Access+ HMO

Health Maintenance Organization (HMO)

Combined Evidence of Coverage and
Disclosure Form for the Basic Plan

Effective January 1, 2017

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

We have included a Summary of Covered Services for the Basic Plan with a comprehensive description following. It will be to your advantage to familiarize yourself with this booklet before you need services.

Take time to review this booklet. The information contained will be useful throughout the year.

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 to your plan, or if you would like additional information, please contact Blue Shield Member Services at the address or telephone number listed on the back cover 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 not 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 Member Services telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Blue Shield Access+ HMO Health Plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. However, the statement of benefits, exclusions and limitations in this Evidence of Coverage is complete and is incorporated by reference into the contract.

The contract is on file and available for review in the office of the CalPERS Health Plan Administration Division, 400 Q Street, Sacramento, CA 95811, or P.O. Box 720724, Sacramento, CA 94229-0724. You may purchase a copy of the contract from the CalPERS Health Plan Administration Division for a reasonable duplicating charge.

Health Information Exchange Participation

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

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

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

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

Your Introduction to the Blue Shield Access+ HMO Health Plan

Welcome to Blue Shield's Access+ HMO Plan. Members enrolled in the Basic Plan may find the description of their plan beginning on page 6.

Your interest in the Blue Shield Access+ HMO Health Plan is appreciated. Blue Shield has served Californians for more than 60 years, and we look forward to serving your health care needs.

Unlike some HMOs, the Access+ HMO offers you a health plan with a wide choice of physicians, hospitals and non-physician health care practitioners. Access+ HMO Members may also take advantage of special features such as Access+ Specialist and Access+ Satisfaction. These features are described fully in this booklet.

You will be able to select your own Personal Physician from the Blue Shield HMO Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Each of your eligible family members may also select a Personal Physician. All covered services must be provided by or arranged through your Personal Physician, except for the following: services received during an Access+ Specialist visit, or obstetrical/gynecological (OB/GYN) services provided by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as your Personal Physician, urgent care provided in your Personal Physician service area by an urgent care clinic when instructed by your assigned medical group or IPA, or emergency services, or mental health and substance use disorder services. See the How to Use the Plan section for information. Note: A decision will be rendered on all requests for prior authorization of services as follows: for urgent services and in-area urgent care, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request; for other services, 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 Member within 2 business days of the decision.

You will have the opportunity to be an active participant in your own health care. Working with the Blue Shield Access+ HMO, we'll help you make a personal commitment to maintain and, where possible, improve your health status. Like you, we believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

As a partner in health with Blue Shield, you will receive the benefit of Blue Shield's commitment to service ... an unparalleled record of more than 60 years.

Please review this booklet which summarizes the coverage and general provisions of the Blue Shield Access+ HMO.

If you have any questions regarding the information, you may contact us through our Member Services Department at 1-800-334-5847. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free text telephone (TTY) number, 1-800-241-1823.

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BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

	Prescription Drugs		
	Up to 30-day supply	**Up to 90-day supply**	**Up to 90-day supply**
	Participating Retail Pharmacy (short-term use medications)	SELECT[1] Retail Pharmacy (long-term use medications)	Mail Services (long-term use medications)
Generic	$5	$10	$10
Formulary Brand	$20	$40	$40
Non-Formulary Brand	$50	$100	$100
Partial Copay Waiver of Non-Formulary Brand	$40	$70	$70
Non-Formulary Brand Drugs with Generic equivalents	Member pays the difference in cost between the brand name drug and the generic equivalent, plus the generic copayment(The difference in cost does not accrue towards the Member out-of-pocket maximum)	Member pays the difference in cost between the brand name drug and the generic equivalent, plus the generic copayment (The difference in cost does not accrue towards the Member out-of-pocket maximum)	Member pays the difference in cost between the brand name drug and the generic equivalent, plus the generic copayment (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum or the $1,000 mail service out of pocket maximum)
Sexual Dysfunction Drugs	50% coinsurance	Not Applicable	Not Applicable
Maximum annual out-of-pocket payments for mail –service Formulary prescription drugs	Not Applicable	Not Applicable	$1,000 per Member (Non-Formulary brand-name drugs and drugs to treat sexual dysfunction do not accumulate towards the $1,000 mail service out-of-pocket maximum)

[1] For a list of select pharmacies, please visit the Pharmacy Resources page at blueshieldca.com/calpers

BASIC PLAN

Benefit Changes for Current Year

Member Calendar Year Out-of-Pocket Maximum

Out of pocket maximum for both pharmacy and medical expenses will be $7,150 per individual (Medical: $1,500 / Pharmacy: $5,650) and $14,300 per family (Medical: $3,000 / Pharmacy: $11,300).

Teladoc

Copayment: $5 per consultation. If medications are prescribed, the applicable prescription drug co-payments apply.

BENEFITS OF THIS PLAN ARE AVAILABLE ONLY FOR SERVICES AND SUPPLIES FURNISHED DURING THE TERM THE PLAN IS IN EFFECT AND WHILE THE INDIVIDUAL CLAIMING BENEFITS IS ACTUALLY COVERED BY THE GROUP AGREEMENT.

THERE IS NO VESTED RIGHT TO RECEIVE ANY PARTICULAR BENEFIT SET FORTH IN THE PLAN. PLAN BENEFITS MAY BE MODIFIED. ANY MODIFIED BENEFIT (SUCH AS THE ELMINIATION OF A PARTICULAR BENEFIT OR AN INCREASE IN THE MEMBERS'S COPAYMENT) APPLIES TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF THE MODIFICAITON.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Member Account Management Division at:

CalPERS
Member Account Management Division P.O. Box 942714
Sacramento, CA 94229-2714
Or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

How to Use the Plan

Choice of Physicians and Providers

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

Payment of Providers

Blue Shield generally contracts with groups of physicians to provide services to Members. A fixed, monthly fee is paid to these groups of physicians for each Member whose Personal Physician is in the group. This payment system, capitation, includes incentives to the groups of physicians to manage all services provided to Members in an appropriate manner consistent with the Agreement.

If you want to know more about this payment system, contact Member Services at the number listed on the back cover of this booklet or talk to your Plan provider.

Selecting a Personal Physician

A close physician-to-patient relationship is an important ingredient that helps to ensure the best medical care. Each Member is therefore required to select a Personal Physician at the time of enrollment. Family members can choose different Personal Physicians in different medical groups or IPAs, except as described for newborns below. This decision is an important one because your Personal Physician will:

- Help you decide on actions to maintain and improve your total health;
- Coordinate and direct all of your medical care needs;
- Authorize emergency services when appropriate;
- Work with your medical group or IPA to arrange your referrals to specialty physicians, hospitals and all other health services, including requesting any prior authorization you will need;
- Prescribe those lab tests, x-rays and services you require;
- If you request it, assist you in obtaining prior approval from the Mental Health Service Administrator (MHSA) for mental health and substance use disorder services. See the Mental Health and Substance Use Disorder Services paragraphs in the How to Use the Plan section for information; and,
- Assist you in applying for admission into a hospice program through a participating hospice agency when necessary.

To ensure access to services, each Member must select a Personal Physician who is located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If you do not select a Personal Physician at the time of enrollment, the Plan will designate a Personal Physician for you and you will be notified of the name of the designated Personal Physician. This designation will remain in effect until you notify the Plan of your selection of a different Personal Physician.

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption, but always within 31 days from the date of birth or placement for adoption. You may designate a pediatrician as the Personal Physician for your child. The Personal Physician selected for the month of birth must be in the same medical group or IPA as the mother's Personal Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the subscriber for adoption, the Personal Physician selected must be a physician in the same medical group or IPA as the subscriber. If you do not select a Personal Physician within 31 days following the birth or placement for adoption, the Plan will designate a Personal Physician from the same medical group or IPA as the natural mother or the subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Personal Physician for the child after the month of birth or placement for adoption, see the section below on Changing Personal Physicians or Designated Medical Group or IPA. If your child is ill during the first month of coverage, be sure to read the information about changing Personal Physicians during a course of treatment or hospitalization.

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you should contact CalPERS Customer Account Services Division – Member Account Management Division and Blue Shield to add your child to your coverage.

Role of the Medical Group or IPA

Most Blue Shield Access+ HMO Personal Physicians contract with medical groups or IPAs to share administrative and authorization responsibilities with them. (Of note, some Personal Physicians contract directly with Blue Shield.) Your Personal Physician coordinates with your designated medical group or IPA to direct all of your medical care needs and refer you to specialists or hospitals within your designated medical group or IPA unless because of your health condition, care is unavailable within the medical group or IPA.

Your designated medical group or IPA (or Blue Shield when noted on your identification card)

ensures that a full panel of specialists is available to provide your health care needs and helps your Personal Physician manage the utilization of your health plan benefits by ensuring that referrals are directed to providers who are contracted with them. Medical groups or IPAs also have admitting arrangements with hospitals contracted with Blue Shield in their area and some have special arrangements that designate a specific hospital as "in network." Your designated medical group or IPA works with your Personal Physician to authorize services and ensure that that service is performed by their in network provider.

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

Changing Personal Physicians or Designated Medical Group or IPA

You or your dependent may change Personal Physicians or designated medical group or IPA by calling the Member Services Department at 1-800-334-5847. Some Personal Physicians are affiliated with more than one medical group or IPA. If you change to a medical group or IPA with no affiliation to your Personal Physician, you must select a new Personal Physician affiliated with the new medical group or IPA and transition any specialty care you are receiving to specialists affiliated with the new medical group or IPA. The change will be effective the first day of the month following notice of approval by Blue Shield. Once your Personal Physician change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN services provided by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as your Personal Physician and Access+ Specialist visits. Once your medical group or IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new medical group or IPA, even if you remain with the same Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician or medical group or IPA.

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

Additionally, changing your Personal Physician or designated medical group or IPA during a course of treatment may interrupt the quality and continuity of your health care. For this reason, the effective date of your new Personal Physician or designated medical group or IPA, when requested during a course of treatment, will be the first of the month following the date it is medically appropriate to transfer your care to your new Personal Physician or designated medical group or IPA, as determined by the Plan.

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

If your Personal Physician discontinues participation in the Plan, Blue Shield will notify you in writing and designate a new Personal Physician for you in case you need immediate medical care. You will also be given the opportunity to select a new Personal Physician of your own choice within 15 days of this notification. Your selection must be approved by Blue Shield prior to receiving any services under the Plan. In the event that your selection has not been approved and an emergency arises, see I. Emergency Services in the Benefit Descriptions section for information.

IT IS IMPORTANT TO KNOW THAT WHEN YOU ENROLL IN THE BLUE SHIELD ACCESS+ HMO, SERVICES ARE PROVIDED THROUGH THE PLAN'S DELIVERY SYSTEM, BUT THE CONTINUED PARTICIPATION OF ANY ONE DOCTOR,

HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

Continuity of Care by a Terminated Provider

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

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician.

How to Receive Care

Use of Personal Physician

At the time of enrollment, you will choose a Personal Physician who will coordinate all covered services. You must contact your Personal Physician for all health care needs, including preventive services, routine health problems, consultations with Plan specialists (except as provided under Obstetrical/Gynecological (OB/GYN) Physician Services, Access+ Specialist, and Mental Health and Substance Use Disorder Services), admission into a hospice program through a participating hospice agency, emergency services, urgent services and for hospitalization. The Personal Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care services and requesting any needed prior authorization. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Personal Physician or the Mental Health Service Administrator (MHSA) and self-arranged appointments to an Access+ Specialist or for OB/GYN services. Because your physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the physician. Some offices may advise you that a fee (not to exceed your copayment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Personal Physician for any reason, you must contact Member Services at 1-800-334-5847, Monday through Friday, between 7 a.m. and 7 p.m. to select a Personal Physician to obtain benefits.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or a family practice physician who is not her designated Personal Physician. A referral from your Personal Physician or from the affiliated medical group or IPA is not needed. However, the obstetrician/gynecologist or family practice physician must be in the same medical group or IPA as her Personal Physician.

Obstetrical and gynecological services are defined as:

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

It is important to note that services by an obstetrician/gynecologist or a family practice physician outside of the Personal Physician's medical group or IPA without authorization will not be covered under this Plan. Before making the appointment, the Member should call the Member Services Department at 1-800-334-5847 to confirm that the obstetrician/gynecologist or family

practice physician is in the same medical group or IPA as her Personal Physician.

The OB/GYN physician services are separate from the Access+ Specialist feature described below.

Referral to Specialty Services and Second Medical Opinions

Although self-referrals to Plan specialists are allowed through the Access+ Specialist feature described below, Blue Shield encourages you to receive specialty services through a referral from your Personal Physician. The Personal Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty services. Your Personal Physician will generally refer you to a Plan specialist or Plan non-physician health care practitioner in the same medical group or IPA as your Personal Physician, but you can be referred outside the medical group or IPA if the type of specialist or non-physician health care practitioner needed is not available within your Personal Physician's medical group or IPA. Your Personal Physician will request any necessary prior authorization from your medical group or IPA. For mental health and substance use disorder services, see the Mental Health and Substance use disorder Services paragraphs in the How to Use the Plan section for information regarding how to access care. The Plan specialist or Plan non-physician health care practitioner will provide a complete report to your Personal Physician so that your medical record is complete.

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, or if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Personal Physician to refer you to another physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from your Personal Physician, the second opinion will be provided by a physician within the same medical group or IPA as your Personal Physician. If you are requesting a second opinion about care received from a specialist, the second opinion may be provided by any Plan specialist of the same or equivalent specialty. All second opinion consultations must be authorized. Your Personal Physician may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Member Services Department at the number listed on the back cover of this booklet.

If your Personal Physician belongs to a medical group or IPA that participates as an Access+ Provider, you may also arrange a second opinion visit with another physician in the same medical group or IPA without a referral, subject to the limitations described in the Access+ Specialist paragraphs later in this section.

To obtain referral for specialty services, including lab and x-ray, you must first contact your Personal Physician. If the Personal Physician determines that specialty services are medically necessary, the physician will complete a referral form and request necessary authorization. Your Personal Physician will designate the Plan provider from whom you will receive services. When no Plan provider is available to perform the needed service, the Personal Physician will refer you to a non-Plan provider after obtaining authorization. This authorization procedure is handled for you by your Personal Physician.

In certain situations where the Member's medical condition or disease is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time, the Personal Physician may make a standing referral (more than one visit) to an appropriate specialist.

Referral by a Personal Physician does not guarantee coverage for referral services. The eligibility provisions, exclusions and limitations will apply.

Access+ Specialist

You may arrange an office visit with a Plan specialist in the same medical group or IPA as your Personal Physician without a referral from your Personal Physician, subject to the limitations described below. Access+ Specialist office visits are available only to Members whose Personal Physicians belong to a medical group or IPA that participates as an Access+ Provider. Refer to the HMO Physician and Hospital Directory or call Blue Shield Member Services at 1-800-334-5847 to determine whether a medical group or IPA is an Access+ Provider.

When you arrange for Access+ Specialist visits without a referral from your Personal Physician, you will be responsible for a $30 copayment for each Access+ Specialist visit. This copayment is in addition to any copayments that you may incur for specific benefits as described in the Summary of Covered Services. Each follow-up office visit with the Plan specialist which is not referred or authorized by your Personal Physician is a separate Access+ Specialist visit and requires a separate $30 copayment.

You should cancel any scheduled Access+ Specialist appointment at least 24 hours in advance. Unless you give 24-hour advance notice or miss the appointment because of an emergency situation, the physician's office may charge you a fee as much as the Access+ Specialist copayment.

Note: When you receive a referral from your Personal Physician to obtain services from a specialist, you are responsible for the physician services copayment.

The Access+ Specialist visit includes:

- An examination or other consultation provided to you by a medical group Plan specialist without referral from your Personal Physician;
- Conventional x-rays such as chest x-rays, abdominal flat plates, and x-rays of bones to rule out the possibility of fracture (but does not include any diagnostic imaging such as CT, MRI, or bone density measurement);
- Laboratory services;
- Diagnostic or treatment procedures which a Plan specialist would regularly provide under a referral from the Personal Physician.

An Access+ Specialist visit does not include:

- Any services which are not covered or which are not medically necessary;
- Services provided by a non-Access+ Provider (such as podiatry and physical therapy), except for the x-ray and laboratory services described above;
- Allergy testing;
- Endoscopic procedures;
- Any diagnostic imaging including CT, MRI, or bone density measurement;
- Injectables, chemotherapy or other infusion drugs, other than vaccines and antibiotics;
- Infertility services;
- Emergency services;
- Urgent services;
- Inpatient services, or any services which result in a facility charge, except for routine x-ray and laboratory services;
- Services for which the medical group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician;
- OB/GYN services by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as the Personal Physician;

NurseHelp 24/7 and LifeReferrals 24/7

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

1. Symptoms you are experiencing, including whether you need emergency care;

2. Minor illnesses and injuries;

3. Chronic conditions;

4. Medical tests and medications;

5. Preventive care.

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

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

These programs include:

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

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

Mental Health and Substance Use Disorder Services

Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to underwrite and deliver all mental health and substance use disorder services through a unique network of mental health Participating Providers. (See Mental Health Service Administrator under the Definitions section for more information.)

All non-emergency mental health and substance use disorder services, except for Access+ Specialist visits, must be arranged through the MHSA. Members do not need to arrange for mental health and substance use disorder services through their Personal Physician. (See 1. Prior Authorization paragraphs below.)

All mental health and substance use disorder services, except for emergency or urgent services, must be provided by a MHSA Participating Provider. A list of MHSA Participating Providers is available in the online Blue Shield of California Provider Directory. Members may also contact the MHSA directly for information and to select a MHSA Participating Provider by calling 1-866-505-3409. Your Personal Physician may also contact the MHSA to obtain information regarding MHSA Participating Providers for you.

Non-emergency mental health and substance use disorder services received from a provider who does not participate in the MHSA Participating Provider network will not be covered, except as stated herein, and all charges for these services will be the Member's responsibility. This limitation does not apply with respect to emergency services. In addition, when no MHSA Participating Provider is available to perform the needed service, the MHSA will refer you to a non-Plan provider and authorize services to be received.

For complete information regarding benefits for mental health and substance Use Disorder services, see Q. Inpatient Mental Health and Substance Use Disorder Services and R. Outpatient Mental Health and Substance Use Disorder Services in the Benefit Descriptions section.

1. Prior Authorization

   Prior authorization is required for all nonemergency Mental Health Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-866-505-3409 at least five business days prior to the admission. Non-Routine Outpatient Mental Health Services, including, but not limited to, Behavioral Health Treatment, Partial

Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA.

The MHSA will render a decision on all requests for prior authorization of services as follows:

- for urgent services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other services, 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 Member within 2 business days of the decision.

If prior authorization is not obtained for a mental health inpatient admission or for any Non-Routine Outpatient Mental Health Services and the services provided to the member are determined not to be a Benefit of the plan, coverage will be denied.

Prior authorization is not required for an emergency admission.

2. Psychosocial Support through LifeReferrals 24/7

   Notwithstanding the benefits provided under R. Outpatient Mental Health and Substance Use Disorder Services, the Member also may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

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

   In the event that the services required of a Member are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Member will be referred to the MHSA intake line to access his mental health and substance use disorder services which are described under R. Outpatient Mental Health and Substance Use Disorder Services.

Emergency Services

What is an Emergency?

An emergency means an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a layperson who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part. If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

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

What to do in case of Emergency:

Life Threatening

Obtain care immediately.

Contact your Personal Physician no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening

Consult your Personal Physician, anytime day or night, regardless of where you are prior to receiving medical care.

Follow-Up Care

Follow-up care, which is any care provided after the initial emergency room visit, must be provided or authorized by your Personal Physician.

For a complete description of the Emergency Services benefit and applicable copayments, see I. Emergency Services in the Benefit Descriptions section.

Urgent Services

The Blue Shield Access+ HMO provides coverage for you and your family for your urgent service needs when you or your family are temporarily traveling outside of your Personal Physician service area.

Urgent services are defined in Section 3, under Definitions. Out-of-area follow-up care is defined in Section 3, under Definitions.

(Urgent care) While in your Personal Physician Service Area

If you require urgent care for a condition that could reasonably be treated in your Personal Physician's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), you must first call your Personal Physician. However, you may go directly to an urgent care clinic when your assigned medical group or IPA has provided you with instructions for obtaining care from an urgent care clinic in your Personal Physician service area.

Outside of California or the United States

The Blue Shield Access+ HMO provides coverage for you and your family for your urgent service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement.

Out-of-area follow-up care is covered and may be received through the BlueCard Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two out-of-area follow-up care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician service area, if possible you should call Blue Shield Member Services at 1-800-334-5847 for assistance in receiving urgent services through a Blue Shield of California Plan provider. You may also locate a Plan provider by visiting our web site at http://www.blueshieldca.com. However, you are not required to use a Blue Shield of California Plan provider to receive urgent services; you may use any provider.

Follow-up care is also covered through a Blue Shield of California Plan provider and may also be received from any provider. However, when outside your Personal Physician service area authorization by Blue Shield is required for more than two out-of-area follow-up care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

If services are not received from a Blue Shield of California Plan provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for urgent services obtained outside of your Personal Physician service area within California will be reviewed retrospectively for coverage.

When you receive covered urgent services outside your Personal Physician service area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's allowed charges.

See J. Urgent Services in the Benefit Descriptions section for benefit description, applicable copayment information, and information on payment responsibility and claims submission.

Inter-Plan Programs

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and

their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

When you access covered services outside of California you may obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating health care providers. Blue Shield's payment practices in both instances are described in this booklet.

BlueCard Program

Under the BlueCard Program, when you obtain covered services within the geographic area served by a Host Plan, Blue Shield will remain responsible for fulfilling our contractual obligations. However the Host Plan is responsible for contracting with and generally handling all interactions with its participating health care providers.

The BlueCard Program enables you to obtain covered services outside of California, as defined, from a health care provider participating with a Host Plan, where available. The participating health care provider will automatically file a claim for the covered services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment and deductible amounts, if any, as stated in this booklet.

Whenever you access covered services outside of California and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your covered services; or

2. The negotiated price that the Host Plan makes available to Blue Shield.

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

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

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

Claims for covered emergency services are paid based on the allowed charges as defined in this booklet.

Inpatient, Home Health Care and Other Services

The Personal Physician is responsible for obtaining prior authorization before you can be admitted to the hospital or a skilled nursing facility, including subacute care admissions, except for mental health and substance use disorder services which are described in the previous Mental Health and Substance Use Disorder Services section. The Personal Physician is responsible for obtaining prior authorization before you can receive home health care and certain other services or before you can be admitted into a hospice program through a participating hospice agency. If the Personal Physician determines that you should receive any of these services, he or she will request authorization. Your Personal Physician will arrange for your admission to the hospital, skilled nursing facility, or a hospice program

through a participating hospice agency, as well as for the provision of home health care and other services.

For hospital admissions for mastectomies or lymph node dissections, the length of hospital stays will be determined solely by the Member's physician in consultation with the Member. For information regarding length of stay for maternity or maternity-related services, see F. Pregnancy and Maternity Care, for information relative to the Newborns' and Mothers' Health Protection Act.

Member Calendar Year Out-of-Pocket Maximum

Out of pocket maximum for both pharmacy and medical expenses will be $7,150 per individual (Medical: $1,500 / Pharmacy: $5,650) and $14,300 per family (Medical: $3,000 / Pharmacy: $11,300).

Once a Member's maximum copayment responsibility has been met, the Plan will pay 100% of the allowed charges for that Member's covered services for the remainder of that calendar year, except as described below. Additionally, for Plans with a Member and a family maximum copayment responsibility, once the family maximum copayment responsibility has been met, the Plan will pay 100% of the allowed charges for the subscriber's and all covered dependents' covered services for the remainder of that calendar year, except as described below.

Charges for services not covered and services not prior approved by the Personal Physician, except those meeting the emergency and urgent care requirements, are your responsibility, do not apply towards the Member calendar year out-of-pocket maximum responsibility, and may cause your payment responsibility to exceed the Member calendar year out-of-pocket maximum responsibility defined above.

Note that copayments and charges for services not accruing to the Member calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached.

Note: It is your responsibility to maintain accurate records of your copayments and to determine and notify Blue Shield when the Member calendar year out-of-pocket maximum responsibility has been reached.

You must notify Blue Shield Member Services in writing when you feel that your Member calendar year out-of-pocket maximum responsibility has been reached. At that time, you must submit complete and accurate records to Blue Shield substantiating your copayment expenditures for the period in question. Member Services address and telephone number may be found on the back cover of this booklet.

Liability of Member for Payment

It is important to note that all services except for those meeting the emergency and out of service area urgent services requirements, Access+ Specialist visits, hospice program services received from a participating hospice agency after the Member has been accepted into the hospice program, OB/GYN services by an obstetrician/gynecologist or a family practice physician who is in the same medical group or IPA as the Personal Physician, and all mental health and substance use disorder services, must have prior authorization by the Personal Physician, medical group or IPA. The Member will be responsible for payment of services that are not authorized or those that are not an emergency or covered out of service area urgent service procedures. (See the previous Urgent Services paragraphs for information on receiving urgent services out of the service area but within California.) Members must obtain services from the Plan providers that are authorized by their Personal Physician, medical group or IPA and, for all mental health and substance use disorder services, from MHSA Participating Providers. Hospice services must be received from a participating hospice agency.

If your condition requires services which are available from the Plan, payment for services rendered by non-Plan providers will not be considered unless the medical condition requires emergency or urgent services.

You are responsible for paying a minimum charge (copayment) to the physician or provider

of services at the time you receive services. The specific copayments, as applicable, are listed after the benefit description. There are no deductibles to be met.

Limitation of Liability

Members shall not be responsible to Plan providers for payment for services if they are a benefit of the Plan. When covered services are rendered by a Plan provider, the Member is responsible only for the applicable copayments, except as set forth in the Third Party Recovery Process and the Member's Responsibility section. Members are responsible for the full charges for any non-covered services they obtain.

Member Identification Card

You will receive your Blue Shield Access+ HMO identification card after enrollment. If you do not receive your identification card or if you need to obtain medical or prescription services before your card arrives, contact the Blue Shield Member Services Department so that they can coordinate your care and direct your Personal Physician or pharmacy.

Right of Recovery

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

Member Services Department

For all services other than mental health and substance use disorder services

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 should call the Blue Shield Member Services Department at 1-800-334-5847. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free TTY number, 1-800-241-1823. Member Services can answer many questions over the telephone.

Expedited Decision

Blue Shield of California has established a procedure for our Members to request an expedited decision (including those regarding grievances). A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other 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 Member Services Department at 1-800-334-5847.

For all mental health and substance use disorder services

For all mental health and substance use disorder services Blue Shield of California has contracted with the Plan's Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about mental health and substance use disorder services, MHSA Participating Providers, or mental health and substance use disorder benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

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

The MHSA can answer many questions over the telephone.

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

For information on additional rights, see the Grievance Process section.

Rates for Basic Plan

State Employees and Annuitants

The rates shown below are effective January 1, 2017, and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	$830.44
Employee and one dependent	$1,660.88
Employee and two or more dependents	$2,159.14

Contracting Agency Employees and Annuitants

The rates charged are based on the pricing region in which the employee/annuitant resides. See below a description of the pricing regions. If the employee/annuitant lives outside of the Plan's service area and is enrolled based on place of employment, then the pricing region for the place of employment will apply. If the employee/annuitant moves from one pricing region to another, rates will change on the first of the month following the change of residence. The rates shown below are effective January 1, 2017, and will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among public agencies. For assistance on calculating your net contribution, contact your agency or retirement system health benefits officer.

Cost of the Program

Type of Enrollment	Monthly Rate
Employee only	
Region 1	$1,024.85
Region 1A	$859.42
Region 2	$954.51
Region 3	$675.98
Region 4	$778.45
Employee and one dependent	
Region 1	$2,049.70
Region 1A	$1,718.84
Region 2	$1,909.02
Region 3	$1,351.96
Region 4	$1,556.90
Employee and two or more dependents	
Region 1	$2,664.61
Region 1A	$2,234.49
Region 2	$2,481.73
Region 3	$1,757.55
Region 4	$2,023.97

Pricing Regions for Contracting Agency Employees and Annuitants

1 San Francisco Bay Area

1A Sacramento Counties

2 Other Northern California Counties

3 Los Angeles/Ventura/San Bernardino Counties

4 Other Southern California Counties

Rate Change

The plan rates may be changed as of January 1, 2018, following at least 60 days' written notice to the Board prior to such change.

BASIC PLAN

Benefit Descriptions

The Plan benefits available to you are listed in this section. The copayments for these services, if applicable, follow each benefit description.

The following are the basic health care services covered by the Blue Shield Access+ HMO without charge to the Member, except for copayments where noted, and as set forth in the Third Party Recovery Process and the Member's Responsibility section. These services are covered when medically necessary, and when provided by the Member's Personal Physician or other Plan provider or authorized as described herein, or received according to the provisions described under Obstetrical/Gynecological (OB/GYN) Physician Services, Access+ Specialist, and Mental Health and Substance Use Disorder Services. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the benefit descriptions below, and to the Exclusions and Limitations set forth in this booklet.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

A. Hospital Services

The following hospital services customarily furnished by a hospital will be covered when medically necessary and authorized.

1. Inpatient hospital services include:

    a. Semi-private room and board, unless a private room is medically necessary;

    b. General nursing care, and special duty nursing when medically necessary;

    c. Meals and special diets when medically necessary;

    d. Intensive care services and units;

    e. Operating room, special treatment rooms, delivery room, newborn nursery and related facilities;

    f. Hospital ancillary services including diagnostic laboratory, x-ray services and therapy services;

    g. Drugs, medications, biologicals, and oxygen administered in the hospital, and up to 3 days' supply of drugs supplied upon discharge by the Plan physician for the purpose of transition from the hospital to home;

    h. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses, other medical supplies and medical appliances and equipment administered in hospital;

    i. Processing, storage and administration of blood, and blood products (plasma), in inpatient and outpatient settings. Includes the storage and collection of autologous blood;

    j. Radiation therapy, chemotherapy and renal dialysis;

    k. Respiratory therapy and other diagnostic, therapeutic and rehabilitation services as appropriate;

    l. Coordinated discharge planning, including the planning of such continuing care as may be necessary;

    m. Inpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon;

    n. Subacute care;

o. Medically necessary inpatient substance use disorder detoxification services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room or when medically necessary inpatient substance use disorder detoxification is prior authorized;

p. Rehabilitation when furnished by the hospital and authorized.

See Section O. for inpatient hospital services provided under the "Hospice Program Services" benefit.

Copayment: No charge.

2. Outpatient hospital services include:

a. Services and supplies for treatment or surgery in an outpatient hospital setting or ambulatory surgery center;

b. Outpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon.

Copayment: No charge except for $15 per visit for physical, occupational, and speech therapy performed on an outpatient basis

3 Transgender Benefit

The Access+ HMO Plan provides coverage for the following benefits for a diagnosis of gender identity disorder (gender dysphoria):

a. Mental Health Services:
Outpatient psychiatric care and Intensive Outpatient Care are covered when authorized and provided through the MHSA (see Mental Health Benefits section).

b. Transgender Surgical Services
Hospital and Professional Services are provided for transgender genital surgical services and mastectomies. Benefits will be provided in accordance with guidelines established by the Plan. These services must be authorized by the Member's Personal Physician or the Access+HMO. Benefits are also provided for necessary travel and lodging expenses to receive these services only when the Member is referred outside of the Plan Service Area by the Plan. These travel and lodging arrangements must be arranged by or approved in advance by the Plan and are limited solely to expenses for the Member who is undergoing transgender surgery. See the Summary of Benefits for the applicable copayments for the services provided.

B. Physician Services (Other Than for Mental Health and Substance Use Disorder Services)

1. Physician Office Visits

Office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations, diabetic counseling, and OB/GYN services from an obstetrician/gynecologist or a family practice physician who is within the same medical group or IPA as the Personal Physician. Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.

Copayment: $15 per visit. No additional charge for surgery or anesthesia; radiation or renal dialysis treatments; medications administered in the physician's office, including chemotherapy.

2. Allergy Testing and Treatment

   Office visits for the purpose of allergy testing and treatment, including injectables and serum.

   Copayment: No charge.

3. Inpatient Medical and Surgical Services

   Physicians' services in a hospital or skilled nursing facility for examination, diagnosis, treatment, and consultation, including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist. Inpatient physician services are covered only when hospital and skilled nursing facility services are also covered.

   Copayment: No charge.

4. Medically necessary home visits by Plan physician

   Copayment: $15 per visit.

5. Treatment of physical complications of a mastectomy, including lymphedemas

   Copayment: $15 per visit.

   Copayment: No charge.

C. Preventive Health Services

1. Preventive health services, as defined, when rendered by a physician are covered.

2. Eye refraction to determine the need for corrective lenses for all Members upon referral by the Personal Physician. (Limited to one visit per calendar year, for Members aged 18 and over. No limit on number of visits for Members under age 18.)

   Copayment: No charge.

D. Diagnostic X-ray/Lab Services

1. X-ray, Laboratory, Major Diagnostic Services. All outpatient diagnostic x-ray and clinical laboratory tests and services, including diagnostic imaging, electrocardiograms, diagnostic clinical isotope services, bone mass measurements, and periodic blood lipid screening.

2. Genetic Testing and Diagnostic Procedures. 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.

See Section F. for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

Copayment: No charge.

E. Durable Medical Equipment, Prostheses and Orthoses and Other Services

Medically necessary durable medical equipment, prostheses and orthoses for activities of daily living, and supplies needed to operate durable medical equipment; oxygen and oxygen equipment and its administration; blood glucose monitors as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. When authorized as durable medical equipment, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standard of practice. If there are two or more

professionally recognized items equally appropriate for a condition, benefits will be based on the most cost-effective item.

1. Durable Medical Equipment

   a. Replacement of durable medical equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item.*

      *This does not apply to the medically necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See Section P. for benefits for asthma inhalers and inhaler spacers.)

   b. Medically necessary repairs and maintenance of durable medical equipment, as authorized by Plan provider. Repair is covered unless necessitated by misuse or loss.

   c. Rental charges for durable medical equipment in excess of the purchase price are not covered.

   d. Benefits do not include environmental control equipment or generators. No benefits are provided for backup or alternate items.

   e. Breast pump rental or purchase.
      Breast pump rental or purchase is only covered if obtained from a designated Plan provider in accordance with Blue Shield medical policy. For further information call Member Services or go to http://www.blueshieldca.com.

See Section V. for devices, equipment and supplies for the management and treatment of diabetes.

If you are enrolled 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. For information see Section O.

2. Prostheses

   a. Medically necessary prostheses for activities of daily living, including the following:

      1) Supplies necessary for the operation of prostheses;

      2) Initial fitting and replacement after the expected life of the item;

      3) Repairs, even if due to damage;

      4) Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;

      5) Prosthetic devices used to restore a method of speaking following laryngectomy, including initial and subsequent prosthetic devices and installation accessories. This does not include electronic voice producing machines;

      6) Cochlear implants;

      7) Contact lenses if medically necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia. Cataract spectacles or intraocular lenses that replace the natural lens of the eye after cataract surgery. If medically necessary with the insertion of the intraocular lens, one pair of conventional eyeglasses or contact lenses;

      8) Artificial limbs and eyes.

   b. Routine maintenance is not covered.

   c. Benefits do not include wigs for any reason, self-help/educational devices or any type of speech or language assistance devices, except as specifically provided above. See the Exclusions and Limitations section for a listing of excluded speech

and language assistance devices. No benefits are provided for backup or alternate items.

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

3. Orthoses

   a. Medically necessary orthoses for activities of daily living, including the following:

      1) Special footwear required for foot disfigurement which includes but is not limited to foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes or by accident or developmental disability;

      2) Medically necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;

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

   b. Benefits for medically necessary orthoses 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, the Plan will provide benefits based on the most cost-effective appliance. Routine maintenance is not covered. No benefits are provided for backup or alternate items.

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

Copayment: No charge.

See Section V. for devices, equipment and supplies for the management and treatment of diabetes.

F. Pregnancy and Maternity Care

The following pregnancy and maternity care is covered subject to the General Exclusions and Limitations.

1. Prenatal and Postnatal Physician Office Visits

   See Section D. for information on coverage of other genetic testing and diagnostic procedures.

   Copayment: No charge.

2. Inpatient Hospital and Professional Services. Hospital and Professional services for the purposes of a normal delivery, C-section, complications or medical conditions arising from pregnancy or resulting childbirth.

   Copayment: No charge.

3. Includes providing coverage for all testing recommended by the California Newborn Screening Program and for participating in the statewide prenatal testing program, administered by the State Department of Health Services, known as the Expanded Alpha Feto Protein Program.

   Copayment: No charge.

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.

5. Abortion Services

   Copayment: See applicable copayments for Physician Services and Hospital Services.

G. Family Planning and Infertility Services

1. Family Planning Counseling

   Copayment: No charge.

2. Infertility Services. Infertility services (including artificial insemination), except as excluded in the General Exclusions and Limitations, including professional, hospital, ambulatory surgery center, ancillary services and injectable drugs administered or prescribed by the provider to diagnose and treat the cause of infertility.

   Copayment: 50% of allowed charges for all services.

3. Vasectomy

   Copayment: See applicable copayments for Physician Services and Hospital Services.

4. Tubal ligation

   Copayment: No charge.

5. Contraceptive Device Fitting

   Copayment: No charge.

6. Contraceptive Drugs & Devices

   Copayment: No charge.

7. Injectable Contraceptives

   Copayment: No charge.

8. Implantable Contraceptives

   Copayment: No charge .

H. Ambulance Services

The Plan will pay for ambulance services as follows:

1. Emergency Ambulance Services

   For transportation to the nearest hospital which can provide such emergency care only if a reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance services, as described in Section I.

2. Non-Emergency Ambulance Services

   Medically necessary ambulance services to transfer the Member from a non-Plan hospital to a Plan hospital, between Plan facilities, or from facility to home when in connection with authorized confinement/ admission and the use of the ambulance is authorized.

   Copayment: No charge.

I. Emergency Services

An emergency means an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a layperson who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health

in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part. If you receive services in a situation that the Blue Shield Access+ HMO determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

1. Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the Personal Physician or the MHSA by phone within 24 hours of the commencement of the emergency services, or as soon as it is medically possible for the Member to provide notice. Failure to provide notice as stated will result in the services not being covered.

2. Whenever possible, go to the emergency room of your nearest Blue Shield Access+ HMO hospital for medical emergencies. A listing of Blue Shield Access+ HMO hospitals is available in your HMO Physician and Hospital Directory.

3. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition.

   Copayment: $50 per visit in the hospital emergency room. (Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit.)

4. Continuing or Follow-up Treatment. If you receive emergency services from a hospital which is a non-Plan hospital, follow-up care must be authorized by Blue Shield or it may not be covered. If, once your emergency medical condition is stabilized, and your treating health care provider at the non-Plan hospital believes that you require additional medically necessary hospital services, the non-Plan hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued medically necessary hospital services by the non-Plan hospital. If Blue Shield determines that you may be safely transferred to a hospital that is contracted with the Plan and you refuse to consent to the transfer, the non-Plan hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the non-Plan hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Plan hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan hospital, you should contact Blue Shield at the telephone number on your identification card.

5. Claims for Emergency and Out-of-Area Urgent Services. Contact Member Services to obtain a claim form.

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

the claim. In the event covered medical transportation services are obtained in such an emergency situation, the Blue Shield Access+ HMO shall pay the medical transportation provider directly.

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

J. Urgent Services

Urgent services are provided in response to the patient's need for a prompt diagnostic workup and/or treatment.

These services are applicable for a medical or mental disorder that: (1) could become an emergency if not diagnosed and/or treated in a timely manner, (2) is likely to result in prolonged temporary impairment, (3) could increase the risk of necessitating more complex or hazardous treatment, and (4) could develop in a chronic illness or inordinate physical or psychological suffering of the patient.

1. When within California, but outside of your Personal Physician service area, if possible contact Blue Shield Member Services at 1-800-334-5847 for assistance in receiving urgent services. Member Services will assist Members in receiving urgent services through a Blue Shield of California Plan provider. Members may also locate a Plan provider by visiting Blue Shield's internet site at http://www.blueshieldca.com. You are not required to use a Blue Shield of California Plan provider to receive urgent services; you may use any provider. However, the services will be reviewed retrospectively by the Plan to determine whether the services were urgent services.

2. When temporarily traveling within the United States, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. When a BlueCard Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-participating BlueCard Program provider. If you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by the Plan to determine whether the services were urgent services. See Section I.5. Claims for Emergency and Out-of-Area Urgent Services for additional information.

   Up to two medically necessary out-of-area follow-up care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits or for care that involves a surgical or other procedure or inpatient stay. Blue Shield may direct the Member to receive the additional follow-up care from the Personal Physician.

3. Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are

responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the How to Use Your Health Plan section. See *BlueCard Program* in the How to Use Your Health Plan section for additional information. Before traveling abroad, Members may call their local Member Services office for the most current listing of providers or they can go on-line at http://www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide".. However, a Member is not required to receive urgent services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

4. To receive urgent care within your Personal Physician service area, call your Personal Physician's office or follow instructions given by your assigned medical group or IPA in accordance with all the conditions of the Agreement.

   Copayment: $15 per visit.

K. Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy

1. Home Health Care Services

   Benefits are provided for home health care services when the services are medically necessary, ordered by the Personal Physician and authorized.

   a. Home visits to provide skilled nursing services* and other skilled services by any of the following professional providers are covered:

      1) Registered nurse;

      2) Licensed vocational nurse;

      3) Certified home health aide in conjunction with the services of 1) or 2), above;

      4) Medical Social Worker.

      Copayment: No charge.

      5) Physical therapist, occupational therapist, or speech therapist.

      Copayment: $15 per visit for therapy provided in the home.

   b. In conjunction with the professional services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan, to the extent the benefit would have been provided had the Member remained in the hospital or skilled nursing facility, except as excluded in the General Exclusions and Limitations.

      Copayment: No charge.

This benefit does not include medications, drugs, or injectables covered under Section K. or P.

See Section O. for information about when a Member is admitted into a hospice program and a specialized description of skilled nursing services for hospice care.

For information concerning diabetes self-management training, see Section V.

2. PKU-Related Formulas and Special Food Products

   Benefits are provided for enteral formulas, related medical supplies and special food products that are medically necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. These benefits must be prior authorized and must be prescribed or ordered by the appropriate health care professional.

Copayment: No charge.

3. Home Infusion/Home Injectable Therapy Provided by a Home Infusion Agency

   Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency. Note: For services related to hemophilia, see item 4. below.

   Services include home infusion agency skilled nursing services, parenteral nutrition services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory services and for medically necessary, FDA approved injectable medications, when prescribed by the Personal Physician and prior authorized, and when provided by a home infusion agency.

   This benefit does not include medications, drugs, insulin, insulin syringes, specialty drugs covered under Section P., and services related to hemophilia which are covered as described below.

   Copayment: No charge.

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

4. Hemophilia Home Infusion Products and Services

   Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by the Plan and must be provided by a participating Hemophilia Infusion Provider. (Note: Most participating home health care and home infusion agencies are not participating Hemophilia Infusion Providers.) A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. You may also verify this information by calling Member Services at the telephone number shown on the back cover of this booklet.

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

   Following evaluation by your physician, a prescription for a blood factor product must be submitted to and approved by the Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in Section I.)

   Included in this benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a participating Hemophilia Infusion Provider, and medically necessary services to treat complications of hemophilia replacement therapy are not covered under this benefit but may be covered under other medical benefits described elsewhere in this Benefit Descriptions section.

   This benefit does not include:

   a. Physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;

   b. Services from a hemophilia treatment center or any provider not prior authorized by the Plan; or,

   c. Self-infusion training programs, other than nursing visits to assist in administration of the product.

   *Services and certain drugs may be covered under Section L., Section P., or as described elsewhere in this Benefit Descriptions section.

   Copayment: $15 per visit.

L. Physical and Occupational Therapy

Rehabilitation services include physical therapy, occupational therapy, and/or respiratory therapy pursuant to a written treatment plan and when rendered in the provider's office or outpatient department of a hospital. Benefits for speech therapy are described in Section M. Medically necessary services will be authorized for an initial treatment period and any additional subsequent medically necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is medically necessary.

Copayment: No charge for inpatient therapy. $15 per visit for therapy provided in the home or other outpatient setting.

See Section K. for information on coverage for rehabilitation services rendered in the home.

M. Speech Therapy

Outpatient benefits for Medically Necessary speech therapy services when diagnosed and ordered by a physician and provided by an appropriately licensed speech therapist/pathologist, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development

Continued outpatient benefits will be provided 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 may be reviewed periodically. When continued treatment is not medically necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Member will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under Section K., no outpatient benefits are provided for speech therapy, speech correction, or speech pathology services.

Copayment: No charge for inpatient therapy. $15 per visit for therapy provided in the home or other outpatient setting.

See Section K. for information on coverage for speech therapy services rendered in the home. See Section A. for information on inpatient benefits and Section O. for hospice program services.

N. Skilled Nursing Facility Services

Subject to all of the inpatient hospital services provisions under Section A., medically necessary skilled nursing services, including subacute care; will be covered when provided in a skilled nursing facility and authorized. This benefit is limited to 100 days during any calendar year except when received through a hospice program provided by a participating hospice agency. Custodial care is not covered.

For information concerning "Hospice Program Services" see Section O.

Copayment: No charge.

O. Hospice Program Services

Benefits are provided for the following services through a participating hospice agency when an eligible Member requests admission to and is formally admitted to an approved hospice program. The Member must have a terminal illness as determined by his Plan provider's certification and the admission must receive prior approval from Blue Shield. (Note: Members with a terminal illness who have not elected to enroll in a hospice program can receive a pre-hospice consultative visit from a participating hospice agency.) Covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Members can continue to receive covered services that are not related to the palliation and management of the terminal illness from the appropriate Plan provider. Member copayments when applicable are paid to the participating hospice agency.

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. If Blue Shield prior authorizes hospice program services from a non-contracted hospice, the Member's copayment for these services will be the same as the copayments for hospice program services when received and authorized by a participating hospice agency.

All of the services listed below must be received through the participating hospice agency.

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

2. Interdisciplinary Team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.

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

4. Bereavement services.

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

6. Medical direction with the medical director being also responsible for meeting the general medical needs for the terminal illness of the Members to the extent that these needs are not met by the Personal Physician.

7. Volunteer services.

8. Short-term inpatient care arrangements.

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

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

11. Nursing care services are covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot 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 5 consecutive days at a time.

Members are allowed to change their participating hospice agency only once during each period of care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another period of care if the Plan provider recertifies that the Member is terminally ill.

Definitions

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

Continuous Home Care - home care provided during a period of crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker services or home health aide services may be provided to

supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care.

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

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

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

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.

2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and the Member's family.

3. Requires the Interdisciplinary Team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

5. Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.

6. Actively utilizes volunteers in the delivery of hospice services.

7. Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

8. Is provided through a participating hospice agency.

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

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

Period of Care - the time when the Personal Physician recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than 1 year. A period of care starts the day the Member begins to receive hospice care and ends when the 90 or 60-day period has ended.

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

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

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

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

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

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

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

Copayment: No charge.

P. Prescription Drugs

Except for the Coordination of Benefits provision, the general provisions and exclusions of the HMO Health Plan Agreement shall apply.

The following applies to Medicare-qualified members only. This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this Plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

Benefits are provided for outpatient prescription drugs which meet all of the requirements specified in this section, are prescribed by a physician or other licensed health care provider within the scope of his or her license as long as the prescriber is a Plan provider, are obtained from a participating pharmacy, and are listed in the Drug Formulary. Blue Shield's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Blue Shield Outpatient Prescription Drug Benefit. Select drugs and drug dosages and most specialty drugs require prior authorization by Blue Shield for medical necessity, including appropriateness of

therapy and efficacy of lower cost alternatives. Over-the-counter and prescription smoking cessation drugs are covered for Members when ordered by a Physician. See Section Y. for more information about smoking cessation.

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most Generic Drugs. The fact that a Drug is listed on the Blue Shield Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

Members may access the Drug Formulary at http://www.blueshieldca.com/bsca/pharmacy/home.sp. Members may also call Shield Concierge at the number provided on the back of the Evidence of Coverage to inquire if a specific drug is included in the Formulary or to obtain a printed copy.

Definitions

Brand Name Drugs - drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which has the same brand name as that of the manufacturer with the original FDA approval.

Drugs - (1) drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by federal or California law, (2) insulin, and disposable hypodermic insulin needles and syringes, (3) pen delivery systems for the administration of insulin as determined by Blue Shield to be medically necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and ketone urine testing strips and test tablets in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes,), (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B, (6) contraceptives drugs and devices, including female OTC contraceptives when ordered by a Physician, and (7) inhalers and inhaler spacers for the management and treatment of asthma. To be considered for coverage, all Drugs require a valid prescription by the Personal Physician.

Formulary - a comprehensive list of drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program, which is designed to assist physicians in prescribing drugs that are medically necessary and cost effective. The Formulary is updated periodically.

Generic Drugs - drugs that (1) are approved by the FDA or other authorized government agency as a therapeutic equivalent or authorized generic to the brand name drug, (2) contain the same active ingredient as the brand name drug, and (3) typically cost less than the brand name drug equivalent.

Maintenance Drugs - covered outpatient prescription drugs prescribed to treat chronic or long-term conditions including conditions such as diabetes, asthma, hypertension and chronic heart disease.

Network Specialty Pharmacy - select participating pharmacies contracted by Blue Shield to provide covered specialty drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of specialty drugs.

To select a specialty pharmacy, the Member may go to http://www.blueshieldca.com or call Member Services at 1-800-334-5847.

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

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

Participating Pharmacy - a pharmacy which participates in the Blue Shield Pharmacy Network. These participating pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members.

To select a participating pharmacy, the Member may go to http://www.blueshieldca.com or call Shield Concierge at 1-800-334-5847.

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain drugs at a participating pharmacy, the Member must present his Blue Shield identification card. Note: Except for covered emergencies, claims for drugs obtained without using the identification card will be denied.

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

> **Copayment: $30 per prescription for a 30-day supply.**

The Member is responsible for paying the applicable copayment for each covered prescription Drug at the time the Drug is obtained.

> **Copayment: You pay nothing for contraceptive drugs and devices*, $5 generic, $20 brand name, $50 Non-Formulary, 50% of the Blue Shield contracted rate for drugs for sexual dysfunction per prescription for the amount prescribed not to exceed a 30-day supply; after 3 months, the copayment for Maintenance drugs is $10 generic, $40 brand name, $100 Non-Formulary per prescription for each subsequent 30-day supply. Brand name when generic equivalent is available, $5 plus difference in cost between generic and brand name drug. (**The difference in cost that the Member must pay is not applied to the Calendar Year Out-of-Pocket Maximum**).**

* If a brand name contraceptive drug is requested when a generic drug equivalent is available, the Member will be responsible for the difference between the cost for the brand name contraceptive drug and its generic drug equivalent. In addition, select brand name contraceptives may require prior authorization to be covered without a copayment.

If the participating pharmacy contracted rate charged by the participating pharmacy is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate.

Prescription drugs administered in a physician's office, except immunizations, are covered by the $15 copayment for the office visit and do not require another copayment.

Some prescriptions are limited to a maximum allowable quantity based on medical necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.

Designated Specialty Drugs may be dispensed for a 15-day trial at a pro-rated Copayment or Coinsurance for an initial prescription, and with the Member's agreement. This Short Cycle Specialty Drug Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Specialty Drug before obtaining the complete 30-day supply, and therefore helps save the Member out-of-pocket expenses. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the Short Cycle Specialty Drug Program, which the Member can elect at that time. At any time, either the

Member, or Provider on behalf of the Member, may choose a full 30-day supply for the first fill.

If the Member has agreed to a 15-day trial, the Network Specialty Pharmacy will also contact the Member before dispensing the remaining 15-day supply to confirm if the Member is tolerating the Specialty Drug. To find a list of Specialty Drugs in the Short Cycle Specialty Drug Program, the Member may visit https://www.blueshieldca.com/bsca/pharmacy/home.sp or call the Shield Concierge-number on the Blue Shield Member ID card.

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

If the Member or physician requests a Brand Name Drug when a Generic Drug equivalent is available the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. The Member or prescribing provider may provide information supporting the medical necessity for using a brand name drug versus an available generic drug equivalent through the Blue Shield prior authorization process. See the section below on Prior Authorization Process for Select Formulary, Non-Formulary, and Specialty Drugs for information on the approval process. If the request is approved, the Member is responsible for paying the Non-Formulary brand name drug copayment.

You or your provider may request a reduced copayment for the Non-Formulary brand name medication through Blue Shield's prior authorization process by providing information supporting the medical necessity and faxing it to 1-888-697-8122. See the section below on Prior Authorization Process for Select Formulary, Non-Formulary, and Specialty Drugs for information on the approval process. If the request is approved, the reduced Non-Formulary brand name medication copayment will be $40 per 30-day prescription at a retail pharmacy, and you will be charged the reduced Non-Formulary brand name medication copayment for that specific Non-Formulary drug until the end of the calendar year. If you wish to continue to receive the reduced copayment at the end of the calendar year approval period, you will need to make a new request using the prior authorization process noted below. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the end of the calendar year. If your request is denied, your Non-Formulary copayment will apply. The reduced Non-Formulary brand name medication copayment does not apply to drugs for sexual dysfunction or brand name drugs with an available generic equivalent.

When Maintenance drugs have been prescribed for a chronic condition and the Member's medication dosage has been stabilized, the Member may obtain a 90-day supply of the drug through the Mail Service Prescription Drug Program or at SELECT retail pharmacies. See the section below on CalPERS Maintenance Drug Program for additional information. If the Member continues to obtain the drug from a participating pharmacy, the higher Maintenance drug copayment will apply for each subsequent 30-day supply. Note: This does not apply to Specialty Drugs, drugs which are not available through or cannot safely be obtained through the Mail Service Prescription Drug Program, or drugs obtained at SELECT retail pharmacies. This also does not apply to Maintenance drugs for which a lower copayment was approved pursuant to the paragraph above.

Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency. When drugs are obtained at a non-participating pharmacy for a covered emergency, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim form noting "Emergency Request" on the form to Blue Shield Pharmacy Services - Emergency Claims, P.O. Box 7168, San Francisco, CA 94120. The Member will be reimbursed the purchase price of covered prescription drug(s) minus any applicable copayment(s). Claim forms are available by contacting Member Services. Claims must be received within

1 year from the date of service to be considered for payment.

Extended Quantity of Maintenance Drugs at SELECT Retail Pharmacies

Members may obtain prescribed maintenance medications for up to a 90-day supply through Blue Shield's Mail Service Prescription Drug Program, or SELECT retail pharmacies. A list of SELECT retail pharmacies can be obtained by going to the Pharmacy Resources page at http://www.blueshieldca.com/calpers or by calling Shield Concierge at 1-800-334-5847.

> **Copayment: You pay nothing for contraceptive drugs and devices*, $10 generic, $40 brand name, $100 Non-Formulary per prescription not to exceed a 90-day supply. Brand name when generic equivalent is available, $10 plus difference in cost between generic and brand name drug. (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum). If the Member's provider 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.**

* If a brand name contraceptive drug is requested when a generic drug equivalent is available, the Member will be responsible for paying the difference between the cost for the brand name contraceptive drug and its generic drug equivalent. In addition, select brand name contraceptives may require prior authorization to be covered without a copayment.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

When Drugs have been prescribed for a chronic condition, a Member may obtain the drug through Blue Shield's Mail Service Prescription Drug Program by enrolling via phone, mail or online. The Member may continue to obtain the drug from a participating pharmacy; however, after 3 months, the higher Maintenance drug copayment will apply for each subsequent 30-day supply. The Member's provider must indicate a prescription quantity which is equal to the amount to be dispensed. Note: This does not apply to Specialty Drugs, nor to any other Drugs which are not available through or cannot safely be obtained through the Mail Service Prescription Drug Program.

The Member is responsible for paying the applicable copayment for each prescription Drug. Copayments will be tracked for the Member.

For more information about the Mail Service Prescription Drug Program or to determine applicable cost share, Members may visit www.blueshieldca.com/bsca/pharmacy/home.sp or call the Shield Concierge number on your Blue Shield member ID card.

> **Copayment: You pay nothing for contraceptive drugs and devices*, $10 generic, $40 brand name, $100 Non-Formulary per prescription not to exceed a 90-day supply; $1,000 out-of-pocket annual mail service maximum, then no charge for Formulary drugs at mail service (Copays for Non-Formulary drugs and drugs for sexual dysfunction do not accrue to the $1,000 out-of-pocket maximum at mail service). Brand name when generic equivalent is available, $10 plus difference in cost between generic and brand name drug. (The difference in cost does not accrue towards the Member calendar year out-of-pocket maximum or the $1,000 mail service out of pocket maximum). If the Member's provider 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.**

* If a brand name contraceptive drug is requested when a generic drug equivalent is available, the Member will be responsible for paying the difference between the cost for the brand name contraceptive drug and its generic drug equivalent. In addition, select brand name contraceptives may require prior authorization to be covered without a copayment.

If the participating pharmacy contracted rate is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate.

If the Member or physician requests a Mail service Brand Name Drug when a mail service Generic Drug equivalent is available the Member is responsible for paying the difference between the contracted rate for the mail service Brand Name Drug and its mail service Generic Drug equivalent, as well as the applicable mail service Generic Drug Copayment.

The Member or prescribing provider may provide information supporting the medical necessity for using a mail service brand name drug versus an available mail service generic drug equivalent through the Blue Shield prior authorization process. See the section below on Prior Authorization Process for Select Formulary, Non-Formulary, and Specialty Drugs for information on the approval process. If the request is approved, the Member is responsible for paying the applicable mail service brand name drug copayment.

You or your provider may request a reduced copayment for the Non-Formulary brand name medication through Blue Shield's prior authorization process by providing information supporting the medical necessity and faxing it to 1-888-697-8122. See the section below on Prior Authorization Process for Select Formulary, Non-Formulary, and Specialty Drugs for information on the approval process. If the request is approved, the reduced Non-Formulary brand name medication copayment will be $70 for up to a 90-day supply prescription at the mail service pharmacy, and you will be charged the reduced Non-Formulary brand name medication copayment for that specific Non-Formulary drug until the end of the calendar year. If you wish to continue to receive the reduced copayment at the end of the calendar year approval period, you will need to make a new request using the prior authorization process noted below. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the end of the calendar year. If your request is denied, your Non-Formulary copayment will apply. The reduced Non-Formulary brand name medication copayment does not apply to drugs for sexual dysfunction or brand name drugs with an available generic equivalent.

For information about the Mail Service Prescription Drug Program, the Member may visit www.blueshieldca.com/bsca/pharmacy/home.sp. or call Shield Concierge at 1-800-334-5847. The TTY telephone number is 1-866-346-7197.

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

Select Formulary drugs, as well as most specialty drugs may require prior authorization for medical necessity. Select contraceptives may require prior authorization for medical necessity in order to be covered without a copayment. Select Non-Formulary drugs may require prior authorization for medical necessity, and to determine if lower cost alternatives are available and just as effective. Compounded drugs are covered only if the requirements listed under the Exclusion section of this Supplement are met. If a compounded medication is approved for coverage, the Non-Formulary Brand Name Drug Copayment applies. You or your physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug

To request coverage for a Non-Formulary Drug, the Member, representative, or the Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72

hours in routine circumstances or 24 hours in exigent circumstances.

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

Exclusions
No benefits are provided under the Prescription Drugs benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of this Evidence of Coverage – you should refer to the applicable section to determine if drugs are covered under that benefit):

1. Drugs obtained from a non-participating pharmacy, except for a covered emergency, and drugs obtained outside of California which are related to an urgently needed service and for which a participating pharmacy was not reasonably accessible;

2. Any drug provided or administered while the Member is an inpatient, or in a provider's office, skilled nursing facility, or outpatient facility (see A. Hospital Services and B. Physician Services);

3. Take home drugs received from a hospital, skilled nursing facility, or similar facility (see A. Hospital Services and N. Skilled Nursing Facility Services);

4. Drugs except as specifically listed as covered under this Section P., 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;

5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;

6. Drugs that are considered to be experimental or investigational;

7. Medical devices or supplies, except as specifically listed as covered herein (see E. Durable Medical Equipment, Prostheses and Orthoses and Other Services). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;

8. Blood or blood products (see A. Hospital Services);

9. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;

10. Dietary or nutritional products (see K. Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy);

11. Any drugs which are not self-administered that are administered by a healthcare professional. These medications may be covered under Y. Additional Services;

12. Appetite suppressants or drugs for body weight reduction except when medically necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;

13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) require a Physi-

cian's prescription, (3) are generally purchased at an outpatient pharmacy, and (4) are self-administered;

14. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined under this Section P., (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered and, (4) it is being prescribed for an FDA-approved indication;

15. Replacement of lost, stolen or destroyed prescription drugs;

16. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

17. Drugs packaged in convenience kits that include non-prescription convenience items, unless the drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma drugs.

18. All Drugs for the treatment of infertility except as may be noted in Section G. Family Planning and Infertility Services in this booklet.

19. Drugs that are reasonable and necessary for the palliation and management of terminal illness and related conditions if they are provided to a Member enrolled in a Hospice Program through a Participating Hospice Agency;

20. Drugs obtained from a pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered emergency;

21. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

22. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;

23. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Call Shield Concierge at 1-800-334-5847 for further information.

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

Q. Inpatient Mental Health and Substance Use Disorder Services

Blue Shield of California's MHSA administers Mental Health Services and Substance Use Disorder Services for Blue Shield Members within California. These services are provided through a unique network of MHSA Participating Providers. All non-emergency mental health and substance use disorder services, including Residential Care, must be prior authorized by the MHSA. For prior authorization for mental health and substance use disorder services, Members should contact the MHSA at 1-866-505-3409.

All non-emergency mental health and substance use disorder services must be obtained from MHSA Participating Providers. (See the How to Use the Plan section, the Mental Health and Substance Use Disorder Services paragraphs for more information.)

Benefits are provided for the following medically necessary covered mental health conditions and substance use disorder conditions, subject to applicable copayments and charges in excess of any benefit maximums. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the benefit description below, and to the Exclusions and Limitations set forth in this booklet.

Benefits are provided for inpatient hospital and professional services in connection with hospitalization for the treatment of mental health conditions and substance use disorder conditions.

Benefits are provided for inpatient and professional services in connection with Residential care admission for the treatment of mental health conditions and substance use disorder conditions. All non-emergency mental health and substance use disorder services must be prior authorized by the MHSA and obtained from MHSA Participating Providers.

See Section A. for information on medically necessary inpatient substance use disorder detoxification.

Copayment: No charge.

R. Outpatient Mental Health and Substance Use Disorder Services

1. Benefits are provided for outpatient facility and office visits for mental health conditions and substance use disorder conditions.

   Copayment: $15 per visit.

2. Benefits are provided for hospital and professional services in connection with partial hospitalization for the treatment of mental health conditions and substance use disorder conditions.

   Copayment: No charge.

3. Psychosocial Support through LifeReferrals 24/7

   See the Mental Health and Substance Use Disorder Services paragraphs under the How to Use the Plan section for information on psychosocial support services.

   Copayment: No charge.

4. Behavioral Health Treatment (BHT)

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

   Behavioral health treatment is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by the MHSA. Treatment must be obtained from MHSA Participating Providers. Behavioral health treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

   Copayment: $15 per office visit. No charge for therapy provided in the home or other non-institutional setting.

5. Transcranial Magnetic Stimulation

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

S. Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones

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

1. The treatment of tumors of the gums;

2. The treatment of damage to natural teeth caused solely by an accidental injury is limited to medically necessary services until the services result in initial, palliative stabilization of the Member as determined by the Plan;

   Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental (e.g., resulting from chewing or biting).

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

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

5. Medically necessary treatment of maxilla and mandible (jaw joints and jaw bones);

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

7. Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate repair.

Copayment: See applicable copayments for Physician Services and Hospital Services.

This benefit does not include:

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

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of reconstructive surgery for cleft palate repair), including treatment to alleviate TMJ;

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

4. Dental implants (endosteal, subperiosteal or transosteal);

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 the Exclusions and Limitations section for additional services that are not covered.

T. Special Transplant Benefits

Benefits are provided for certain procedures listed below only if: (1) performed at a Transplant Network Facility approved by Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from the Blue Shield Corporate Medical Director, and (3) the recipient of the transplant is a Member.

The Blue Shield Corporate Medical Director shall review all requests for prior authorization and shall approve or deny benefits, based on the medical circumstances of the patient, and in accordance with established Blue Shield medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Blue Shield approved Transplant Network Facility will result in denial of claims for this benefit.

Pre-transplant evaluation and diagnostic tests, transplantation and follow-ups will be allowed only at a Blue Shield approved Transplant Network Facility. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than a Blue Shield Transplant Network Facility will not be approved. Evaluation of potential candidates at a Blue Shield Transplant Network Facility is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or more than one Transplant Network Facility will not be authorized unless the medical necessity of repeating the service is documented and approved. For information on Blue Shield of California's approved Transplant Network, call 1-800-334-5847.

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 (kidney only transplants are covered under Section U.);

6. Human bone marrow transplants, including autologous bone marrow transplantation 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.

Reasonable charges for services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Copayment: Physician Services and Hospital Services copayments apply.

U. Organ Transplant Benefits

Hospital and professional services provided in connection with human organ transplants are a benefit to the extent that they are provided in connection with the transplant of a cornea, kidney, or skin, and the recipient of such transplant is a Member.

Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered.

Copayment: Physician Services and Hospital Services copayments apply.

V. Diabetes Care

1. Diabetic Equipment

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

   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 and/or video-assisted devices, designed to assist the visually impaired with proper dosing of insulin;

   e. for coverage of diabetic testing supplies including blood and urine testing strips and test tablets, generic glucose (blood) test strips, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, see Section P.

   Copayment: No charge.

2. Diabetes Self-Management Training

   Diabetes outpatient self-management training, education and medical nutrition therapy that is medically necessary to enable a Member to properly use the diabetes-related devices and equipment and any additional treatment for these services if directed or prescribed by the Member's Personal Physician and authorized. 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.

   Copayment: $15 per visit.

W. Reconstructive Surgery

Medically necessary services in connection with reconstructive surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when reconstructive surgery offers more than a minimal improvement in appearance (including congenital

anomalies) are covered. In accordance with the Women's Health & Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and reconstructive surgery on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas, are covered. Surgery must be authorized as described herein. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for reconstructive surgery:

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

2. Surgery to reform or reshape skin or bone;

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

4. Hair transplantation; and

5. Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

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

Copayment: Physician Services and Hospital Services copayments apply.

X. Clinical Trials for Treatment of Cancer or Life Threatening Conditions

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

1. The clinical trial has a therapeutic intent and the Personal Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and

2. The hospital and/or physician conducting the clinical trial is a Plan provider, unless the protocol for the trial is not available through a Plan provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other covered services.

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

1. The investigational item, device, or service, itself;

2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;

5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or

treatment of cancer and other life-threatening condition, and is limited to a trial that is:

1. federally funded and approved by one or more of the following:

   a. one of the National Institutes of Health;

   b. the Centers for Disease Control and Prevention;

   c. the Agency for Health Care Research and Quality;

   d. the Centers for Medicare & Medicaid Services;

   e. a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;

   f. qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

   g. the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

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

Copayment: Physician Services and Hospital Services copayments apply.

Y. Additional Services

1. Personal Health Management Program

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

   Copayment: No charge.

2. Medications Administered by a Healthcare Professional

   Medications approved by the FDA and that require administration by a healthcare professional are covered for the medically necessary treatment of medical conditions when prescribed or authorized by the Personal Physician or as described herein. See Section P. outpatient prescription drug coverage for self-administered drugs.

   Copayment: No charge.

3. Away From Home Care® Program

   The Blue Shield Access+ HMO offers to CalPERS members who are long-term travelers, students and families living apart, Away From Home Care (AFHC).

   AFHC offers full HMO benefits with a local ID card. Membership eligibility is applicable to spouses, domestic partners and dependents who are away from home for at least 90 days, or to members who are away from home for at least 90 days but not more than 180 days. There is no additional charge to the member. AFHC is coordinated by calling 1-800-334-5847.

   AFHC also offers a special short-term service which is available to members requiring specific follow-up treatment. This option is particularly beneficial for members who will be out-of-state on a short-term basis but require special treatment.

4. Hearing Aid Services

   a. Audiological Evaluation. To measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

      Copayment: No charge. Evaluation is in addition to the $1,000 maximum allowed every 36 months for both ears for the hearing aid and ancillary equipment.

   b. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid.

      Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months. Also excludes surgically implanted hearing devices. Cochlear implants are not considered surgically implanted hearing devices and are covered as a prosthetic under Section E.

      Limitations: Up to maximum of $1,000 per Member every 36 months for both ears for the hearing aid instrument, and ancillary equipment.

   To receive these services, you may either contact your Personal Physician to obtain a referral or self-refer to an Access+ Specialist as described in the How to Use the Plan section.

4. Smoking Cessation

   Members who participate and complete a smoking cessation class or program will be reimbursed up to $100 per class or program per calendar year. Members may contact their medical group or IPA for information about these classes and programs. If you have a question about the smoking cessation benefit, you should call Blue Shield Member Services at 1-800-334-5847.

5. Teladoc

   Your Plan includes a service, Teladoc, that provides you confidential consultations using a net-work of board certified physicians who are available to assist you 7 days a week either over the telephone, 24 hours a day or over secure video, between 7 a.m. and 9 p.m. Teladoc is not meant to replace your Personal Physician but is meant to serve as a supplemental service. You do not need to contact your Personal Physician before using the Teladoc service.

   Before this service can be accessed, you must complete a Medical History Disclosure (MHD) form. The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc.

   If your Personal Physician's office is closed or you need quick access to a physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc. The Teladoc physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

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

   Teladoc service is not available for mental health and substance use disorder services consultations.

Copayment: $5 per consultation. If medications are prescribed, the applicable prescription drug copayments apply.

6. Acupuncture Benefits

   Benefits are provided for routine acupuncture Services up to the maximum visits per Calendar Year as shown below for acupuncture care when received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. Services provided by Non-Participating Providers will not be covered except for Emergency Services.

   Copayment: $15 per visit. Covered up to a combined Benefit maximum of 20 visits with Chiropractic Care covered services.

7. Chiropractic Care

   Manipulation of the spine to correct a subluxation, when provided by an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. Benefits are provided up to the maximum visits per Calendar Year as shown below. Services provided by Non-Participating Providers will not be covered except for Emergency Services.

   Copayment: $15 per visit. Covered up to a combined Benefit maximum of 20 visits with Acupuncture Benefits covered services. Chiropractic appliances are limited to $50 per Calendar Year.

8. Biofeedback

   Biofeedback therapy is covered only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

   Copayment: $15 per visit in a medical office setting; $20 per mental health visit.

9. Blood and Blood Products

   Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood.

   Copayment: No charge

Member Calendar Year Out-of-Pocket Maximum

The Member calendar year out-of-pocket maximum responsibility for covered services excluding those specified, is listed in the Summary of Covered Services. (Also, see the Member Calendar Year Out-of-Pocket Maximum paragraphs under How to Use the Plan.)

Note that copayments and charges for services not accruing to the Member calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached.

Exclusions and Limitations

General Exclusions and Limitations

Unless exceptions to the following exclusions are specifically made elsewhere in the Agreement, no benefits are provided for services which are:

1. **Behavioral Problems.** For learning disabilities, behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for a severe mental illness or a serious emotional disturbance of a child;

2. **Cosmetic Surgery.** For cosmetic surgery, or any resulting complications, except medically necessary services to treat complications of cosmetic surgery (e.g., infections or hemor-

rhages) will be a benefit, but only upon review and approval by a Blue Shield physician consultant.

3. **Custodial or Domiciliary Care.** For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance, domiciliary care or residential care, except as provided under O.; or rest;

4. **Dental Care, Dental Appliances.** 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 S.; for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic, and other services such as dental cleaning, tooth whitening, x-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under A. and S.;

5. **Experimental or Investigational Procedures.** Experimental or investigational medicine, surgery or other experimental or investigational health care procedures as defined, except for services for Members who have been accepted into an approved clinical trial for cancer as provided under X.;

   See section entitled "External Independent Medical Review Involving a Disputed Health Care Service" for information concerning the availability of a review of services denied under this exclusion.

6. **Eye Surgery.** For surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, contact lenses, except as provided under E., and video-assisted visual aids or video magnification equipment for any purpose;

7. **Foot Care.** For routine foot care, including 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, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot; special footwear (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically provided under E. and V.;

8. **Genetic Testing.** For genetic testing except as described under D. and F.;

9. **Home Monitoring Equipment.** For home testing devices and monitoring equipment, except as specifically provided under E.;

10. **Infertility Reversal.** For or incident to the treatment of infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for medically necessary treatment of medical complications;

11. **Infertility Services.** For any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, ovum transplants, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT) procedure or any other form of induced fertilization (except for artificial insemination), services or medications to treat low sperm count or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield of California health plan;

12. **Limited or Excluded Services.** Benefits for services limited or excluded in your HMO health service plan; however, drugs customarily provided by dentists and oral surgeons, or customarily provided for nervous or mental disorders, or incident to pregnancy, or customarily provided for substance use disorder, or incident to physical therapy are not excluded;

13. **Massage Therapy.** For massage therapy performed by a massage therapist;

14. **Member Not Legally Obligated to Pay.** Services for which the Member is not legally obligated to pay;

15. **Mental Health.** For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a mental health condition;

16. **Miscellaneous Equipment.** For orthopedic shoes except for therapeutic footwear for diabetics and except as provided under V., environmental control equipment, generators, exercise equipment, self-help/ educational devices, vitamins, any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistance devices, except as provided under E. and comfort items;

17. **Nutritional and Food Supplements.** For prescription or non-prescription nutritional and food supplements except as provided under K., and except as provided through a hospice agency;

18. **Organ Transplants.** Incident to an organ transplant, except as provided under T. and U.;

19. **Over-the-Counter Medical Equipment or Supplies.** For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, and bath chairs, that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under E., K., O. and V.;

20. **Over-the-Counter Medications.** For over-the-counter medications not requiring a prescription, except as specified under Section P;

21. **Pain Management.** 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;

22. **Personal Comfort Items.** Convenience items such as telephones, TVs, guest trays, and personal hygiene items;

23. **Physical Examinations.** For physical exams required for licensure, employment, or insurance unless the examination corresponds to the schedule of routine physical examinations provided under C.;

24. **Prescription Orders.** Prescription orders or refills which exceed the amount specified in the prescription, or prescription orders or refills dispensed more than a year from the date of the original prescription.

25. **Private Duty Nursing.** In connection with private duty nursing, except as provided under A., K. and O.;

26. **Reading/Vocational Therapy.** For or incident to reading therapy; vocational, educational, recreational, art, dance or music therapy; weight control or exercise programs; nutritional counseling except as specifically provided for under V. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for a severe mental illness or a serious emotional disturbance of a child;

27. **Reconstructive Surgery.** For reconstructive surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins).

In addition, no benefits will be provided for the following surgeries or procedures unless for reconstructive surgery:

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

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

28. **Services by Close Relatives.** Services performed by a close relative or by a person who ordinarily resides in the Member's home;

29. **Sexual Dysfunctions.** For or incident to sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

30. **Speech Therapy.** 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 provided under K., M. and O.;

31. **Spinal Manipulation.** For spinal manipulation or adjustment;

32. **Therapeutic Devices.** Devices or apparatuses, regardless of therapeutic effect (e.g., hypodermic needles and syringes, except as needed for insulin and covered injectable medication), support garments and similar items;

33. **Transportation Services.** For transportation services other than provided for under H.;

34. **Unapproved Drugs/Medicines.** Drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (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;

35. **Unauthorized Non-Emergency Services.** For unauthorized non-emergency services;

36. **Unauthorized Treatment.** Not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or a family practice physician within the same medical group or IPA as the Personal Physician, emergency services or urgent services as provided under the Agreement provisions, when specific authorization has been obtained in writing for such services as described herein, for mental health and substance use disorder services which must be arranged through the MHSA or for hospice services received by a participating hospice agency;

37. **Unlicensed Services.** For services provided by an individual or entity that is not licensed, certified, or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification, or state authorization, except as specifically stated herein;

38. **Workers' Compensation/Work-Related Injury.** For or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits

up to the reasonable cash value of benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges;

39. **Not Specifically Listed as a Benefit.**

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

Medical Necessity Exclusion

All services must be medically necessary. The fact that 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 may limit or exclude benefits for services which are not medically necessary.

Limitations for Duplicate Coverage

In the event that you are covered under the 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 to the Member for the treatment of any one illness or injury shall 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 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 18 of the Social Security Act ("Medicare"). If a Member receives services to which the Member is entitled under Medicare and those services are also covered under this Plan, the Plan provider may recover the amount paid for the services under Medicare. This provision does not apply to Medicare Part D (outpatient prescription drug) benefits. This limitation for Medicare does not apply when the employer is subject to the Medicare Secondary Payor Laws and the employer maintains:

   a. an employer group health plan that covers

      1) persons entitled to Medicare solely because of end-stage renal disease, and

      2) 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 Payor laws that covers persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to a Member who becomes eligible for Medicare on the date that the Member received notice of his eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision, except that this exclusion does not apply to Medi-Cal; or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the 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

A Plan provider may seek reimbursement from other third party payors for the balance of its reasonable charges for services rendered under this Plan.

Claims and Services Review

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

General Provisions

Members Rights and Responsibilities

You, as a Blue Shield Access+ HMO Plan Member, 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 Access+ HMO Health Plan, the services we offer you, the physicians and other practitioners available to care for you;

5. Select a Personal Physician and expect his/her team of health workers to provide or arrange for all the care that you need;

6. Have reasonable access to appropriate medical services;

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

8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;

9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment;

10. Receive preventive health services;

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

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

13. Communicate with and receive information from Member Services in a language you can understand;

14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available;

15. Obtain a referral from your Personal Physician for a second opinion;

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

17. Voice complaints about the Access+ HMO Health Plan or the care provided to you;

18. Participate in establishing public policy of the Blue Shield Access+ HMO, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.

19. Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

You, as a Blue Shield Access+ HMO Plan Member, have the responsibility to:

1. Carefully read all Blue Shield Access+ HMO 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 Access+ HMO membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement;

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

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

4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.

5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;

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

7. Make and keep medical appointments and inform the Plan physician ahead of time when you must cancel;

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

9. Offer suggestions to improve the Blue Shield Access+ HMO Plan;

10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;

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

12. Select a Personal Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection;

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

14. Pay your dues, copayments and charges for non-covered services on time;

15. For all mental health and substance use disorder services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all non-emergency mental health and substance use disorder services.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy for 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 patients who rely on the plan's facilities to provide health care services to them, their families, and the public (Health & Safety Code Section 1369).

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

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

Please follow these procedures:

- 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;
- Your name, address, phone number, subscriber number and group number should be included with each communication;
- 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;
- 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 Medical Records and Personal Health Information

Blue Shield of California protects the confidentiality/privacy of your personal 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 Member Services Department at the number listed on the back cover of this booklet, or by accessing Blue Shield of California's internet site located at http://www.blueshieldca.com and printing a copy.

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

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

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Agreement. 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.

Non-Assignability

Benefits of this Plan are not assignable.

Facilities

The Plan has established a network of physicians, hospitals, participating hospice agencies and non-physician health care practitioners in your service area.

The Personal Physician(s) you and your dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of medically necessary care. The hospitals in the Plan network provide access to 24-hour emergency services. The list of the hospitals, physicians and participating hospice agencies in your service area indicates the location and phone numbers of these providers. Contact Member Services at the number listed on the back cover of this booklet for information on Plan non-physician health care practitioners in your Personal Physician Service Area.

For urgent services when you are within the United States, you simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, 7 days a week. For urgent services when you are outside the United States, you can call collect 1-804-673-1177 24 hours a day. We will identify the BlueCard Program participating provider closest to you. Urgent services when you are outside the United States are available through the BlueCard Worldwide Network. For urgent services when you are within California, but outside of your Personal Physician Service Area, you should contact Blue Shield Member Services in accordance with the How to Use the Plan section. For urgent care services when you are within your Personal Physician Service Area, contact your Personal Physician or follow instructions provided by your assigned medical group or IPA.

Independent Contractors

Plan providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield of California conducts a process of credentialling and certification of all physicians who participate in the Access+ HMO network. However, 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.

Access+ Satisfaction

You may provide Blue Shield with feedback regarding the service you receive from Plan physicians. If you are dissatisfied with the service provided during an office visit with a Plan physician, you may contact Member Services to request a refund of your office visit copayment, as shown in the Summary of Covered Services under Physician Services.

Web Site

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

Utilization Review Process

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

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

To request a copy of the document describing this Utilization Review, call the Member Services Department at 1-800-334-5847.

Grievance Process

You, an authorized representative (Member), or a provider on behalf of the Member, may request a grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD), and must be submitted in one of the following ways:

- Call Customer Service at 1-800-334-5847; or
- Fill out a Member Grievance Form on the website at http://www.blueshieldca.com; or
- In writing by sending information to:
  Blue Shield of California
  Appeals and Grievance Department
  P.O. Box 272520
  Chico, CA 95927-2520

The grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the Blue Shield of California Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the Service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale.

If your grievance involves Mental Health or Substance Abuse Services call the MHSA at 1-877-263-9952, or write to:

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

The Member may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

For all grievances except denial of coverage for a Non-Formulary Drug:

Blue Shield will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Customer Service at 1-800-334-5847.

If Blue Shield upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to the Member:

- For FABDs involving medical judgment, the member may pursue the Independent External Review process described below;
- For FABDs involving benefit, the Member may pursue the CalPERS Administrative Review process as described in the CalPERS Administrative Review section.

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Blue Shield determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; OR
- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; OR
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If Blue Shield determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR, at 1-888-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

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

Experimental or Investigational Denials

Blue Shield does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Blue Shield denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of Blue Shield's decision from the DMHC. **Note**: DMHC does not require you to exhaust Blue Shield's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by calling us at 1-800-334-5847 or write to us at Blue Shield of California, P.O. Box 272520, Chico, CA 95927-2520. To qualify for this review, all of the following conditions must be met:

You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:

- A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
- A seriously debilitating condition or disease is one that causes major irreversible morbidity.

Your medical group/physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this plan that is more beneficial than the proposed treatment.

The proposed treatment must either be:

- Recommended by a/an Blue Shield provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
- Requested by you or by a licensed board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:
  - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
  - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  - Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;
  - Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;
  - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your doctor. Any newly developed or discovered relevant medical records that we or an Blue Shield provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your doctor determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Independent Medical Review Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your Blue Shield Plan have been improperly denied, modified or delayed, in whole or in part, by Blue Shield or one of its providers because the service is deemed not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.

You have the right to provide information in support of the request for an IMR. Blue Shield must provide you with an IMR application form and Blue Shield's FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Blue Shield regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have had urgent care or emergency services that a provider determined was medically necessary, or
   (c) You have been seen by an Blue Shield provider for the diagnosis or treatment of the medical condition for which you want an IMR;
2. The disputed health care service has been denied, changed, or delayed by us or your medical group, based in whole or in part on a decision that the health care service is deemed not medically necessary; and
3. You have filed a complaint with us or your medical group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review

Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of Blue Shield. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor Blue Shield will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds Blue Shield's FABD, you may have additional review rights under the CalPERS Administrative Review section.

For more information regarding the IMR process or to request an application form, please call Customer Service at 1-800-334-5847.

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 toll free at **1-800-334-5847** (TTY users call 1-800-241-1823) 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 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 enrollment for you or your dependents and you feel that such action was due to health or utilization of benefits, you or your dependents may request a review by the Department of Managed Health Care Director.

Upon receipt of a denial of coverage from Blue Shield, the following option is available to the Member:

If you have a benefit coverage dispute, dissatisfied with the outcome of the grievance process, or your grievance has been denied based on medical necessity, in whole or in part, you may request review by the Department of Managed Health Care as described in the section *External Independent Medical Review*.

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 in the Member Services Department section 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 Member Services. 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. In addition, you have 6 months from the date you receive a written denial from Blue Shield or a contracting provider that your claim or services was denied to request an external review from the Department of Managed Health Care. For more information regarding the external review process, or to request an application form, please contact Member Services.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, Grievance Procedures, Experimental or Investigational Denials, Independent Medical Review Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. **Eligibility Issues**

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account Services Section
Attn: Enrollment Administration P.O. Box 942714
Sacramento, CA 94229-2714

888 CalPERS (or 888-225-7377) CalPERS Customer Service and Outreach Division toll free telephone number

1-916-795-1277 fax number

2. **Coverage Issues**

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care service.

If you are dissatisfied with the outcome of Blue Shield's internal appeal process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care, proceed to court or Small Claims Court, if your coverage dispute is within the jurisdictional limits of Small Claims Court, or request an Administrative Review by CalPERS. You may not request a CalPERS Administrative Review if you decide to proceed to court or Small Claims Court.

3. **Malpractice and Bad Faith**

You must proceed directly to court.

4. **Disputed Health Care Service Issue**

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or Experimental or Investigational.

If you are dissatisfied with the outcome of Blue Shield's internal grievance process or if you

have been in the process for 30 days or more, you may request an IMR from the Department of Managed Health Care.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to court. If you choose to proceed to court, you may not request a CalPERS Administrative Review.

If the Department of Managed Health Care or External Independent review upholds Blue Shield's denial, you have additional review rights under the *CalPERS Administrative Review and Hearing Process* section.

CalPERS Administrative Review

If you remain dissatisfied with Blue Shield's determination, the DMHC's determination or the IMR's determination, the Member may request an Administrative Review. The Member must exhaust Blue Shield's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC FABD or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

The Member is encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. If the Member would like to designate an Authorized Representative to represent him/her in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. The Member must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding a Member's request for Administrative Review. The ARHI form will be provided to the Member with the FABD letter from Blue Shield. If the Member has additional medical records from Providers or scientific studies that the Member believes are relevant to CalPERS review, those records should be included with the written request. The Member should send copies of documents, not originals, as CalPERS will retain the documents for its files. The Member is responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 30 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) calendar days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if the Member requests an IMR at the same time the Member submits a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

Administrative Hearing

The Member must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

The Member must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); the Member may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to the Member within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If the Member is still dissatisfied with the Board's decision, the Member may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** The Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, the Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, the Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

Alternate Arrangements

Blue Shield will make a reasonable effort to secure alternate arrangements for the provision of care by another Plan provider without additional expense to you in the event a Plan provider's contract is terminated, or a Plan provider is unable or unwilling to provide care to you.

If such alternate arrangements are not made available, or are not deemed satisfactory to the Board, then Blue Shield will provide all services and/or benefits of the Agreement to you on a fee-for-service basis (less any applicable copayments), and the limitation contained herein with respect to use of a Plan provider shall be of no force or effect.

Such fee-for-service arrangements shall continue until any affected treatment plan has been completed or until such time as you agree to obtain services from another Plan provider, your enrollment is terminated, or your enrollment is transferred to another plan administered by the Board, whichever occurs first. In no case, however, will such fee-for-service arrangements continue beyond the term of the Plan, unless the Extension of Benefits provision applies to you.

Termination of Group Membership - Continuation of Coverage

Termination of Benefits

Coverage for you or your dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the group Agreement is discontinued, (2) the last day of the month in which the subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your employer, (3) the end of the period for which the premium is paid, or (4) the last day of the month in which 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.

Except as specifically provided under the Extension of Benefits and COBRA provisions, there is no right to receive benefits for services provided following termination of this group Agreement.

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 COBRA and/or Cal-COBRA provisions described in this booklet for information on continuation of coverage.

If the subscriber no longer lives or works in the Plan service area, coverage will be terminated for him and all his dependents. If a dependent no longer lives or works in the Plan service area, then that dependent's coverage will be terminated. (Special arrangements may be available for dependents who are full-time students, dependents of subscribers who are required by court order to provide coverage, and dependents and subscribers who are long-term travelers. Please contact the Member Services Department to request a brochure which explains these arrangements including how long coverage is available. This brochure is also available at http://www.blueshieldca.com for HMO Members.)

In the event any Member believes that his or her benefits under this Agreement have been terminated because of his or her health status or health requirements, the Member may seek from the Department of Managed Health Care, review of the termination as provided in California Health & Safety Code Section 1365(b).

Reinstatement

If you cancel or your coverage is terminated, refer to the CalPERS "Health Program Guide."

Cancellation

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Extension of Benefits and COBRA provisions in this booklet.

The group Agreement also may be cancelled by CalPERS at any time provided written notice is given to Blue Shield to become effective upon receipt, or on a later date as may be specified on the notice.

Extension of Benefits

If a person becomes totally disabled while validly covered under this Plan and continues to be totally disabled on the date group coverage terminates, Blue Shield 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) the date the covered person is no longer totally disabled, (2) 12 months from the date group coverage terminated, (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 without limitation as to the totally disabling condition.

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

COBRA and/or Cal-COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

COBRA

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled family member who lose their regular group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her family member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months. The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

1. The covered employee's separation from employment for reasons other than gross misconduct.

2. Reduction in the covered employee's hours to less than half-time.

Four "qualifying events" allow an active or retired employee's enrolled family member(s) to elect the continuation coverage for up to 36 months. Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer 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.

1. The employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS).

2. Divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.

3. A dependent child ceases to be a dependent child.

4. The primary COBRA subscriber becomes entitled to Medicare.

If elected, COBRA continuation coverage is effective on the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the specified time, or until one of the following events terminates the coverage:

1. The termination of all employer provided group health plans, or

2. The enrollee fails to pay the required premium(s) on a timely basis, or

3. The enrollee becomes covered by another health plan without limitations as to pre-existing conditions, or

4. The enrollee becomes eligible for Medicare benefits, or

5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.

You will receive notice from your employer of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact your (former) employing agency or CalPERS directly if you need more information about your eligibility for COBRA group continuation coverage.

Cal-COBRA

COBRA enrollees who became eligible for COBRA coverage on or after January 1, 2003, and who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

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

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

Monthly rates for Cal-COBRA coverage shall be 102% of the applicable group monthly rates.

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

Blue Shield of California 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.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for medical disability.

Payment by Third Parties

Third Party Recovery Process and the Member's Responsibility

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

This right to restitution, reimbursement or other available remedy is against any recovery the

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

The Member is required to:

1. Notify Blue Shield, the Member's designated medical group, or the IPA in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and

3. Agree in writing to reimburse Blue Shield for benefits paid by Blue Shield from any recovery when the recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and

4. Provide a lien 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; and

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and the Member's designated medical group or IPA, in writing, within 10 days after any recovery has been obtained.

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

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

Workers' Compensation

No benefits are provided for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.

However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges.

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 value or 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 value or amount payable by each plan separately.

If the covered person is also entitled to benefits under any of the conditions as outlined under the Limitations for Duplicate Coverage provision, benefits received under any such condition will not be coordinated with the benefits of this Plan. The following rules determine the order of benefit payments:

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

Except for cases of claims for a dependent child whose parents are separated or divorced, the plan which covers the dependent child of a person whose date of birth (excluding year of birth) occurs earlier in a calendar year, shall determine its benefits before a plan which covers the dependent child 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 shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall 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 shall 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. Notwithstanding 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 the parent with that financial responsibility shall 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 patient for the longer period of time shall determine its benefits first, provided that:

   a. A plan covering a patient as a laid-off or retired employee, or as a dependent of such an employee, shall 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 the provisions of a. above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its benefits without reduction because of benefits available from any other plan.

When this Plan is secondary in the order of payments, and Blue Shield 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 provide the benefits that would be due as if it were the primary plan, provided that the covered person: (1) assigns to Blue Shield the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Blue Shield actually provides and the value of the benefits that Blue Shield would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield in obtaining payment of benefits from the other plan, and (3) allows Blue Shield 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.

Definitions

Access+ Provider - a medical group or IPA, and all associated physicians and Plan Specialists, that participate in the Access+ HMO Plan and for mental health and substance use disorder services, a MHSA Participating Provider.

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

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

Adverse Benefit Determination (ABD) - a decision by Blue Shield to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Blue Shield plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Agreement - see Group Health Service Agreement.

Allowed Charges - the amount a Plan provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan providers (except that physicians rendering emergency services and hospitals rendering any services who are not Plan providers will be paid based on the reasonable and customary charge, as defined).

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an adverse benefit determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Authorized Representative - means an individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Blue Shield.

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

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

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Close Relative - the spouse, domestic partner, child, brother, sister or parent of a Member.

Copayment - the amount that a Member is required to pay for specific covered services.

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

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

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 or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self care or supervisory care by a physician); or care furnished to a Member who is mentally or physically disabled, and

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

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Dental Care and Services - services or treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth or gums.

Disputed Health Care Service - any Health Care Service eligible for coverage and payment under your Blue Shield Plan that has been denied, modified or delayed by Blue Shield or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

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 Member by the contractholder.

Durable Medical Equipment - equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable medical equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are durable medical equipment.

Emergency Services - services for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a layperson who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following:

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

2. serious impairment to bodily functions; or,

3. serious dysfunction of any bodily organ or part.

Employer (Contractholder) - means any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least two 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 the purposes of buying health care coverage or insurance.

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.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Group Health Service Agreement (Agreement) - the Agreement issued by the Plan to the contractholder that establishes the services Members are entitled to from the Plan.

Hemophilia Infusion Provider - a provider who has an agreement with Blue Shield to provide hemophilia therapy products and necessary supplies and services for covered home infusion and home intravenous injections by Members.

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 - either 1., 2. or 3. below:

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

2. a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or,

3. a "psychiatric health facility" as defined in Section 1250.2 of the Health & Safety Code.

Independent Practice Association (IPA) - a group of physicians with individual offices who form an organization in order to contract, manage and share financial responsibilities for providing benefits to Members. For mental health and substance use disorder services, this definition includes the MHSA.

Infertility - the Member must be actively trying to conceive and has either: (1) the presence of a demonstrated bodily malfunction recognized by a licensed physician as a cause of not being able to conceive; or (2) for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or (3) for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or (4) failure to achieve a successful pregnancy (live birth) after 6 cycles of artificial insemination supervised by a physician (These initial 6 cycles are not a benefit of this Plan.); or (5) 3 or more pregnancy losses.

Inpatient - an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

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

Life-Threatening Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Medical Group - an organization of physicians who are generally located in the same facility and

provide benefits to Members. For mental health and substance use disorder services, this definition includes the MHSA.

Medical Necessity (Medically Necessary) -

1. Benefits are provided only for services which are medically necessary.

2. Services which are medically necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield, are:

   a. consistent with Blue Shield medical policy; and,

   b. consistent with the symptoms or diagnosis; and,

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

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

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

4. Hospital inpatient services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care.

   Inpatient services which are not medically necessary include hospitalization:

   a. for diagnostic studies that could have been provided on an outpatient basis; or,

   b. for medical observation or evaluation; or,

   c. for personal comfort; or,

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

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

5. Blue Shield reserves the right to review all services to determine whether they are medically necessary.

Medicare - refers to the program of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member - refers to an employee, annuitant, or family member as those terms are defined in Sections 22760, 22772 and 22775 and domestic partner as defined in Sections 22770 and 22771 of the Government Code.

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

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

Mental Health Services - services provided to treat a mental health condition.

MHSA Participating Provider - a provider who has an agreement in effect with the MHSA for the provision of mental health and substance use disorder services.

Occupational Therapy - treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts,

or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period - a fixed time period designated by CalPERS to initiate enrollment or change enrollment from one plan to another.

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

Out-of-Area Follow-up Care - non-emergent medically necessary out-of-area services to evaluate the Member's progress after an initial emergency or urgent service.

Outpatient - an individual receiving services under the direction of a Plan provider, but not as an inpatient.

Outpatient Facility - a licensed facility, not a physician's office, or a hospital that provides medical and/or surgical services on an outpatient basis.

Partial Hospitalization Program / Day Treatment – an outpatient treatment program that may be free-standing or hospital-based and provides services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

Participating Hospice or Participating Hospice Agency - an entity which: 1) provides hospice services to terminally ill Members and holds a license, currently in effect, as a hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) either has 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.

Personal Physician - a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with the Plan as a Personal Physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with the Agreement.

Personal Physician Service Area - that geographic area served by the Personal Physician's medical group or IPA.

Physical Therapy - treatment provided by a physician or under the direction of a physician and 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 - an individual licensed and authorized to engage in the practice of medicine or osteopathy.

Plan - the Blue Shield Access+ HMO Health Plan and/or Blue Shield of California.

Plan Hospital - a hospital licensed under applicable state law contracting specifically with Blue Shield to provide benefits to Members under the Plan.

Plan Non-Physician Health Care Practitioner - a health care professional who is not a physician and has an agreement with one of the contracted IPAs, medical groups, Plan hospitals or Blue Shield to provide covered services to Members when referred by a Personal Physician. For all mental health and substance use disorder services, this definition includes MHSA Participating Providers.

Plan Provider - a provider who has an agreement with Blue Shield to provide Plan benefits to Members and a MHSA Participating Provider.

Plan Service Area - the designated geographical area, approved by the CalPERS Board of Administration, within which a Member must live or work to be eligible for enrollment in this Plan.

Plan Specialist - a physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide services to Members either according to an authorized referral by a Personal Physician, or according to the Access+ Specialist program, or for OB/GYN physician services. For mental health and substance use disorder services, this definition includes MHSA Participating Providers.

Preventive Health Services — mean those primary preventive medical covered services provided by a physician, including related laboratory services, for early detection of disease as specifically listed below:

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

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

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

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

Preventive health services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered preventive health services is available in Blue Shield's Preventive Health Guidelines. The Guidelines are available at http://www.blueshieldca.com/preventive or by calling Member Services and requesting that a copy be mailed to you.

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

Prosthesis - an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Reasonable and Customary Charge - in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Plan to be the reasonable and customary value for the services rendered by a non-Plan provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered; outside of California: The lower of (1) the provider's billed charge, or, (2) the amount, if any, established by the laws of the state to be paid for emergency services.

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

Rehabilitation – inpatient or outpatient care furnished to an individual disabled by injury or illness, including severe mental illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of physical therapy, occupational therapy, and/or respiratory therapy.

Benefits for speech therapy are described in Speech Therapy in the Benefit Descriptions section.

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

Respiratory Therapy - treatment, under the direction of a physician 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 1 year without treatment;

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

Seriously Debilitating Condition – having a disease or condition that could cause major irreversible morbidity

Services - includes medically necessary health care services and medically necessary supplies furnished incident to those services.

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

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, 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 - the person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

Substance Use Disorder Condition - for the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

Total Disability -

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

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

Urgent Services - those covered services rendered outside of the Personal Physician service area (other than emergency services) which are medically necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Personal Physician service area.

Notice of the Availability of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BASIC PLAN

Service Area

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

Alameda County[1]
(Entire County Served)
Butte County[2]
(Entire County Served)
Contra Costa County[1]
(Entire County Served)
El Dorado County[1Λ]
Cameron Park
Cool
El Dorado Hills
Georgetown
Greenwood
Pilot Hill
Rescue
Shingle Springs
Fresno County[4]
(Entire County Served)
Glenn County[2]
(Entire County Served)
Humboldt County[1]
(Entire County Served)
Imperial County[4]
(Entire County Served)
Kern County[4]
(Entire County Served)
Kings County[4]
(Entire County Served)
Los Angeles County[3]
(Entire County Served)
Madera County[4]
(Entire County Served)
Marin County[1]
(Entire County Served)
Mariposa County[2]
(Entire County Served)
Merced County[2]
(Entire County Served)
Nevada County[1]
Cedar Ridge
Chicago Park
Grass Valley
Nevada City
North San Juan
Penn Valley
Rough and Ready
Smartsville
Washington
Orange County[4]
(Entire County Served)
Placer County[1Λ]
Alta
Applegate
Auburn
Bowman
Colfax
Dutch Flat
Foresthill
Gold Run
Lincoln
Loomis
Meadow Vista
Newcastle
Penryn
Rocklin
Roseville
Sheridan
Stanford Ranch
Weimar
Riverside County[4]
(Entire County Served)
Sacramento County[1Λ]
(Entire County Served)
San Bernardino County[3]
Adelanto
Alta Loma
Amboy
Angelus Oaks
Apple Valley
Baker
Barstow
Big Bear City
Big Bear Lake
Bloomington
Blue Jay
Bryn Mawr
Cedar Glen
Cedarpines Park
Chino
Chino Hills
Cima
Colton
Crest Park
Crestline
Daggett
Edwards
Essex
Etiwanda
Fawnskin
Fontana
Forest Falls
Fort Irwin
George AFB
Grand Terrace
Green Valley Lake
Guasti
Helendale
Hesperia
Highland
Hinkley
Joshua Tree
Lake Arrowhead
Landers
Loma Linda
Lucerne Valley
Ludlow
Lytle Creek
Mentone
Montclair
Morongo Valley
Mount Baldy
Mountain Pass
Newberry Springs
Nipton
Ontario
Oro Grande
Patton
Phelan
Pinon Hills
Pioneertown
Rancho Cucamonga
Red Mountain
Redlands
Rialto
Rimforest
Running Springs
San Bernardino
Skyforest
Sugarloaf
Trona
Twentynine Palms
Twin Peaks
Upland
Victorville
Wrightwood
Yermo
Yucaipa
Yucca Valley
San Diego County[4]
Alpine
Bonita
Bonsall
Borrego Springs
Bostonia
Boulevard
Camp Pendleton
Campo
Cardiff by the Sea
Carlsbad
Chula Vista
Coronado
Del Mar
Descanso
Dulzura
El Cajon
Encinitas
Escondido
Fallbrook
Grossmont
Guatay
Imperial Beach
Jamul
Julian
La Jolla
La Mesa
Lakeside
Lemon Grove
Leucadia
Lincoln Acres
Mira Mesa
Miramar NAS
Mount Laguna
National City
North Island NAS
Ocean Beach
Oceanside
Otay Mesa
Pacific Beach
Pala
Palomar Mountain
Pauma Valley
Pine Valley
Point Loma
Potrero
Poway
Ramona

Ranchita
Rancho Bernardo
Rancho Santa Fe
San Diego
San Luis Rey
San Marcos
San Ysidro
Santa Ysabel
Santee
Solana Beach
Spring Valley
Tecate
Valley Center
Vista
Warner Springs

San Francisco County[1]
(Entire County Served)

San Joaquin County[1]
(Entire County Served)

San Luis Obispo County[4]
(Entire County Served)

San Mateo County[1]
(Entire County Served)

Santa Barbara County[4]
(Entire County Served)

Santa Clara County[1]
(Entire County Served)

Santa Cruz County[1]
(Entire County Served)

Solano County[1]
(Entire County Served)

Sonoma County[1]
(Entire County Served)

Stanislaus County[2]
(Entire County Served)

Tulare County[4]
(Entire County Served)

Ventura County[3]
(Entire County Served)

Yolo County[1]
(Entire County Served)

Pricing Regions for Contracting Agency Employees and Annuitants

1 San Francisco Bay Area Counties

1A Sacramento Counties

2 Other Northern California Counties

3 Los Angeles/San Bernardino/Ventura Counties

4 Other Southern California Counties

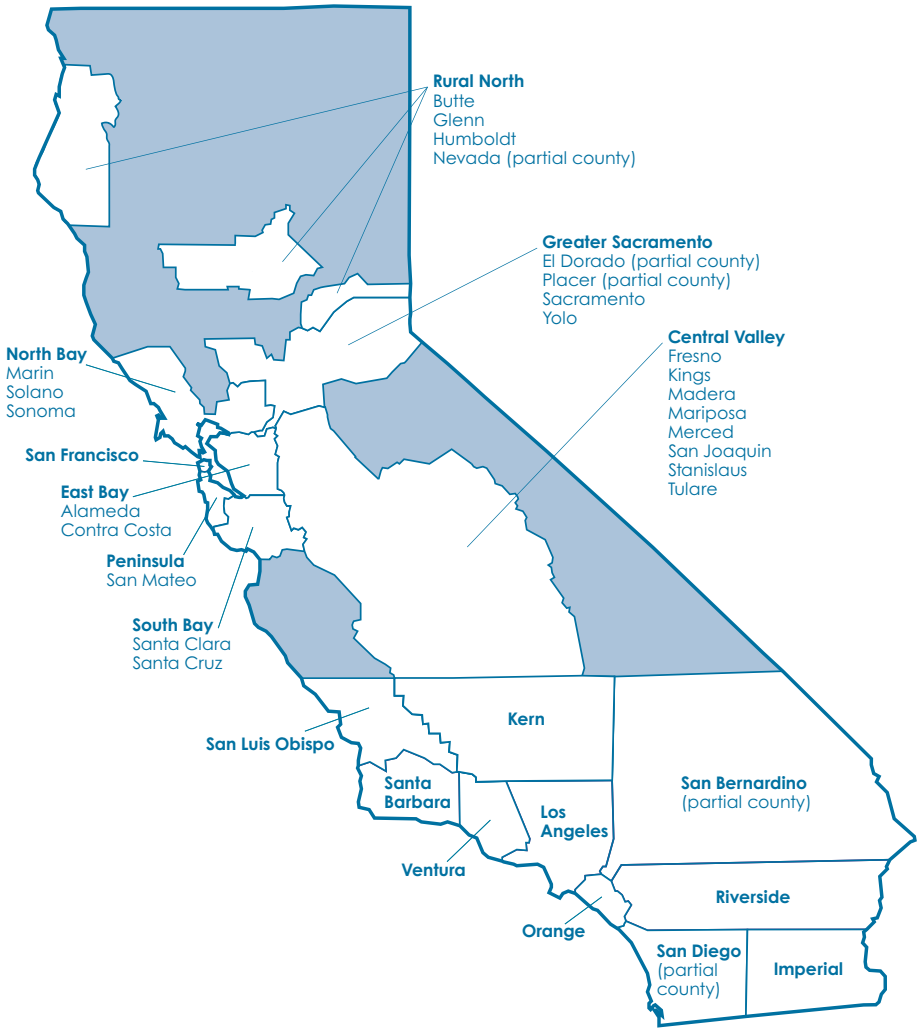
Notes

Notes

This Combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of Blue Shield Access+ HMO.

Should you have any questions, please call Member Services at 1-800-334-5847.

Blue Shield of California HMO Service Areas By Geographical Cluster and County



Refer to pages 77-78 for alphabetical list of all counties in the service areas.
Contact the Plan for up-to-date confirmation of service areas and providers.

Blue Shield of California

Access+ HMO

For inquiries, issues, or requests, please contact Member Services:

1-800-334-5847

www.blueshieldca.com/calpers

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