

Preferred Savings Plan

Benefit Booklet

North Coast Schools' Medical Insurance Group

Pine Plan

Group Number: W0051563-M0017092 & M0017093

Effective Date: July 1, 2018

An independent member of the Blue Shield Association

This Plan is intended to qualify as a “high deductible health plan” for the purposes of qualifying for a health savings account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Although the Claims Administrator believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, the Claims Administrator will make efforts to amend this Plan, if necessary, to meet the requirements of a qualified plan. If the Claims Administrator determines that the amendment necessitates a change in the Plan provisions, the Claims Administrator will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

Important Information Regarding HSAs

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

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

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

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

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health Plan at the Customer Service telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

The Preferred Savings Plan

Participant Bill of Rights

As a Preferred Plan Participant, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your Preferred Savings Plan, the Services we offer you, the Physicians and other practitioners available to care for you.
5. Have reasonable access to appropriate medical services.
6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive preventive health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
12. Communicate with and receive information from Customer Service in a language you can understand.
13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
14. Be fully informed about the Claims Administrator dispute procedure and understand how to use it without fear of interruption of health care.
15. Voice complaints or grievances about the Preferred Savings Plan or the care provided to you.
16. Make recommendations regarding the Claims Administrator's Member rights responsibilities policy.

The Preferred Savings Plan

Participant Responsibilities

As a Preferred Plan Participant, you have the responsibility to:

1. Carefully read all Claims Administrator Preferred Plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Claims Administrator Preferred Savings Plan as explained in this booklet.
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 developing treatment goals with your medical provider, whenever possible.
5. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
8. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Claims Administrator Preferred Savings Plan.
10. Help the Claims Administrator to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
11. Notify the Claims Administrator as soon as possible if you are billed inappropriately or if you have any complaints.
12. Treat all Plan personnel respectfully and courteously as partners in good health care.
13. Pay your fees, Copayments and charges for non-covered services on time.
14. Follow the provisions of the Claims Administrator's Benefits Management Program.

TABLE OF CONTENTS

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?	20
HOW A HEALTH SAVINGS ACCOUNT WORKS.....	20
INTRODUCTION.....	20
Preferred Providers.....	20
Continuity of Care by a Terminated Provider.....	21
Financial Responsibility for Continuity of Care Services.....	21
Submitting a Claim Form.....	21
Eligibility.....	21
EFFECTIVE DATE OF COVERAGE	23
RENEWAL OF PLAN	23
SERVICES FOR EMERGENCY CARE	24
UTILIZATION REVIEW	24
SECOND MEDICAL OPINION POLICY	24
HEALTH EDUCATION AND HEALTH PROMOTION SERVICES	24
RETAIL-BASED HEALTH CLINICS.....	24
NURSEHELP 24/7 SM	24
THE CLAIMS ADMINISTRATOR ONLINE.....	24
BENEFITS MANAGEMENT PROGRAM.....	25
PRIOR AUTHORIZATION.....	25
DEDUCTIBLES.....	27
Individual Coverage Deductible (applicable to 1 Member coverage).....	27
Family Coverage Deductible (applicable to 2 or more Member coverage).....	27
Services Not Subject to the Deductible.....	27
Prior Carrier Deductible Credit.....	27
NO LIFETIME BENEFIT MAXIMUM.....	27
NO ANNUAL DOLLAR LIMITS ON ESSENTIAL BENEFITS.....	27
PAYMENT	27
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	29
Individual Coverage (applicable to 1 Member coverage).....	29
Family Coverage (applicable to 2 or more Member coverage)	29
PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES).....	29
Acupuncture Benefits.....	30
Allergy Testing and Treatment Benefits.....	30
Ambulance Benefits.....	30
Ambulatory Surgery Center Benefits.....	30
Bariatric Surgery Benefits.....	30
Chiropractic Benefits	30
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Benefits	30
Diabetes Care Benefits.....	31
Dialysis Centers Benefits.....	32
Durable Medical Equipment Benefits.....	32
Emergency Room Benefits	32
Family Planning Benefits.....	32
Hearing Aid Benefits.....	33
Home Health Care Benefits	33
Home Infusion/Home Injectable Therapy Benefits	33
Hospice Program Benefits.....	34
Hospital Benefits (Facility Services)	36
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits.....	37
Mental Health and Substance Use Disorder Benefits	38
Orthotics Benefits.....	39
Outpatient Prescription Drug Benefits	39
Outpatient X-ray, Pathology and Laboratory Benefits	43
PKU Related Formulas and Special Food Products Benefits	43
Podiatric Benefits.....	43
Pregnancy and Maternity Care Benefits	43
Preventive Health Benefits.....	44
Professional (Physician) Benefits	44
Prosthetic Appliances Benefits	45

TABLE OF CONTENTS

Rehabilitation and Habilitation Benefits (Physical, Occupational and Respiratory Therapy).....	46
Skilled Nursing Facility Benefits	46
Special Radiological Procedures.....	46
Speech Therapy Benefits.....	46
Transplant Benefits	46
Special Transplants	47
Principal Limitations, Exceptions, Exclusions and Reductions	47
General Exclusions and Limitations	47
Medical Necessity Exclusion	50
Limitations for Duplicate Coverage.....	50
Exception for Other Coverage	51
Claims Review	51
Reductions – Third Party Liability.....	51
Coordination of Benefits	52
TERMINATION OF BENEFITS	53
GROUP CONTINUATION COVERAGE	54
Continuation of Group Coverage	54
Continuation of Group Coverage for Members on Military Leave	55
GENERAL PROVISIONS	55
Liability of Participants in the Event of Non-Payment by the Claims Administrator	55
Independent Contractors	56
Non-Assignability	56
Plan Interpretation	56
Confidentiality of Personal and Health Information.....	56
Access to Information	56
Right of Recovery	56
CUSTOMER SERVICE.....	57
SETTLEMENT OF DISPUTES.....	57
DEFINITIONS.....	58
Plan Provider Definitions.....	58
All Other Definitions.....	60
NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES.....	67
NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS	69

This booklet constitutes only a summary of the health Plan. The health Plan document must be consulted to determine the exact terms and conditions of coverage.

The Plan Document is on file with your Employer and a copy will be furnished upon request.

This is a Preferred Savings Plan. Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

Please read this Benefit Booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

Should you have any questions regarding your health Plan, see your Employer or contact any of the Claims Administrator offices listed on the last page of this booklet.

IMPORTANT

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

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

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

North Coast Schools' Medical Insurance Group is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Note: The following Summary of Benefits contains the Benefits and applicable Co-payments of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, Benefits and exclusions of the Plan.



Summary of Benefits

Group Plan

Preferred Savings Benefit Plan

Preferred Savings Plan

This Summary of Benefits shows the amount you will pay for covered services under this Claims Administrator benefit plan. It is only a summary and it is part of the contract for health care coverage, called the Benefit Booklet.¹ Please read both documents carefully for details.

Provider Network:

Preferred Provider Network

This benefit plan uses a specific network of health care providers, called the preferred provider network. Providers in this network are called participating providers. You pay less for covered services when you use a participating provider than when you use a non-participating provider. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

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

When using a participating³ or non-participating⁴ provider

Calendar year medical and pharmacy deductible	<i>Individual coverage</i>	\$1,500
<i>This plan combines medical and pharmacy deductibles into one calendar year deductible.</i>	<i>Family coverage</i>	\$2,700: individual \$3,000: family

Calendar Year Out-of-Pocket Maximum⁵

An out-of-pocket maximum is the most a member will pay for covered services each calendar year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

No Lifetime Benefit Maximum

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

	When using a participating provider ³	When using a non-participating provider ⁴
<i>Individual coverage</i>	\$4,000	\$5,786
<i>Family coverage</i>	\$4,000: individual \$8,000: family	\$5,786: individual \$11,572: family

Blue Shield of California is an independent member of the Blue Shield As-

Benefits⁶

Your payment

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Preventive Health Services⁷	\$0		30%	
Physician services				
Primary care office visit	\$0	✓	30%	✓
Specialist care office visit	\$0	✓	30%	✓
Physician home visit	20%	✓	30%	✓
Physician or surgeon services in an outpatient facility	20%	✓	30%	✓
Physician or surgeon services in an inpatient facility	20%	✓	30%	✓
Other professional services				
Other practitioner office visit <i>Includes nurses, nurse practitioners, and therapists.</i>	\$0	✓	30%	✓
Acupuncture services <i>Up to 24 visits per member, per calendar year.</i>	20%	✓	20% (Plan payment limited to \$25/visit)	✓
Chiropractic services <i>Up to 24 visits per member, per calendar year.</i>	20%	✓	30% (Plan payment limited to \$25/visit)	✓
Teladoc consultation	\$0/consult	✓	Not covered	
Family planning				
• Counseling, consulting, and education	\$0		30%	✓
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		30%	✓
• Tubal ligation	\$0		30%	✓

Benefits⁶

Your payment

	When using a participating provider³	CYD² applies	When using a non-participating provider⁴	CYD² applies
<ul style="list-style-type: none"> Vasectomy Infertility services 	20%	✓	30%	✓
Podiatric services	\$0	✓	30%	✓
Pregnancy and maternity care⁸				
Physician office visits: prenatal and postnatal	\$0	✓	30%	✓
Physician services for pregnancy termination	20%	✓	30%	✓
Emergency services and urgent care				
Emergency room services	\$100/visit plus 20%	✓	\$100/visit plus 20%	✓
<i>If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room physician services	20%	✓	20%	✓
Urgent care physician services	\$0	✓	30%	✓
Ambulance services	30%	✓	30%	✓
Outpatient facility services				
Ambulatory surgery center	20%	✓	30%	✓
Outpatient department of a hospital: surgery	20%	✓	30%	✓
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✓	30%	✓
Inpatient facility services				
Hospital services and stay	20%	✓	30%	✓

Benefits⁶

Your payment

	When using a participating provider³	CYD² applies	When using a non-participating provider⁴	CYD² applies
<p>Transplant services</p> <p><i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i></p> <ul style="list-style-type: none"> • Special transplant facility inpatient services 20% ✓ Not covered • Physician inpatient services 20% ✓ Not covered <p><i>Transplant Travel Expense: Transportation to and from the Transplant Facility on an approved flight, train or current IRS mileage for auto travel for recipient and companion per transplant episode (limited to 6 round trips per episode). Hotel accommodations for recipient and companion per transplant episode (limited to 6 round trips per episode). Hotel accommodations are limited to one room, double occupancy up to a Benefit maximum of \$100 per day; meals not to exceed \$75/day per person. There is a \$5,000 one-time maximum amount for recipient and companion expenses in total. Donor costs to be included.</i></p>				
<p>Diagnostic x-ray, imaging, pathology, and laboratory services</p> <p><i>This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.</i></p> <p>Laboratory services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p> <ul style="list-style-type: none"> • Laboratory center 20% ✓ 30% ✓ • Outpatient department of a hospital 20% ✓ 30% ✓ • California Prenatal Screening Program \$0 \$0 				

Benefits⁶

Your payment

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
<p>X-ray and imaging services</p> <p><i>Includes diagnostic mammography.</i></p> <ul style="list-style-type: none"> Outpatient radiology center 20% ✓ 30% ✓ Outpatient department of a hospital 20% ✓ 30% ✓ 				
<p>Other outpatient diagnostic testing</p> <p><i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i></p> <ul style="list-style-type: none"> Office location 20% ✓ 30% ✓ Outpatient department of a hospital 20% ✓ 30% ✓ 				
<p>Radiological and nuclear imaging services</p> <ul style="list-style-type: none"> Outpatient radiology center 20% ✓ 30% ✓ Outpatient department of a hospital 20% ✓ 30% ✓ 				
<p>Rehabilitation and habilitative services</p> <p><i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.</i></p> <ul style="list-style-type: none"> Office location 10% ✓ 30% ✓ Outpatient department of a hospital 10% ✓ 30% up to \$350/day plus 100% of additional charges ✓ 				
<p>Durable medical equipment (DME)</p> <ul style="list-style-type: none"> DME 20% ✓ 30% ✓ Breast pump \$0 Not covered Orthotic equipment and devices 20% ✓ 30% ✓ 				

Benefits⁶

Your payment

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Prosthetic equipment and devices	20%	✓	30%	✓
Home health services				
<i>Up to 120 visits per member, per calendar year, by a home health care agency. All visits count towards the limit, including visits during any applicable deductible period, except hemophilia and home infusion nursing visits.</i>				
Home health agency services	20%	✓	Not covered	
<i>Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>				
Home visits by an infusion nurse	20%	✓	Not covered	
Home health medical supplies	20%	✓	Not covered	
Home infusion agency services	20%	✓	Not covered	
Hemophilia home infusion services	20%	✓	Not covered	
<i>Includes blood factor products.</i>				
Skilled nursing facility (SNF) services				
<i>Up to 120 days per member, per benefit period, except when provided as part of a hospice program. All days count towards the limit, including days during any applicable deductible period and days in different SNFs during the calendar year.</i>				
Freestanding SNF	20%	✓	20% (with prior authorization)	✓
Hospital-based SNF	20%	✓	30%	✓
Hospice program services				
Pre-hospice consultation, routine home care, and in-patient respite care.	\$0	✓	Not covered	

Benefits⁶

Your payment

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
24-hour continuous home care and short-term inpatient care for pain and symptom management	20%	✓	Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✓	30%	✓
• Self-management training	\$0	✓	30%	✓
Dialysis services	20%	✓	30%	✓
PKU product formulas and special food products	20%	✓	20%	✓
Allergy serum	20%	✓	30%	✓
Hearing services				
• Hearing aids and equipment				
<i>Up to \$5,000 combined maximum per member, per 24 months.</i>	20%	✓	20%	✓
• Audiological evaluations	20%	✓	20%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

	When using a MHSA participating provider ³	CYD ² applies	When using a MHSA non-participating provider ⁴	CYD ² applies
<i>Mental health and substance use disorder benefits are provided through the Claims Administrator's mental health services administrator (MHSA).</i>				
Outpatient services				
Office visit, including physician office visit	\$0	✓	30%	✓
Other outpatient services, including intensive outpatient care, behavioral health treatment for pervasive developmental disorder or autism in a home, or other non-institutional facility setting, and office-based opioid treatment	20%	✓	30%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

<i>Mental health and substance use disorder benefits are provided through the Claims Administrator's mental health services administrator (MHSA).</i>	When using a MHSA participating provider ³	CYD ² applies	When using a MHSA non-participating provider ⁴	CYD ² applies
Other outpatient services: behavioral health treatment for pervasive developmental disorder or autism in an office setting	\$0	✓	30%	✓
Partial hospitalization program	20%	✓	30%	✓
Psychological testing	20%	✓	30%	✓
Inpatient services				
Physician inpatient services	20%	✓	30%	✓
Hospital services	20%	✓	30%	✓
Residential care	20%	✓	30%	✓

Prescription Drug Benefits^{8,9}

Your payment

	When using a participating pharmacy ³	CYD ² applies	When using a non-participating pharmacy ⁴	CYD ² applies
Retail pharmacy prescription drugs				
<i>Per prescription, up to a 30-day supply.</i>				
Generic Drugs	\$10/prescription	✓	25% plus \$10/prescription	✓
Preferred Brand Drugs	\$30/prescription	✓	25% plus \$30/prescription	✓
Non-Preferred Brand Drugs	\$40/prescription	✓	25% plus \$40/prescription	✓
Contraceptive drugs and devices	\$0		25% of purchase price plus applicable Generic, Brand or Non-Formulary Copayment	✓

Prescription Drug Benefits^{8,9}

Your payment

	When using a participating pharmacy ³	CYD ² applies	When using a non-participating pharmacy ⁴	CYD ² applies
Mail service pharmacy prescription drugs				
<i>Per prescription, up to a 90-day supply.</i>				
Generic Drugs	\$15/prescription	✓	Not covered	
Preferred Brand Drugs	\$45/prescription	✓	Not covered	
Non-Preferred Brand Drugs	\$80/prescription	✓	Not covered	
Contraceptive drugs and devices	\$0	✓	Not covered	
Specialty drugs				
	30% up to \$150/prescription	✓	Not covered	
<i>Per prescription. Specialty drugs are covered when dispensed by a network specialty pharmacy. Specialty drugs from non-participating pharmacies are not covered except in emergency situations.</i>				
Oral anticancer drugs				
	30% up to \$150/prescription	✓	Not covered	
<i>Per prescription, up to a 30-day supply.</i>				

Prior Authorization

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

- Radiological and nuclear imaging services
- Mental health services, except outpatient office visits
- Inpatient facility services
- Hospice program services
- Home health services from non-participating providers
- Some prescription drugs (see blueshieldca.com/pharmacy)

Please review the Benefit Booklet for more about benefits that require prior authorization.

1 Benefit Booklet:

The Benefit Booklet describes the benefits, limitations, and exclusions that apply to coverage under this benefit plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

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

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before the Claims Administrator pays for Covered Services under the benefit plan.

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

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

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

3 Using Participating Providers:

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

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

4 Using Non-Participating Providers:

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

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

"Allowable Amount" is defined in the Benefit Booklet. In addition:

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

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

Your payment after you reach the calendar year OOPM. You will continue to pay all charges above a benefit maximum.

Essential health benefits count towards the OOPM.

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

This benefit plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

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

6 Separate Member Payments When Multiple Covered Services are Received:

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

7 Preventive Health Services:

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

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This benefit 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 benefit plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to the Claims Administrator for the Brand Drug and its Generic Drug equivalent plus any applicable Drug tier Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Member payment.

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

Benefit Plans may be modified to ensure compliance with Federal requirements.

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

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

HOW A HEALTH SAVINGS ACCOUNT WORKS

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

Please note that the Claims Administrator does not offer HSAs itself, and only offers high deductible health plans.

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

INTRODUCTION

If you have questions about your Benefits, contact the Claims Administrator before Hospital or medical services are received.

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

You should read your Benefit Booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your Claims Administrator ID card to your Physician, Hospital, or other licensed healthcare provider. Your ID card has your Participant and group numbers on it. Be sure to include these numbers on all claims you submit to the Claims Administrator.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Preferred Providers" section).

You are responsible for following the provisions shown in the "Benefits Management Program" section of this booklet, including:

1. You or your Physician must obtain the Claims Administrator approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services. (See the "Preferred Providers" section for information.)
2. You or your Physician must notify the Claims Administrator within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Prior Authorization" in the "Benefits Management Program" section for a listing of Services requiring prior authorization.

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

Note: The Claims Administrator will render a decision on all requests for prior authorization 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 Participant within 2 business days of the decision. For Urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, the Claims Administrator will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

PREFERRED PROVIDERS

The Claims Administrator Preferred Plan is specifically designed for you to use the Claims Administrator Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other Providers. Preferred Providers are listed in the Preferred Provider Directories. All Claims Administrator Physician Members are Preferred Providers. So are selected Hospitals in your community. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing the Claims Administrator's Internet site located at <http://www.blueshieldca.com>, or by calling Customer Service at the telephone number shown on the

last page of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by the Claims Administrator for services.

Preferred Providers agree to accept the Claims Administrator's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums, as payment in full for covered Services, except as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability. This is not true of Non-Preferred Providers.

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

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

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

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Claims Administrator within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

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 Claims Administrator provider network. Contact Customer Service to receive information

regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES

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

SUBMITTING A CLAIM FORM

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

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

To submit a claim for payment, send a copy of your itemized bill, along with a completed Claims Administrator Participant's Statement of Claim form to the Claims Administrator service center listed on the last page of this booklet.

Claim forms are available on the Claims Administrator's Internet site located at <http://www.blueshieldca.com> or you may call Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Claims Administrator claim form.

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

ELIGIBILITY

1. To enroll and continue enrollment, a Member must meet all of the eligibility requirements of the Plan.

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

gible at the same time.

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period, they will be eligible at the Employer's next Open Enrollment Period. The Claims Administrator will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under a previous employer's health plan or other health insurance, and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish the Claims Administrator written proof of the loss of coverage.

Newborn infants of the Participant, spouse, or his or her Domestic Partner will be covered immediately after birth for the first 31 days. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by the Claims Administrator within 60 days from the date of birth.

A child placed for adoption will be covered immediately upon the date the Participant, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Participant's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by the Claims Administrator within 31 days from the date of placement for adoption of such Dependent.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents (other than newborns) and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

- a. to continue coverage of a child placed for adoption;
- b. to add a spouse after marriage, or add a Domestic Partner after establishing a domestic partnership;
- c. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;
- d. to add yourself and spouse after marriage;
- e. to add yourself and your child placed for adoption, following placement for adoption.

A newborn may be added to the Plan by submitting an application within 60 days from the date of birth; the mother of the newborn may add herself within 31 days of the birth. The effective date of enrollment for both you and your newborn will be the date of birth.

Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are eligible to be Participants, then they are both eligible for Dependent benefits. Their children may be eligible and may be enrolled as a Dependent of both parents.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of such disabling condition. The Claims Administrator or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Plan Administrator or by the Plan. Proof of continuing disability and dependency must be submitted by the Employee as requested by the Claims Administrator but not more frequently than 2 years after the initial certification and then annually thereafter.

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

2. If a Member commits any of the following acts, they will immediately lose eligibility to continue enrollment:
 - a. Abusive or disruptive behavior which:
 - (1) threatens the life or well-being of Plan personnel, or providers of services;
 - (2) substantially impairs the ability of the Claims Administrator to arrange for services to the Member; or
 - (3) substantially impairs the ability of providers of Services to furnish Services to the Member or to other patients.
 - b. Failure or refusal to provide the Claims Administrator access to documents and other information necessary to determine eligibility or to administer benefits under the Plan.

3. Employer eligibility – The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group Plan. See your Employer for further information.

EFFECTIVE DATE OF COVERAGE

Coverage will become effective for employees the first day of the month coinciding with or following the date you are hired. Coverage for dependents will become effective the first date of the month coinciding with or following the date on which they become eligible for coverage, with the exception of newborns. All coverage requires submission of a completed application form and any required supporting documentation. A completed application form and any required supporting documentation must be submitted within 31 days from the date the employee or dependent becomes eligible for coverage.

Newborns will be eligible for coverage as of their date of birth. Coverage for newborns will become effective as of their date of birth, if a completed application and all supporting documentation is received within 60 days from their date of birth.

Failure to meet these timelines will result in your dependent having to wait to enroll until the next Open Enrollment period.

If you or your Dependent is a Late Enrollee, your coverage will become effective at the next Open Enrollment Period.

If you or your Dependent is a Late Enrollee, your coverage will become effective at the next Open Enrollment Period. The Claims Administrator will not consider applications for earlier effective dates.

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

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

1. For marriage or domestic partnership, the first of the month following the date of marriage or domestic partnership certification;

2. For a child placed for adoption, the effective date will be the date the Participant, spouse, or Domestic Partner has the right to control the child's health care.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of birth you may request enrollment for yourself within 31 days and you may request enrollment for your newborn within 60 days. The effective date of enrollment for both you and your newborn will be the date of birth.

Once each Calendar Year, your plan has an annual Open Enrollment. Please contact your benefits administrator for these open enrollment dates.

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

Any newborn who becomes eligible at a time other than during the annual Open Enrollment Period must have a completed enrollment form submitted within 60 days of birth.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Participant, spouse or Domestic Partner has the right to control the child's health care, following the submission of stamped court documents for controlling healthcare. In order to have coverage continue beyond the first 31 days (60 days for newborns) without lapse, a written application must be submitted to and received by the Claims Administrator within 31 days (within 60 days for newborns). A Dependent spouse becomes eligible on the first of the month following or coinciding with the date of marriage. A Domestic Partner becomes eligible on the first of the month following or coinciding with the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective the date of the court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code. No coverage is provided for ex-spouses or domestic partners once they have severed their relationships.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents may, if eligible, be covered at the next Open Enrollment Period.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your Employer, you and all your Dependents who were validly covered under the previous group health

plan on the date of discontinuance, will be eligible under this Plan if you and your dependents meet the eligibility criteria under this plan.

RENEWAL OF PLAN

The Claims Administrator will offer to renew the Plan except in the following instances:

1. non-payment of fees (see “Termination of Benefits”);
2. fraud, or intentional misrepresentation of a material fact;
3. failure to comply with the Claims Administrator's applicable eligibility, participation or contribution rules;
4. termination of plan type by the Claims Administrator;

All groups will renew subject to the above.

SERVICES FOR EMERGENCY CARE

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

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

Note: For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up Services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

UTILIZATION REVIEW

The Claims Administrator has a documented utilization review process. To request a copy of this document, call the Customer Service Department at the number listed on the last page of this booklet.

SECOND MEDICAL OPINION POLICY

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

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

State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call Customer Service Department at the number provided on the back page of this booklet.

HEALTH EDUCATION AND HEALTH PROMOTION SERVICES

Health education and health promotion Services provided by the Claims Administrator's Center for Health and Wellness offer a variety of wellness resources including, but not limited to: a Participant newsletter and a prenatal health education program.

RETAIL-BASED HEALTH CLINICS

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at <http://www.blueshieldca.com>. See the Preferred Providers section for information on the advantages of choosing a Preferred Provider.

NURSEHELP 24/7SM

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 phone 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.) The telephone number is listed on your Member identification card.

The NurseHelp 24/7 program provides Members with no charge, confidential telephone support for information, consultations, and referrals for health issues. Members may ob-

tain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

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

THE CLAIMS ADMINISTRATOR ONLINE

The Claims Administrator's Internet site is located at <http://www.blueshieldca.com>. Members with Internet access and a Web browser may view and download healthcare information.

BENEFITS MANAGEMENT PROGRAM

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

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

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

PRIOR AUTHORIZATION

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

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

For Prior Authorizations of prescription Drugs covered under the medical benefit: Drugs administered in the office, infusion center or provided by a home infusion agency are

covered as a medical benefit. For these prescription Drugs, once all required supporting information is received, the Claims Administrator will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

If prior authorization is not obtained, and services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

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

- CT (Computerized Tomography) scan
- MRI (Magnetic Resonance Imaging)
- MRA (Magnetic Resonance Angiography)
- PET (Positron Emission Tomography) scan
- Diagnostic cardiac procedures utilizing nuclear medicine

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

If the radiological or nuclear imaging services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

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

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

Failure to obtain prior authorization for hemophilia home infusion products and Services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage.

To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back page of this Benefit Booklet.

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

For certain medical services, Benefits are limited to Services rendered by a Participating Provider. If the medical services provided to the Member are determined not to be a Benefit of the Plan or are not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

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

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

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

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

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

Prior authorization is required for all nonemergency mental health Hospital admissions including acute Inpatient care and Residential Care. The provider should call Customer Service at the telephone number listed on the back page of this Benefit Booklet at least five business days prior to the admission. Other Outpatient Mental Health and Substance Use Disorder Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the Claims Administrator.

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

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

Prior authorization is not required for an emergency Mental Health or Substance Use Disorder Hospital admission; See the Emergency Admission Notification section for additional information.

Emergency Admission Notification

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

Inpatient Utilization Management

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

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

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

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, the Claims Administrator will work with the Member, the attending Physician and the Hospital discharge planner to determine the most appropriate and cost effective way to provide this care.

Case Management

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

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

Palliative Care Services

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

DEDUCTIBLES

INDIVIDUAL COVERAGE DEDUCTIBLE (APPLICABLE TO 1 MEMBER COVERAGE)

This plan's Deductible is for services rendered by Preferred and Non-Preferred Providers combined.

The Calendar Year Deductible amount is shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. After the Calendar Year individual Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

Note: If you are enrolled in an Individual Plan, and have a newborn or a child placed for adoption, the child is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan. While the child's coverage is provided, you and this Dependent will be enrolled in the Family Coverage Plan. The Family Deductible amount as described in the Family Coverage Deductible section below will apply to you and this Dependent.

FAMILY COVERAGE DEDUCTIBLE (APPLICABLE TO 2 OR MORE MEMBER COVERAGE)

This plan's Deductible is for services rendered by Preferred and Non-Preferred Providers combined.

The Calendar Year per Member and Family Deductible amounts are shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan, and must be satisfied once during each Calendar Year. Once a member satisfies the individual Deductible within the Family Deductible, Benefits will be provided for that Family member.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

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

SERVICES NOT SUBJECT TO THE DEDUCTIBLE

The Calendar Year Deductible applies to all covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

PRIOR CARRIER DEDUCTIBLE CREDIT

If you satisfied all or part of a Deductible under this plan sponsored by your Plan Administrator during the same Calendar Year this Plan becomes effective, that amount will be applied to the Deductible required under this Plan.

NO LIFETIME BENEFIT MAXIMUM

There is no maximum limit on the aggregate payments by the Plan for covered Services provided under the Plan.

NO ANNUAL DOLLAR LIMITS ON ESSENTIAL BENEFITS

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

PAYMENT

The Participant Copayment amounts, applicable Deductibles, and Copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on Benefit and Copayment maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Out-of-Area Services

Overview

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

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area

(Host Blue). Non-participating providers don't contract with the Host Blue. The Claims Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services

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

BlueCard Program

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

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare 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, Coinsurance and Deductible amounts, if any, as stated in this booklet.

The Claims Administrator calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted

above. However, such adjustments will not affect the price the Claims Administrator used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue 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 Services according to applicable law.

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

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

Non-participating Providers Outside of California

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

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

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Claims Administrator pays claims for covered Emergency Services based on the Allowable Amount as defined in this Benefit Booklet.

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

Blue Shield Global® Core

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

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available

within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

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

Submitting a Blue Shield Global Core Claim

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

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

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

BlueCard® Program

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

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

INDIVIDUAL COVERAGE (APPLICABLE TO 1 MEMBER COVERAGE)

The per Member Out-of-Pocket Maximum required each Calendar Year for covered Services is shown in the Summary of Benefits.

Once the Out-of-Pocket Maximum has been met, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

FAMILY COVERAGE (APPLICABLE TO 2 OR MORE MEMBER COVERAGE)

The per Family Out-of-Pocket Maximum required each Calendar Year for covered Services* is shown in the Summary of Benefits. The Family Out-of-Pocket Maximum will be satisfied by the Member and all of his covered Dependents collectively.

Once a Family member’s maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for that Family member’s Covered Services for the remainder of that Calendar Year.

There is an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means that the Out-of-Pocket Maximum will be met for any Family member who meets the individual Calendar Year Out-of-Pocket Maximum amount before the Family Calendar Year Out-of-Pocket Maximum is met.

Once the Out-of-Pocket Maximum has been met*, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

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

Charges for Services which are not covered, charges above the Allowable Amount, and charges in excess of the amount covered by the Plan, are the Participant’s responsibility and are not included in the Calendar Year maximum out-of-pocket responsibility calculations.

For the Outpatient Prescription Drugs Benefit, if the Participant requests a brand name drug when a generic drug equivalent is available, the difference in cost that the Participant must pay is not included in the Calendar Year maximum out-of-pocket responsibility calculations. See the Outpatient Prescription Drugs Benefits section for details.

PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES)

Benefits are provided for the following Medically Necessary covered Services, subject to applicable Deductibles, Copayments and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Plan, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, the Claims Administra-

tor will provide Benefits based on the most cost-effective service.

The Copayments for covered Services, if applicable, are shown on the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Participants will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Participant Copayment.

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

ACUPUNCTURE BENEFITS

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.), licensed acupuncturist, or other appropriately licensed or certified Health Care Provider up to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

ALLERGY TESTING AND TREATMENT BENEFITS

Benefits are provided for allergy testing and treatment.

AMBULANCE BENEFITS

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

AMBULATORY SURGERY CENTER BENEFITS

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

Note: Reconstructive Surgery is only covered 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. In ac-

cordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

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.

BARIATRIC SURGERY BENEFITS

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity when Services are consistent with the Claims Administrator's medical policy and prior authorization is obtained, in writing, from the Claims Administrator's Medical Director.

CHIROPRACTIC BENEFITS

Benefits are provided for Chiropractic Services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial and subsequent office visits, an initial examination, adjustments, conjunctive therapy, and X-ray services up to the benefit maximum.

Benefits are limited to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Covered X-ray Services provided in conjunction with this Benefit have an additional Copayment or Coinsurance as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition where the

clinical trial has a therapeutic intent and when prior authorized by the Claims Administrator, and:

1. the Member's Physician or another Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the Member; or
2. the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

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

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

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

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 identi-

fied in the guidelines issued by the National Institutes of Health for center support grants;

- g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
- 2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

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

DIABETES CARE BENEFITS

Diabetes 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:

1. blood glucose monitors, including those designed to assist the visually impaired;
2. Insulin pumps and all related necessary supplies;
3. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;
4. visual aids, excluding eyewear and/or video-assisting devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug Benefit section.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Participant to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, reg-

istered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

DIALYSIS CENTERS BENEFITS

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

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

DURABLE MEDICAL EQUIPMENT BENEFITS

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

Medically necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section, except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;
2. 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. (Note: For benefits for asthma inhalers and inhaler spacers, see the Outpatient Prescription Drug Benefit section.);

3. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with the Claims Administrator medical policy. For further information call Customer Service or go to <http://www.blueshieldca.com>.

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

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

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

EMERGENCY ROOM BENEFITS

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician's office.

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

When a Member is admitted to the Hospital for Emergency Services, the Claims Administrator should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by 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.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Claims Administrator determines is not an emergency will be paid as part of the Inpatient Hospital Services. The Participant Copayment for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown on the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Participant is responsible for the Emergency Room Participant Copayment plus the appropriate Admitting Hospital Services Participant Copayment as shown on the Summary of Benefits.

FAMILY PLANNING BENEFITS

Benefits are provided for the following Family Planning Services without illness or injury being present.

For Family Planning Services, for Plans with a Calendar Year Deductible for Services by Preferred Providers, the Calendar Year Deductible only applies to male sterilizations and to abortions.

Note: No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fitting or injectable contraceptives;
2. Intrauterine devices (IUDs), including insertion and/or removal;
3. Implantable contraceptives;
4. Injectable contraceptives when administered by a Physician;
5. Voluntary sterilization (tubal ligation and vasectomy) and abortion services;
6. Diaphragm fitting procedure.

HEARING AID BENEFITS

Your Plan provides coverage for hearing aid Services, subject to the conditions and limitations listed below.

The hearing aid Services Benefit provides a \$5,000 combined maximum allowance every 24 months towards covered hearing aids, audiological examinations and Services as specified below. The hearing aid Services Benefit is separate and apart from the other Benefits described in your Summary of Benefits. You are not required to use the Claims Administrator Preferred Provider to obtain these services as the Claims Administrator does not maintain a network of contracted providers for these services. You may obtain these services from any provider of your choosing and submit a claim to the Claims Administrator for reimbursement for covered Services up to the combined maximum allowance. For information on submitting a claim, see the "Submitting a Claim Form" paragraphs in the Introduction section of your Summary of Benefits.

Hearing Aids and Ancillary Equipment

The Benefit allowance is provided for hearing aids and ancillary equipment up to a maximum of \$5,000 per Member in any 24-month period. You are responsible for the cost of any hearing aid Services which are in excess of this Benefit allowance.

The hearing aid Benefit includes: a hearing aid instrument, monaural or binaural including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

1. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
2. Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
3. Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any 24-month period;
4. Surgically implanted hearing devices.

HOME HEALTH CARE BENEFITS

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the attending Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by the Claims Administrator.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Person per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2. or 3. above;
5. Medical social worker.

For the purpose of this Benefit, visits from home health aides of 4 hours or less shall be considered as one visit.

In conjunction with 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 are covered to the extent the Benefits would have been provided had the Member remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the Outpatient Prescription Drugs Benefits.

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

Note: See the Hospice Program Services section for information about when a Member is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.

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

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral 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 a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing must be prior authorized by the Claims Administrator.

This Benefit does not include medications, drugs, Insulin, Insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drugs Benefits, and Services related to hemophilia which are described below.

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

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion Agencies must be prior authorized by the Claims Administrator.

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 Claims Administrator (see the Benefits Management Program section for specific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling Customer Service at the telephone number shown on the last page 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 Claims Administrator. Once prior authorized by the Claims Administrator, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the Emergency Room Benefits section.)

Included in this Benefit is the blood factor product for in-home infusion 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 Preferred 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 Principal Benefits and Coverages (Covered Services) section.

This Benefit does not include:

1. physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2. services from a hemophilia treatment center or any Non-Preferred Hemophilia Infusion Provider; or,
3. self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), Outpatient Prescription Drug Benefits if selected as an optional Benefit by your Employer, or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

HOSPICE PROGRAM BENEFITS

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 their Physician's certification and the admission must receive prior approval from the Claims Administrator. (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 provider. Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by the Claims Administrator.

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 Member to the extent that these needs are not met by the Member's other providers.
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 can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

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

Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by the Claims Administrator.

DEFINITIONS

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

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

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

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

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

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and their 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.
6. Actively utilizes volunteers in the delivery of Hospice Services.

7. Provides Services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.
8. Is provided through a Participating Hospice.

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

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

Period of Care - the time when the Participating Provider recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one 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 provider to the Member and his family that pertain to the palliative, supportive services required by the Member with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Participant or Dependent 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, eco-

nomie, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

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

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

HOSPITAL BENEFITS (FACILITY SERVICES)
(Other than Mental Health and Substance Use Disorder Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, and Dialysis Center Benefits, which are described elsewhere under Covered Services)

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3. In conjunction with a covered delivery, routine nursery care for a newborn of the Participant, covered spouse or Domestic Partner.
4. Reconstructive Surgery is covered 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. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

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.

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
6. Rehabilitation when furnished by the Hospital and approved in advance by the Claims Administrator under its Benefits Management Program.
7. Drugs and oxygen.
8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
9. X-ray examination and laboratory tests.
10. Dialysis and radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
11. Use of medical appliances and equipment.
12. Subacute Care.
13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
14. Medically Necessary Inpatient 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 detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.
2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.
3. Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
4. Reconstructive Surgery is covered 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. In accordance with the Women's Health & Cancer Rights

Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

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.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
6. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

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

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

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

1. the treatment of tumors of the gums;

- 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;

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

- Medically Necessary non-surgical treatment (e.g., splint and Physical Therapy) of Temporomandibular Joint Syndrome (TMJ);
- surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
- Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones);
- orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or
- dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

- services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
- 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;
- dental implants (endosteal, subperiosteal or transosteal);
- any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
- fluoride treatments except when used with radiation therapy to the oral cavity.

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

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

See the Out-Of-Area Services, BlueCard Program section for an explanation of how payment is made for out of state services.

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

Office Visits for Outpatient Mental Health and Substance Use Disorder Services

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

Other Outpatient Mental Health and Substance Use Disorder Services

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

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

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

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.

- Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure; used in the treatment of severe mental health conditions.
- Intensive Outpatient Program - an Outpatient Mental Health or Substance Use Disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment

5. Partial Hospitalization Program – an Outpatient treatment program that may be freestanding or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.
6. Psychological Testing - testing to diagnose a Mental Health Condition when referred by a Participating Provider.
7. Transcranial Magnetic Stimulation - a noninvasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

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

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

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

ORTHOTICS BENEFITS

Benefits are provided for orthotic appliances, including:

1. shoes only when permanently attached to such appliances;
2. special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
3. 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;
4. 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;
5. initial fitting and replacement after the expected life of the orthosis is covered.

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. No benefits are provided for backup or alternate items.

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

OUTPATIENT PRESCRIPTION DRUG BENEFITS

This plan provides benefits for Outpatient Prescription Drugs as specified in this section. A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. The Member must obtain all Drugs from a Participating Pharmacy, except as noted below.

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

Some Drugs, most Specialty Drugs, and prescription for Drugs exceeding specific quantity limits require prior authorization by the Claims Administrator for Medical Necessity, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section. The Member or his/her Physician or Health Care Provider may request prior authorization from the Claims Administrator.

Outpatient Drug Formulary

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

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

The prescription drug benefit is tiered, as described in the chart below. Your Copayment or Coinsurance will vary based on the drug tier.

Drug Tier

Formulary Generic Drugs

Formulary Brand Drugs

Non-Formulary Brand Drugs

Specialty Drugs

The Member can find the Drug Formulary at <https://www.blueshieldca.com/bzca/pharmacy/home.sp>. The

Member can also contact Customer Service at the number provided on the back page of his/her Evidence of Coverage to ask if a specific Drug is included in the Formulary, or to request a printed copy.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Member Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Pharmacy by visiting

<https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service.

If the Member obtains Drugs without a Claims Administrator Identification Card, the Claims Administrator will deny the claim, unless it is for an Emergency Service.

The Claims Administrator negotiates contracted rates with Participating Pharmacies for covered Drugs. The Member is responsible for paying the full contracted rate for all Drugs until the Member's Deductible has been met, except as stated below.

The Member must pay the applicable Copayment or Coinsurance for each prescription Drug when the Member obtains it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate.

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

If the Member's Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, the Member pays the applicable Formulary or Non-Formulary Brand Drug Copayment or Coinsurance.

If the Member selects a Brand Drug when a Generic Drug equivalent is available, the Member must pay the difference in cost, plus the Member's Generic Drug Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Generic Drug Copayment or Coinsurance. For example, the Member selects Brand Drug "A" when there is an equivalent Generic Drug "A" available. The Participating Pharmacy's contracted rate for Brand Drug "A" is \$300, and the contracted rate for Generic Drug "A" is \$100. The Member would be responsible for paying the \$200 difference in cost, plus the Member's Generic Drug Copayment or Coinsurance. This difference in cost does not apply to the Member's Calendar Year Deductible or Calendar Year- Out-of-Pocket

Maximum.

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

If the Member's Physician or Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, the Member pays the applicable tier Copayment or Coinsurance.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

When the Member obtains Drugs from a Non-Participating Pharmacy:

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

Blue Shield of California

Argus Health Systems, Inc.

P.O. Box 419019,

Dept 191

Kansas City, MO 64141

- The Claims Administrator will reimburse the Member as shown on the Summary of Benefits, based on the price he or she paid for the Drugs.

If the Member obtains Drugs from a Non-Participating Pharmacy for a covered emergency, the Claims Administrator will reimburse the Member based on the price the Member paid for the Drugs, minus any applicable Deductible and Copayment or Coinsurance.

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

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

The Member has the option to use the Claims Administrator's Mail Service Prescription Drug Program when he or she takes maintenance Drugs for an ongoing condition. This allows the Member to receive up to a 90-day supply of his/her Drug and may help save money. The Member may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. The Member's Physician or Health Care

Provider must indicate a prescription quantity equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

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

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

Obtaining Specialty Drugs through the Specialty Drug Program

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

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

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

Go to <http://www.blueshieldca.com> for a complete list of Specialty Drugs. Most Specialty Drugs require prior authorization for Medical Necessity by the Claims Administrator, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section.

Prior Authorization/Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

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

The Claims Administrator covers compounded medication(s) when:

- The compounded medication(s) include at least one

Drug,

- There are no FDA-approved, commercially available, medically appropriate alternatives,
- The compounded medication is self administered, and
- Medical literature supports its use for the diagnosis.

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

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

To request coverage for a Non-Formulary Drug, the Member, representative, or the Provider may submit an exception request to the Claims Administrator. Once all required supporting information is received, the Claims Administrator 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 the Claims Administrator denies a request for prior authorization or an exception request, the Member, representative, or the Provider can file a grievance with the Claims Administrator, as described in the *Settlement of Disputes* section.

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

1. Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a prescription Drug is available only in supplies greater than 30 days, the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.
2. The Claims Administrator has a Short Cycle Specialty

Drug Program. With the Member's agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows the Member to receive a 15-day supply of his/her Specialty Drug and determine whether the Member will tolerate it before he or she obtains the full 30-day supply. This program can help the Member save out of pocket expenses if he or she cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the program, which he or she can elect at that time. The Member or Physician may choose a full 30-day supply for the first fill.

If the Member agrees to a 15-day trial, the Network Specialty Pharmacy will contact him/her prior to dispensing the remaining 15-day supply to confirm that the Member is tolerating the Specialty Drug. The Member can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service.

3. The Member may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if the Member's Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and the Member is responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.
4. Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
5. The Member may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

The Claims Administrator does not provide coverage in the Outpatient Prescription Drug Benefit for the following. The Member may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of this Evidence of Coverage to determine if the Plan covers Drugs under that Benefit.

1. Any Drug the Member receives while Inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional (Physician) Benefits* and *Hospital Benefits (Facility Services)* sections of this Evidence of Coverage.
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of this Evidence of Coverage.
3. Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage

as the prescription drug.

4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
5. Drugs that are considered to be experimental or investigational.
6. Medical devices or supplies except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits*, *Durable Medical Equipment Benefits*, and the *Orthotics Benefits* sections of this Evidence of Coverage.
7. Blood or blood products. See the *Hospital Benefits* section of this Evidence of Coverage.
8. Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.
9. Medical food, dietary, or nutritional products. See the *Home Health Care Benefits*, *Home Infusion and Home Injectable Therapy Benefits*, *PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.
10. Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits*, *Home Infusion and Home Injectable Therapy Benefits*, *Hospice Program Benefits*, or *Family Planning Benefits* sections of this Evidence of Coverage.
11. All Drugs for the treatment of infertility
12. Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases, prior authorization by the Claims Administrator is required.
13. Contraceptive drugs or devices which do not meet all of the following requirements:
 - Are FDA-approved
 - Are ordered by a Physician or Health Care Provider
 - Are generally purchased at an outpatient pharmacy, and
 - Are self-administered.Other contraceptive methods may be covered under the *Family Planning Benefits* section of this Evidence of Coverage.
14. Compounded medication(s) which do not meet all of the following requirements:
 - The compounded medication(s) include at least one Drug,
 - There are no FDA-approved, commercially available, medically appropriate alternatives,

- The compounded medication is self-administered, and
 - Medical literature supports its use for the diagnosis.
15. Replacement of lost, stolen or destroyed Drugs.
 16. If the Member is enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the Hospice Program Benefits section.
 17. Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to:
 - Antibiotics prescribed to treat infection,
 - Drugs prescribed to treat pain, or
 - Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
 18. Except for a covered emergency, Drugs obtained from a pharmacy:
 - Not licensed by the State Board of Pharmacy, or
 - Included on a government exclusion list.
 19. Immunizations and vaccinations solely for the purpose of travel.
 20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
 21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

OUTPATIENT X-RAY, PATHOLOGY AND LABORATORY BENEFITS

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

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

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

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

PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS BENEFITS

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. All Benefits must be prescribed and/or ordered by the appropriate health care professional.

PODIATRIC BENEFITS

Benefits are provided for office visits, surgical procedures, and other covered Services customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures provided in conjunction with this Benefit, are described under the Professional (Physician) Benefits section. Covered lab and x-ray Services provided in conjunction with this Benefit are described under the Outpatient or Out-of-Hospital X-ray, Pathology and Laboratory Benefits section.

PREGNANCY AND MATERNITY CARE BENEFITS

Benefits are provided for maternity services, including the following:

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

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

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

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed Health Care

Provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

PREVENTIVE HEALTH BENEFITS

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

- 1) evidence-based items, drugs or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- 2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- 4) with respect to women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

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

PROFESSIONAL (PHYSICIAN) BENEFITS (Other than Preventive Health Benefit, Mental Health Benefits, Hospice Program Benefits, and Dialysis Center Benefits, which are described elsewhere under Covered Services.)

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

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found in the Preferred Provider Directory or the Online Physician Directory located at <http://www.blueshieldca.com>.

NCSMIG members can call Customer Service in advance of receiving services to request that an out of network (OON) professional physician visit be processed as in network when no other provider, of that specialty, is in network within 50 miles from the members home ZIP Code. If a member has to travel to an area that has in-network providers with the same specialty to receive service (e.g. Santa Rosa or San Francisco), the exception will not apply. In that case, the member will need to see an in-network provider. The plan will verify that there are no other in-network providers with that specialty within 50 miles of the member's ZIP Code or in the area the member is seeking services and will send the request to the group to confirm and approve the request.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
4. Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
5. Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room;
6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;
7. Surgical procedures. When multiple surgical procedures are performed during the same operation, benefits for the secondary procedure(s) will be determined based on the Claims Administrator Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;
8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery of-

fers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

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;

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10. Extra time spent when a Physician is detained to treat a Member in critical condition;
11. Necessary preoperative treatment;
12. Treatment of burns;
13. Outpatient routine newborn circumcisions.*
*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth;
14. Diagnostic audiometry examination.
15. Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit <http://www.teladoc.com/bsc>. The Teladoc Physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

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

Teladoc consultation Services are not intended to replace services from your Physician but are a supplemental service. You do not need to contact your Physician before using Teladoc consultation Services.

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

Note: If medications are prescribed, the applicable Out-patient Prescription Drug Benefits Copayments and requirements will apply. Teladoc consultation services are not available for specialist services or Mental Health and Substance Use Disorder Services.

PROSTHETIC APPLIANCES BENEFITS

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

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

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

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

REHABILITATION AND HABILITATIVE BENEFITS (PHYSICAL, OCCUPATIONAL AND RESPIRATORY THERAPY)

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

Benefits for Speech Therapy are described in the section on Speech Therapy (Rehabilitation and Habilitative Services) Benefits. The Claims Administrator may periodically review the provider's treatment plan and records for Medical Necessity. If the Claims Administrator determines that continued treatment is not Medically Necessary and not provided with the expectation that the patient has restorative potential pursuant to the treatment plan, the Claims Administrator will notify the Participant of this determination and benefits will not be provided for services rendered after the date of the written notification.

Services provided by a chiropractor are not included in this Rehabilitation Benefit. See the section on Chiropractic Benefits.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation/Habilitative Services rendered in the home.

Note: Covered lab and X-ray Services provided in conjunction with this Benefit are paid as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

SKILLED NURSING FACILITY BENEFITS (Other than Hospice Program Benefits which are described elsewhere under Covered Services.)

Benefits are provided for Medically Necessary Services provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility or Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

SPECIAL RADIOLOGICAL PROCEDURES

Benefits are provided for the following radiological procedures, when performed on an Outpatient, non-emergency basis.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and
5. any cardiac diagnostic procedure utilizing Nuclear Medicine.

SPEECH THERAPY BENEFITS (REHABILITATION AND HABILITATIVE SERVICES)

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

Continued Outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, to help the Member regain his or her previous performance level or to keep, learn, or improve skills and functioning. The Claims Administrator may periodically review the provider's treatment plan and records for Medical Necessity. 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/ pathologist, the Member will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

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

TRANSPLANT BENEFITS

Cornea, Kidney or Skin

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

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

In addition to the above procedures, Benefits are provided for the following Services for the recipient and one companion per transplant episode (limited to 6 trips per episode).

1. Pre-authorized Round trip air fare, train or current IRS mileage for auto travel to the Transplant Facility for each Member and companion up to the per trip maximum as shown on the Summary of Benefits.
2. Hotel accommodations limited to one double occupancy room for up to the daily maximum shown on the Summary of Benefits.

Benefits will be charged against the maximum aggregate

payment amount as shown on the Summary of Benefits.

Special Transplants

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

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

The following procedures are eligible for coverage under this provision:

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

In addition to the above procedures, Benefits are provided for the following Services for the recipient and one companion per transplant episode (limited to 6 trips per episode).

3. Pre-authorized Round trip air fare, train or current IRS mileage for auto travel to the Transplant Facility for each Member and companion up to the per trip maximum as shown on the Summary of Benefits. Note: Ground transportation is also covered if transported from one Special Transplant Facility to another Special Transplant Facility.
4. Hotel accommodations limited to one double occupancy room for up to the daily maximum shown on the Summary of Benefits.

Benefits will be charged against the maximum aggregate payment amount as shown on the Summary of Benefits.

PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. home for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns and other professionals in training without the supervision of an attending physician in association with an accredited clinical education program;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Member's home;
6. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;
7. for hearing aids, except as specifically listed;;
8. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual

- aids or video magnification equipment for any purpose;
9. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
 10. for routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
 11. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;
 12. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;
 13. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use;
 14. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to Medically Necessary Services which the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
 15. for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
 16. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
 17. for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications;
 18. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;
 19. which are Experimental or Investigational in nature, except for Services for Members who have been accepted into an approved clinical trial for treatment of cancer or life-threatening conditions as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits;
 20. for learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary Services which the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
 21. hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
 22. 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 Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

23. 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 Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
24. incident to organ transplant, except as explicitly listed under Transplant Benefits;
25. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the Claims Administrator consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
- Lower eyelid blepharoplasty;
 - Spider veins;
 - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
 - Hair removal by electrolysis or other means; and
 - Reimplantation of breast implants originally provided for cosmetic augmentation; and
 - Voice modification surgery.
26. 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.
 - 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;
27. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
28. for which the Member is not legally obligated to pay, or for services for which no charge is made;
29. 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 the Claims Administrator provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Claims Administrator for the treatment of such injury or disease;
30. in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
31. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Spe-

- cial Food Products Benefit and except as provided through a Participating Hospice Agency;
32. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
 33. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;
 34. 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 Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
 35. incident to bariatric surgery Services, except as specifically provided under Bariatric Surgery Benefits;
 36. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy Benefits under the Claims Administrator health plan;
 37. for services provided by an individual or entity that is not appropriately 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. for massage therapy that is not Physical Therapy or a component of a multimodality rehabilitation treatment plan;
 39. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drugs Supplement or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section;
 40. not specifically listed as a Benefit. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.

MEDICAL NECESSITY EXCLUSION

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

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

1. Your Claims Administrator group plan will provide benefits before Medicare in the following situations:
 - a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
 - b. When you are eligible for Medicare due to disability, if the Participant is covered by a

group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).

- c. When you are eligible for Medicare solely due to end-stage renal disease during the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
2. Your Claims Administrator group plan will provide benefits after Medicare in the following situations:
 - a. When you are eligible for Medicare due to age, if the Participant is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
 - b. When you are eligible for Medicare due to disability, if the Participant is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
 - c. When you are eligible for Medicare solely due to end-stage renal disease after the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
 - d. When you are retired and age 65 years or older.

When your Claims Administrator group plan provides benefits after Medicare, the combined benefits from Medicare and your Claims Administrator group plan may be lower but will not exceed the Medicare allowed amount.

When you are eligible for Medi-Cal

Medi-Cal always provides benefits last.

When you are a qualified veteran

If you are a qualified veteran your Claims Administrator group plan will pay the reasonable value or the Claims Administrator's Allowable Amount for covered Services provided to you at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Claims Administrator group plan will pay the reasonable

value or the Claims Administrator's Allowable Amount for covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Claims Administrator group plan will equal, but not exceed, what the Claims Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or the Claims Administrator's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how the Claims Administrator coordinates your group plan benefits in the above situations.

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS REVIEW

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

REDUCTIONS – THIRD PARTY LIABILITY

If a Member's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable or paid under the Plan unless the Member agrees in writing, in a form satisfactory to the Plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;

2. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Member's own uninsured or underinsured motorist coverage;
3. Execute a lien in favor of the Plan for the full amount of Benefits paid by the Plan;
4. Ensure that any Recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the Plan;
5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any Recovery has been obtained;
6. Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If a Member fails to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the Plan, through deductions from future benefit payments to the Member or others enrolled through the Member in the Plan.

"Recovery" includes 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 your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the Member or on the Member's behalf, and without regard to whether the Member has been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in the name of the Member, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of

how held, and includes monies directly received as well as any monies held in any account or trust on behalf of the Member, such as an attorney-client trust account.

The Member shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, the Member shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

The Member's acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys fees and costs incurred in connection with the claims against the third party.

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If the Member receives Services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such Services when payment or reimbursement is received by the Member for medical expenses.

COORDINATION OF BENEFITS

Coordination of Benefits is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive payments.

When a Member 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 Member 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 Member 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 Member as an employee will provide its benefits before the plan covering the Member 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 Member 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 Member 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 will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. 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 cov-

ering that Member 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 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 the Claims Administrator 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 Member (1) assigns to the Claims Administrator the right to receive benefits from the other plan to the extent of the difference between the value of the Benefits which the Claims Administrator actually provides and the value of the Benefits that the Claims Administrator would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator 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, the Claims Administrator 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. The Claims Administrator shall be fully discharged from liability under this Plan to the extent of these payments.

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

The Claims Administrator may release to or obtain from any organization or person any information which the Claims Administrator 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 the Claims Administrator with such information as may be necessary to implement these provisions.

TERMINATION OF BENEFITS

Except as specifically provided under the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this health Plan.

Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Plan is discontinued, (2) the last day of the month in which the Par-

Participant's employment terminates, unless a different date has been agreed to between the Claims Administrator and your Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer; 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 Participant, entry of a final decree of divorce, annulment or dissolution of marriage from the Participant. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your Employer is subject to the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of fees will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

The Claims Administrator may terminate your and your Dependent's coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or the Claims Administrator;
2. Permitting use of your Participant identification card by someone other than yourself or your Dependents to obtain Services; or
3. Obtaining or attempting to obtain Services under the Plan Document by means of false, materially misleading, or fraudulent information, acts or omissions.

If a written or electronic application for the addition of a newborn or a child placed for adoption is not submitted to and received by the Claims Administrator within the 60 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 31st day at 11:59 p.m. Pacific Time.

GROUP CONTINUATION COVERAGE

CONTINUATION OF GROUP COVERAGE

Applicable to Members when the Participant's Employer is subject to Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, a Member will be entitled to elect to continue group coverage under this Plan if the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Employer is subject

to the continuation of group coverage provisions of COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

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

1. With respect to the Participant:
 - a. the termination of employment (other than by reason of gross misconduct); or
 - b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Participant or Domestic Partner during a COBRA continuation period may be immediately 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):
 - a. the death of the Participant; or
 - b. the termination of the Participant's employment (other than by reason of such Participant's gross misconduct); or
 - c. the reduction of the Participant's hours of employment to less than the number of hours required for eligibility; or
 - d. the divorce or legal separation of the Participant from the Dependent spouse or termination of the domestic partnership; or
 - e. the Participant's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
 - f. a Dependent child's loss of Dependent status under this Plan.
3. With respect to a Participant who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA.

Notification of a Qualifying Event

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

The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Participant's death, termination, or reduction of hours of employment, the Participant's Medicare entitlement or the Employer's filing for re-organization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

Duration and Extension of Continuation of Group Coverage

In no event will continuation of group coverage under 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.

Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group dues rate, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be no more than 150 percent of the applicable group dues rate.

If the Member is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all dues contributions to the Claims Administrator in the manner and for the period established under this Plan.

Effective Date of the Continuation of Coverage

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

Termination of Continuation of Group Coverage

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

1. discontinuance of this group health plan (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to the Claims Administrator as applicable. Coverage will end as of the end of the period for which dues were paid;
3. the Member becomes covered under another group health plan;
4. the Member becomes entitled to Medicare;
5. the Member commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA will not be terminated except as described in this provision.

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 Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

GENERAL PROVISIONS

LIABILITY OF PARTICIPANTS IN THE EVENT OF NON-PAYMENT BY THE CLAIMS ADMINISTRATOR

In accordance with the Claims Administrator's established policies, and by statute, every contract between the Claims Administrator and its Participating Providers and Preferred Providers stipulates that the Participant shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Participant's Plan. Participating Providers and Preferred Providers have agreed to accept the Plan's payment as payment-in-full for covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the

Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Participant is responsible for all amounts the Claims Administrator does not pay.

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

INDEPENDENT CONTRACTORS

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

NON-ASSIGNABILITY

Coverage or any Benefits of this Plan may not be assigned without the written consent of the Claims Administrator. Possession of an ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Member must be a Participant or Dependent who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment under the terms of this Plan.

Participating Providers and Preferred Providers are paid directly by the Claims Administrator.

If the Member receives Services from a Non-Preferred Provider, payment will be made directly to the Participant, and the Participant is responsible for payment to the Non-Preferred Provider. The Member or the provider of Service may not request that the payment be made directly to the provider of Service.

PLAN INTERPRETATION

The Claims Administrator shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan. The Claims Administrator shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

The Claims Administrator protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. The Claims Administrator will not disclose this information without your authorization, except as permitted by law.

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

The Claims Administrator's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed on the back of this booklet, or by accessing the Claims Administrator's internet site located at <http://www.blueshieldca.com> and printing a copy.

If you are concerned that the Claims Administrator 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

The Claims Administrator 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 Plan. You agree that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. You agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in your possession. Failure to assist the Claims Administrator 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 the Claims Administrator will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

RIGHT OF RECOVERY

Whenever payment on a claim has been made in error, the Claims Administrator will have the right to recover such payment from the Participant or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. The Claims Administrator reserves the right to deduct or offset any amounts paid in er-

ror 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 Participant or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant or Member's eligibility, or payments on fraudulent claims.

CUSTOMER SERVICE

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact the Customer Service Department as noted on the last page of this booklet.

The hearing impaired may contact the Customer Service Department through the Claims Administrator's toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: The Claims Administrator has established a procedure for our Participants and Dependents 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 Claims Administrator shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other healthcare Services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number provided on the last page of this booklet.

SETTLEMENT OF DISPUTES

INTERNAL APPEALS

Initial Internal Appeal

If a claim has been denied in whole or in part by the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may request that the Claims Administrator give further consideration to the claim by contacting the Customer Service Department via telephone or in writing including any additional information that would affect the processing of the claim. The Claims Administrator will acknowledge receipt of an appeal within 5 calendar days. Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be filed within 180 days after you receive notice of an adverse benefit decision. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator.

Final Internal Appeal

If you are dissatisfied with the initial internal appeal determination by the Claims Administrator, the determination may be appealed in writing to the Claims Administrator within 60 days after the date of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefore. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse you for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator. Written requests for final internal appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Expedited Appeal (Initial and Final)

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. The Claims Administrator will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon as possible to accommodate your condition, not to exceed 72 hours. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Final Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health.

EXTERNAL REVIEW

Standard External Review

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment or a rescission of coverage, you, a designated representative, a provider or an attorney on your behalf may request an external review within four months after notice of the final internal appeal determination. Instructions for filing a request for external review will be outlined in the final internal appeal response letter.

Expedited External Review

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the adverse benefit decision without participating in the initial or final internal appeal process. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may fax a request to (916) 350-7585, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California
Attn: Expedited External Review
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Other Resources to Help You

For questions about your appeal rights, or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

DEFINITIONS

PLAN PROVIDER DEFINITIONS

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

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

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

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

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

Hospital —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.
2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

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

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

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

Non-Participating/Non-Preferred Providers — any provider who has not contracted with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Deductible, Copayment, or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services.

Non-Preferred Hemophilia Infusion Provider — a provider that has not contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has not been designated as a contracted hemophilia infusion product provider by the Claims Administrator. Note: Non-Preferred Hemophilia Infusion Providers may include Participating Home Health Care and Home Infusion Agency Providers if that provider does not also have an agreement with the Claims Administrator to furnish blood factor replacement products and services.

Other Providers —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dietitians; certified nurse midwives; licensed occupational therapists; licensed acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2. Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray

companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

Participating Ambulatory Surgery Center — an Outpatient surgery facility which:

1. is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,
2. provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and,
3. has contracted with the Claims Administrator to provide Services on an Outpatient basis.

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

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

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

Participating Physician — a selected Physician or a Physician Member that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

Participating Provider — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applica-

ble Deductibles and Copayments, as payment in full for covered Services.

Note: This definition does not apply to Hospice Program Services. For Participating Providers for Hospice Program Services, see the Participating Hospice or Participating Hospice Agency definitions above.

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

Physician Member — a Doctor of Medicine who has enrolled with the Claims Administrator as a Physician Member.

Preferred Dialysis Center — a dialysis services facility which has contracted with the Claims Administrator to provide dialysis Services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Laboratory Facility (Laboratory Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide laboratory services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Free-Standing Radiology Facility (Radiology Center) — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide radiology services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hemophilia Infusion Provider — a provider that has contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has been designated as a contracted Hemophilia Infusion Provider by the Claims Administrator.

Preferred Hospital — a Hospital under contract to the Claims Administrator which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Claims Administrator.

Preferred Provider — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider.

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.

ALL OTHER DEFINITIONS

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

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

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

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

Allowable Amount — unless otherwise stated in this booklet, the lower of either the Claims Administrator's Agreed Amount, or the Claims Administrator's Reasonable Amount.

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 (Services) — those Services which a Member is entitled to receive pursuant to the Plan Document.

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

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

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

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

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

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

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

Claims Administrator — the claims payor designated by the Employer to adjudicate claims and provide other services

as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

Claims Administrator's Agreed Amount — the amount agreed upon by the Claims Administrator and the provider or, if there is no agreement, the provider's billed charges.

Claims Administrator's Reasonable Amount — the amount determined by the Claims Administrator to be the fair value of the Services. In its discretion, the Claims Administrator may determine fair value based upon a variety of data or methods that the Claims Administrator determines to be appropriate based on the type of Service and the particular circumstances. The Claims Administrator's determination of fair value typically may include use of one or more of the following factors: (1) the amounts paid by the Claims Administrator to providers who have agreements with the Claims Administrator; (2) studies, surveys or third-party compilations of amounts charged by providers for the Services; or (3) amounts paid by governmental or private payors for the Services. In addition, if the Services were rendered outside of California, the Claims Administrator may determine fair value based upon the amounts paid by the local Blue Cross and/or Blue Shield plan for the Services. If the Claims Administrator has not made a determination of the fair value of the Services, then the Claims Administrator's Reasonable Amount will be the provider's billed charges.

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

Contractholder — is North Coast Schools' Medical Insurance Group and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for benefits under the Plan.

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

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

Covered Services (Benefits) — those Services which a Member is entitled to receive pursuant to the terms of the Plan Document.

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

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

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

Deductible — the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dependent —

1. a Participant's legally married spouse who is:
not legally separated from the Participant;
or,
2. a Participant's Domestic Partner;
or,
3. a child of, adopted by, or in legal guardianship of the Participant, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Participant, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Participant who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship)

and who has been enrolled and accepted by the Claims Administrator as a Dependent and has maintained participation in accordance with the Claims Administrator Plan.

Note: Children of Dependent children (i.e., grandchildren of the Participant, spouse, or Domestic Partner) are not Dependents unless the Participant, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:
 - a. the child must be chiefly dependent upon the Participant, spouse, or Domestic Partner for support and maintenance;
 - b. the Participant, spouse, or Domestic Partner submits to the Claims Administrator a Physician's written certification of disability within 60 days from the date of the Employer's or the Claims Administrator's request; and
 - c. thereafter, certification of continuing disability and dependency from a Physician is submitted to the Claims Administrator on the following schedule:
 - (1) within 24 months after the month when the Dependent would otherwise have been terminated; and
 - (2) annually thereafter on the same month when certification was made in accordance with item

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

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

- 1) Both partners are (a) 18 years of age or older and (b) of the same or different sex;
- 2) The partners share (a) an intimate and committed relationship of mutual caring and (b) the same common residence;
- 3) The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
- 4) Both partners were mentally competent to consent to a contract when their domestic partnership began.

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

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

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

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

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 items such as wheelchairs, Hospital beds, respirators, and other items that the Claims Administrator determines are Durable Medical Equipment.

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

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

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

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

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

Employee — an individual who meets the eligibility requirements set forth in the Plan Document.

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

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

authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Participant and all enrolled Dependents.

Family Coverage — coverage provided for two or more Members, as defined herein.

Formulary — A list of preferred Generic and Brand Drugs maintained by the Claims Administrator's Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

Generic Drugs — Drugs that are approved by the FDA or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug.

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

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

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

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

Infertility —

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

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.

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

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent shall not be considered a Late Enrollee

if any of the following paragraphs (1.), (2.), (3.), (4.), (5.), (6.) or (7.) is applicable:

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
 - a. The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time he or she was offered enrollment under this Plan; and
 - b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan or had other health insurance coverage, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
 - c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
 - d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and the eligible Employee elects this Plan during an open enrollment period; or
3. A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period

permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or

5. For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
6. For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or
7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Medical Necessity (Medically Necessary) —

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

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Claims Administrator, are:
 - a. consistent with the Claims Administrator medical policy;
 - b. consistent with the symptoms or diagnosis;
 - c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
 - d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. If there are two or more medically necessary services that may be provided for the illness, injury or medical condition, the Claims Administrator will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are medically necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services not medically necessary include hospitalization:

- a. for diagnostic studies that could have been provided on an Outpatient basis;
 - b. for medical observation or evaluation;
 - c. for personal comfort;
 - d. in a pain management center to treat or cure chronic pain; and
 - e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.
4. The Claims Administrator reserves the right to review all claims to determine whether services are medically necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member — either a Participant or Dependent.

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

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

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

Network Specialty Pharmacy— select Participating Pharmacies contracted by the Claims Administrator to provide covered Specialty Drugs.

Non-Formulary Drugs — Drugs that the Claims Administrator’s Pharmacy and Therapeutics Committee has determined do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment or Coinsurance.

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

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

Open Enrollment Period — that period of time set forth in the plan document during which eligible employees and their Dependents may transfer from another health benefit plan sponsored by the employer to the Preferred Plan.

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

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

- 1) Partial Hospitalization
- 2) Intensive Outpatient Program
- 3) Electroconvulsive Therapy
- 5) Transcranial Magnetic Stimulation
- 6) Psychological Testing

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

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

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

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

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.

Participant — an employee who has been accepted by the Employer and enrolled by the Claims Administrator as a Participant and who has maintained enrollment in accordance with this Plan.

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

Plan — the Preferred Savings Plan for eligible Employees of the Employer.

Plan Administrator — is North Coast Schools' Medical Insurance Group.

Plan Document — the document issued by the Plan that establishes the services that Participants and Dependents are entitled to receive from the Plan.

Plan Sponsor — is North Coast Schools' Medical Insurance Group.

Preventive Health Services — mean those primary preventive medical Covered Services, 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 at <http://www.blueshieldca.com/preventive> or by calling Customer Service.

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

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

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

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

Reasonable and Customary Charge — in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Claims Administrator 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, if applicable.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible; dental and orthodontic Services that are an integral part of Reconstructive 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 and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

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

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

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

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

features, risk of suicide or risk of violence due to a mental disorder.

Services — includes medically necessary healthcare 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.

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

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

Specialty Drugs - Drugs requiring coordination of care, close monitoring, or extensive patient training 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, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

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

Subacute Care — skilled nursing or skilled 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.

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 (or Totally Disabled) —

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

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

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

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 문은 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 Լեզվախոս Ծառայություններ: Դուք կարող եք թարգման և երբ քերել և փաստաթղթերը ընթերցել տալ և ևս ևս համար հայերեն լեզվով: Օգնության համար մեզ գանգառարեք ևեր ինքնաբերական (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 جانی مربوط به زبان. می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی بر اینان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما فید شده است و با این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਆਰੀਏ 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 និងអាសនៈការព្រះសង្ឃជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដៃសមាស ចង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក 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 ntauv 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

For claims submission and information contact the Claims Administrator.

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

Participants may call Customer Service toll free:

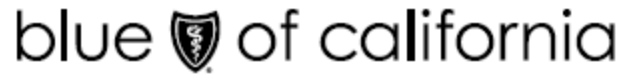
1-855-256-9404

The hearing impaired may call Customer Service through the toll-free TTY number:
711

Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the Customer Service telephone number indicated on the back of the Member's identification card

Please refer to the Benefits Management Program section of this booklet for information.



NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

Phone: (844) 831-4133 (TTY: 711)

Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

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

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

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

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

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

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

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng isang tao na makatutulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito sa iyong wika. Para sa tulong na walang gastos, mangyaring tumawag kaagad sa numero ng telepono ng Serbisyo sa Miyembro/Customer na nasa likod ng iyong Dental ID kard ng Blue Shield. (Tagalog)

Baa' ákohwiindzindoogí: Díí naaltsoosish yíiniilta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'í' yiidóoltahígíí la' nihee hóóló. Díí naaltsoos aldó' t'áá Diné k'ehjí ádoolnííł nínízingo bíighah. Doo bąąh ilínígó shíká' adoowol nínízingó nihich'í' béésh bee hodiilnih dóó námboo éí díí Blue Shield bee néího' dílzínígí bine'déé' bikáá'. (Navajo)

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

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

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

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

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

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

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អភិវឌ្ឍន៍ដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

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

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

สำคัญ: คุณอาจเจตหมายฉบับนี้ไม่ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้ช่วยได้ คุณอาจได้รับเจตหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

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

