital in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child), are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20%.

b. Rendered by a MHSA Non-Participating Hospital for Emergency Services:

   Inpatient Hospital facility emergency Services from a MHSA Non-Participating Hospital in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child), are paid at 80% of billed charges. Subscribers are responsible for the remaining 20%.

c. Rendered by a MHSA Non-Participating Hospital for Non-Emergency Services:

   Inpatient Hospital facility non-emergency Services from a MHSA Non-Participating Hospital in connection with hospitalization for the treatment of mental illness
(including treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child), are paid at 50% of allowed charges of no more than $600 per Person per day. Subscribers are responsible for the remaining 50% of the $600, as well as all charges in excess of $600.

2. Partial Hospitalization Services
   a. Rendered by an MHSA Participating Hospital:

   Partial Hospitalization Services from an MHSA Participating Hospital for the treatment of mental illness (including treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child), are paid at 80% of the Allowable Amount. Subscribers are responsible for the remaining 20%.

   b. Rendered by an MHSA Non-Participating Hospital:

   Partial Hospitalization Services from an MHSA Non-Participating Hospital for the treatment of mental illness (including treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child), are paid at 50% of the Allowable Amount of no more than $600 per Person per day. Subscribers are responsible for the remaining 50% of the $600, as well as all charges in excess of $600.

   Residential care is not covered.

   **All Inpatient Hospital care or psychiatric Partial Hospitalization must be prior authorized by the MHSA, except for emergency care, as outlined in the Benefits Management Program section.**

2. Outpatient Hospital Facility Services, including Intensive Outpatient Care
   a. Rendered by a MHSA Participating Hospital:

   (1) Outpatient Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, or Outpatient Services provided to diagnose or to treat substance abuse are paid at 50% of the Allowable Amount. Subscribers are responsible for the remaining 50%. This Benefit is limited to a combined maximum of **20 visits** per Person per Calendar Year. Intensive Outpatient Care is not covered under this Benefit.

   (2) Outpatient visits and Intensive Outpatient Care for Mental Health Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child, are paid at 80% of the Allowable Amount.* Subscribers are responsible for the remaining 20%.

   *Copayment includes both Outpatient Facility and Professional Services.

   b. Rendered by a MHSA Non-Participating Hospital:

   (1) Outpatient Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, or Outpatient Services provided to diagnose or to treat substance abuse are **not covered** when rendered by a Non-Participating Hospital, except for the initial visit which will be paid at 50% of the Allowable Amount.

   (2) Outpatient Mental Health Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child, are paid at 50% of the Allowable Amount.* Subscribers are responsible for the remaining 50%, as well as all charges above the Allowable Amount.
*Copayment includes both Outpatient Facility and Professional Services.

**Principal Limitations, Exceptions, Exclusions and Reductions**

**General Exclusions**

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

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;

2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, the Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products, the Outpatient Rehabilitation Benefits and the Hospice Program Services sections;

3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance or Domiciliary Care, except as provided under the Hospice Program Services (see the Hospice Program Services Benefit for exception);

4. performed in a Hospital by house officers, residents, interns, and others in training;

5. performed by a Close Relative or by a person who ordinarily resides in the covered Person's home;

6. for substance abuse treatment or rehabilitation on an Inpatient, Partial Hospitalization or Outpatient basis, except as specifically listed under Mental Health and Substance Abuse Services;

7. for Outpatient Mental Health Services, except as specifically listed under Mental Health and Substance Abuse Services;

8. for hearing aids;

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

10. for eyeglasses, contact lenses or surgery for refractive error (e.g., radial keratotomy);

11. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances and Home Medical Equipment Benefits;

12. for routine physical examinations, except as specifically listed under Preventive Care Benefits, or for immunizations for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;

13. for or incident to acupuncture, except as specifically listed;

14. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products, Speech Therapy Benefits and Hospice Program Services;

15. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be
denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

16. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs;

17. for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is medically necessary;

18. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

19. for or incident to Infertility, including but not limited to reversal of surgical sterilization, in vitro fertilization, or complications of any such procedures, except as specifically listed;

20. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthoses Benefits and Diabetes Care; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;

21. which are Experimental or Investigational in nature, except for Services for Persons who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer;

22. for learning disabilities or behavioral problems;

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

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

25. for or incident to services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits;

26. incident to organ transplant, except as explicitly listed under the Organ Transplant Benefit and Special Transplant Benefit;

27. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for medically necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by a Blue Shield of California consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:

- Lower eyelid blepharoplasty;
- Spider veins;
- Procedures to smooth the skin (i.e., chemical face peels, laser resurfacing, and abrasive procedures);
- Hair removal by electrolysis or other means; and
- Reimplantation of breast implants originally provided for cosmetic augmentation;

28. for Reconstructive Surgery and procedures in situations: 1) where there is another more appropriate surgical procedure that is approved by a Blue Shield Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited in the Reconstructive Surgery Benefit section;

29. for penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary Services as provided under Reconstructive Surgery Benefits;

30. in connection with the treatment of a Pre-existing Condition, except as specifically listed;

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

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

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

34. in connection with private duty nursing, except as provided under the Home Health Care, Home Infusion Care and PKU Related Formulas and Special Food Products covered Services and except as provided through a Participating Hospice Agency;

35. for prescription and non-prescription food and nutritional supplements, except as provided under the Home Health Care, Home Infusion Care Benefits, and PKU Related Formulas and Special Food Products Benefit, and except as provided through a Participating Hospice Agency;

36. for home testing devices and monitoring equipment except for use of the peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, and the apnea monitor for management of newborn apnea when authorized as home medical equipment;

37. for contraceptives and contraceptive devices, except as specifically included in the family planning and consultation services Benefit under the Preventive Care Benefits section and under the Outpatient Prescription Drugs Benefit; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drugs Benefit; no benefits are provided for contraceptive implants;

38. for genetic testing except as described in the section on Outpatient or Out-of-Hospital X-Ray and Laboratory Benefits;

39. for non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Services, Hospice Program Services, Diabetes Care, Home Medical Equipment/Prostheses and Other Services.

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

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

PRE-EXISTING CONDITIONS

Pre-existing Conditions are covered immediately if you were validly covered under your present employer's previous group health plan when that plan was terminated and are enrolled on the original effective date of this Plan within 63 days of the termination of that previous plan, except that:

If you or your Dependents were enrolled in the previous group health plan for less than 6 months and were Totally Disabled on the date of discontinuance of the previous group health plan and were entitled to an extension of benefits under Section 1399.62 of the California Health and Safety Insurance Code or Section 10128.2 of the California Insurance Code, you or your Dependents will not be entitled to any benefits under this Plan for services or expenses directly related to any condition which caused such Total Disability for a period not to exceed 6 months. Blue Shield will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan’s Pre-existing Condition exclusion.

If you or any Dependent was not validly covered under your present employer's previous group health plan, then coverage under this Plan is provided for Pre-existing Conditions only after you have been continuously covered for 6 consecutive months including your present employer's waiting period, if any.

However, if you or your Dependents had prior Creditable Coverage and you enrolled in this Plan within 63 days after termination (exclusive of any waiting period) of the prior Creditable Coverage or within 180 days (exclusive of the waiting period) if your prior Creditable Coverage was Employer-sponsored, then Blue Shield will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan's Pre-existing Condition exclusion.

To receive credit for your prior Creditable Coverage, submit to Blue Shield a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact Blue Shield of California's Customer Service area for assistance.

This Plan's Pre-existing Condition exclusion does not apply to:

1. pregnancy Benefits;
2. newborns or children placed for adoption who had prior Creditable Coverage within 30 days of the birth or placement for adoption, who enrolled in this Plan within 63 days of that prior Creditable Coverage (exclusive of any waiting period).

EXCLUSION FOR DUPLICATE COVERAGE

In the event that you are covered under this Plan and are also entitled to benefits under any of the conditions listed below, Blue Shield's liability for services (including room and board) provided for the treatment of any one illness or injury will be reduced by the amount of benefits paid, or the reasonable value or the amount of Blue Shield’s fee-for-service payment to the provider, whichever is less, of the services or supplies provided without any cost to you, because of your entitlement to such other benefits. This exclusion is applicable to benefits received from any of the following sources:
1. Benefits provided under Title XVIII of the Social Security Act (commonly known as Medicare). If a covered Person receives services for which he is entitled to benefits under Medicare and those services are also covered under this Plan, the Benefits of this Plan will be provided less the amount paid under Medicare. Any deductible or Copayment requirement of this Plan will be waived when Medicare is primary and the provider of services has accepted Medicare assignment. This exclusion for Medicare does not apply when the Employer is subject to the Medicare Secondary Payer laws and the Employer maintains:

   a. an employer group health plan that covers Persons entitled to Medicare solely because of end-stage renal disease and active Employees or spouses or Domestic Partners entitled to Medicare by reason of age; and/or

   b. a large group health plan as defined under the Medicare Secondary Payer laws that covers Persons entitled to Medicare by reason of disability.

This paragraph shall also apply to an individual who becomes eligible for Medicare benefits prior to age 65, but who had not enrolled under Medicare on the date that he received notice from Blue Shield of California of eligibility for such enrollment.

2. Any services, including room and board, provided by any other Federal or State governmental agency, or by any Municipality, County or other political subdivision, except that this exclusion does not apply to the Medical program, or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States or for reasonable costs of services provided to the Person at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the Person is not on active duty.

**Exception for Other Coverage**

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

**Claims Review**

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

**Reductions**

Third-Party Liability — If a covered Person is injured through the act or omission of another person (a “third party”), Blue Shield of California shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution or other available remedy to recover the reasonable costs of the Services provided to the covered Person paid by Blue Shield on a fee-for-service basis.

The covered Person is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such covered Person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agree to fully cooperate with Blue Shield to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide Blue Shield with a lien, in the amount of reasonable costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.
A covered Person’s failure to comply with 1. through 3. above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

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

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

The following rules determine the order of benefit payments:

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

The plan which covers the Person as a Dependent of a Person whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, will determine its benefits before a plan which covers that Person as a Dependent of a Person whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the plan which does not have the provisions of this paragraph will determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order:

   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

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

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

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

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

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

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

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

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

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

CONTINUATION OF GROUP COVERAGE

Applicable to Persons when the Subscriber’s Employer (Contractholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber’s Employer 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 Person will be entitled to elect to continue group coverage under this Plan if the Person would otherwise lose coverage because of a Qualifying Event that occurs while the contract holder 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 Person if the Qualifying Event had not occurred (including any changes in such coverage).

Note: A Person will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Person is entitled to benefits under Title XVIII of the Social Security Act (“Medicare”) or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any Pre-existing condition. Under COBRA, a Person is entitled to benefits if at the time of the qualifying event such Person is entitled to Medicare. However, if Medicare entitlement arises after COBRA coverage begins, it will cease.

Qualifying Event

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

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

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

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

a. the death of the Subscriber; or

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

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

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

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

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

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

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

Notification of a Qualifying Event

1. With respect to COBRA enrollees

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

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

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

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

2. With respect to Cal-COBRA enrollees

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

The Employer 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 Person by first class mail of his or her right to continue group coverage under this Plan. The Person must then give Blue Shield notice in writing of the Person’s election of continuation coverage within 60 days of the later of (1) the date of the notice of the Person’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 Person does not notify Blue Shield within 60 days, the Person’s coverage will terminate on the date the Person would have lost coverage because of the Qualifying Event.

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

Duration and Extension of Continuation of Group Coverage

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

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Person’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 Person to continue group coverage under this Plan. However, a Person may qualify for continuation of group coverage after COBRA and/or Cal-COBRA. This coverage is explained under Continuation of Group Coverage After COBRA and/or Cal-COBRA.

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

Payment of Dues

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

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

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

Cal-COBRA enrollees must submit dues directly to Blue Shield of California. The initial dues must be paid within 45 days of the date the Person provided written notification to the Plan of the election to continue coverage and be sent to Blue Shield by first-class or other reliable means. The dues 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 Person from continuation coverage.

Effective Date of the Continuation of Coverage

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

Termination of Continuation of Group Coverage

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

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

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

3. the Person becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Person;

4. the Person becomes entitled to Medicare;

5. the Person no longer resides in Blue Shield’s service area;

6. the Person commits fraud or deception in the use of the Services of this Plan.

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

Continuation of Group Coverage after COBRA and/or Cal-COBRA

The following section only applies to enrollees who became eligible for Continuation of Group Coverage After COBRA and/or Cal-COBRA prior to January 1, 2005:
Certain former Employees and their Dependent spouses or Dependent Domestic Partners (including a spouse who is divorced from the current Employee/former Employee and/or a spouse who was married to the Employee/former Employee at the time of that Employee/former Employee’s death, or a Domestic Partner whose partnership with the current Employee/former Employee has terminated and/or a Domestic Partner who was in a Domestic Partner relationship with the Employee/former Employee at the time of that Employee/former Employee’s death) may be eligible to continue group coverage beyond the date their COBRA and/or Cal-COBRA coverage ends.

Blue Shield will offer the extended coverage to former Employees of employers that are subject to the existing COBRA or Cal-COBRA, and to the former Employees’ Dependent spouses, including divorced or widowed spouses as defined above, or Dependent Domestic Partners, including surviving Domestic Partners or Domestic Partners whose partnership was terminated as defined above. This coverage is subject to the following conditions:

1. The former Employee worked for the Employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended.

2. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)

3. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent Domestic Partner (a former Domestic Partner, i.e., a surviving Domestic Partner or Domestic Partner whose partnership has been terminated as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)

Items 1., 2. and 3. above are not applicable to a former spouse or former Domestic Partner electing continuation coverage. The former spouse or former Domestic Partner must elect such coverage by notifying the Plan in writing within 30 calendar days prior to the date that the former spouse’s or former Domestic Partner’s initial COBRA and/or Cal-COBRA benefits are scheduled to end.

If elected, this coverage will begin after the COBRA and/or Cal-COBRA coverage ends and will be administered under the same terms and conditions as if COBRA and/or Cal-COBRA had remained in force.

For Persons who transfer to this coverage from COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 102 percent of the applicable age adjusted group dues rate. For Persons who transfer to this coverage from Cal-COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 110 percent of the applicable age adjusted group dues rate. Payment is due at the time the Employer’s payment is due.

**Notification Requirements**

The Employer is solely responsible for notifying former Employees or Dependent spouses or Dependent Domestic Partners (including former spouses or former Domestic Partners as defined above) of the availability of the coverage at least 90 calendar days before COBRA or Cal-COBRA is scheduled to end. To elect this coverage, the former Employee (and/or former spouse or former Domestic Partner) must notify the Plan in writing at least 30 calendar days before COBRA or Cal-COBRA is scheduled to end.

**Termination of Continuation Coverage after COBRA and/or Cal-COBRA**

This coverage will end automatically on the earliest of the following dates:

1. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner reaches 65;

2. the date the Employer discontinues this Group Health Service Contract and ceases to main-
tain any group health plan for any active Employees;

3. the date the former Employee, spouse or Domestic Partner, or former spouse or former Domestic Partner transfers to another health plan, whether or not the benefits of the other health plan are less valuable than those of the health plan maintained by the Employer;

4. the date the former Employee, spouse or Domestic Partner, or former spouse or former Domestic Partner becomes entitled to Medicare;

5. for a spouse or Domestic Partner, or former spouse or former Domestic Partner, five years from the date the spouse’s or Domestic Partner’s COBRA or Cal-COBRA coverage would end.

**AVAILABILITY OF BLUE SHIELD OF CALIFORNIA INDIVIDUAL PLANS**

Blue Shield's Individual Plans described below may be available to Persons whose group coverage, COBRA or Cal-COBRA coverage, or Continuation of Group Coverage After COBRA and/or Cal-COBRA is terminated or expires while covered under this group Plan. (Note, only Individual Conversion Coverage is available to Persons who are terminated from Continuation of Group Coverage After COBRA and/or Cal-COBRA.)

**INDIVIDUAL CONVERSION PLAN**

**Continued Protection**

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

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

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

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

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

A conversion plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for Dependent coverage under the group Plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse or Domestic Partner of a Subscriber if their marriage or domestic partnership has been terminated;

5. Dependents, when continuation of coverage under COBRA and/or Cal-COBRA expires, or is terminated.

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

Guaranteed Issue Individual Coverage

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

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

If you elect Conversion Coverage, “Continuation of Group Coverage After COBRA and/or Cal-COBRA”, or other Blue Shield individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Customer Service representative at the telephone number noted on your ID Card.

EXTENSION OF BENEFITS

If a Person becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the group contract terminates, Blue Shield of California will extend the Benefits of this Plan, subject to all limitations and restrictions, for covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) 12:01 a.m. on the day following a period of twelve months from the date coverage terminated; (2) the date the covered Person is no longer Totally Disabled; (3) the date on which the covered Person's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Person that is not subject to a Pre-Existing Condition exclusion. The time the Person was covered under this Plan will apply toward the replacement plan’s pre-existing condition exclusion.

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

TERMINATION OF BENEFITS

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this health Plan.
Coverage for you or your Dependents terminates at 12:01 a.m. Pacific Time on the earliest of these dates: (1) the date the Group Health Service Contract is discontinued, (2) the last day of the month in which your status as an Employee terminates, unless a different date on which you no longer meet the requirements for eligibility has been agreed to between Blue Shield and your Employer, (3) fifteen (15) days following the date of mailing of the notice to the Employer that Dues are not paid (see “Cancellation for Non-Payment of Dues – Notices”), or (4) the date you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

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

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

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

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or Blue Shield of California; see the Cancellation/Rescission for Fraud, Misrepresentations or Omissions provision;

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

3. Obtaining or attempting to obtain Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions;

4. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield of California personnel and providers of Services, or, (2) substantially impairs the ability of Blue Shield of California to arrange for services to the Person, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Person or to other patients.

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 31 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 32nd day at 12:01 a.m. Pacific Time.

**REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS**

**Reinstatement**

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

**Cancellation Without Cause**

This group health Plan may be cancelled by your employer at any time provided written notice is given to Blue Shield of California to become effective upon receipt, or on a later date as may be specified by the notice.
Cancellation for Non-Payment of Dues - Notices

Blue Shield of California may cancel this group health Plan for non-payment of Dues. If your Employer fails to pay the required Dues when due, Blue Shield of California will mail your Employer a Prospective Notice of Cancellation at least 15 days before any cancellation of coverage. This notice will provide information to your Employer regarding the consequences of your Employer’s failure to pay the Dues due within 15 days of the date the notice was mailed.

If payment is not received from your Employer within 15 days of the date the Prospective Notice of Cancellation is mailed, Blue Shield of California will cancel the Group Health Service Contract at the end of that 15 day period and coverage for you and all your Dependents will end on that date. Blue Shield of California will send your Employer a Notice Confirming Termination of Coverage. Your Employer must provide you with a copy of the Notice Confirming Termination of Coverage.

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

Cancellation/Rescission for Fraud, Misrepresentations or Omissions

Blue Shield of California may cancel the group contract for fraud or misrepresentation by your Employer, or with respect to coverage of Employees or Dependents, for fraud or misrepresentation of the Employee, Dependent, or their representative.

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

Misrepresentations or omissions on an application or a health statement (if a health statement is required by the Employer) may result in the cancellation or rescission of this group health Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

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

Right of Cancellation

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

Any Dues paid Blue Shield of California for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer will be responsible to Blue Shield of California for unpaid Dues prior to the date of cancellation.

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

See the Cancellation and Rescission provision for termination for misrepresentations or omissions.

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

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield of California and its Participating Providers and Preferred Providers stipulates that the Subscriber shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Subscriber's group contract. When Services are provided by a Participating Provider or Preferred Provider, the Subscriber is responsible for applicable deductibles, Copay-
ments and charges in excess of the Benefit maximums.

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

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

NON-ASSIGNABILITY

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

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

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

SERVICES FOR EMERGENCY CARE

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

PLAN INTERPRETATION

Blue Shield of California shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive benefits under this Plan. Blue Shield of California shall exercise this authority for the benefit of all Persons entitled to receive Benefits under this Plan.

CUSTOMER SERVICE

1. For all Services other than Mental Health and substance abuse-

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact Blue Shield’s Customer Service Department as noted on the last page of this booklet.

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

Customer Service can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Subscribers and Dependents to request an expedited decision. A Person, Physician, or representative of a Person may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Person, or when the Person is experiencing severe pain. Blue Shield shall make a decision and notify the Person and Physician within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health-care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number noted on the last page of this booklet.
2. For all Mental Health and substance abuse Services-

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

1-877-263-9952

U. S. Behavioral Health Plan, California
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

Note: The MHSA has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. The MHSA shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the number listed above.

GRIEVANCE PROCESS

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

For all Services other than Mental Health and substance abuse

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

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

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

For all Mental Health and substance abuse Services

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

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

1-877-263-9952

U. S. Behavioral Health Plan, California
Attn: Customer Service
P. O. Box 880609
San Diego, CA 92168

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

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

NOTE: If your Employer’s health Plan is governed by the Employee Retirement Income Security Act (“ERISA”), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

**For all Services**

**External Independent Medical Review**

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

**DEPARTMENT OF MANAGED HEALTH CARE REVIEW**

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

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

**PUBLIC POLICY PARTICIPATION PROCEDURE**

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

Public policy means acts performed by a Plan or its employees and staff to assure the comfort, dignity, and convenience of Persons 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:

Director, Consumer Affairs  
Blue Shield of California  
50 Beale Street  
San Francisco, CA 94105  
Phone: 1-415-229-5104

Please follow the following procedure:

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

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

A STATEMENT DESCRIBING BLUE SHIELD’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Blue Shield’s policies and procedures regarding our confidentiality/privacy practices are contained in the “Notice of Privacy Practices”, which you may obtain either by calling the Customer Service Department at the number listed in the back of this booklet, or by accessing Blue Shield of California’s Internet site located at http://www.mylifepath.com and printing a copy.

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

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

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

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

INDEPENDENT CONTRACTORS

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

BLUE SHIELD OF CALIFORNIA
P.O. Box 272560
Chico, CA 95927-2560

You may call toll free:


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

Benefits Management Program Telephone Numbers

For Preadmission Review: 1-800-343-1691

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

For prior authorization for Inpatient Mental Health and substance abuse Services, contact the Mental Health Services Administrator at: 1-877-263 -7178

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