Preferred PPO Premium Plan
Medicare

Benefit Booklet

CSAC Excess Insurance Authority

City of Redding

Group Number: W0052147-M0018744

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An independent member of the Blue Shield Association

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Claims Administered by Blue Shield of California

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Grandfathered Health Plan Notice

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

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

ERISA Notice

This Plan is a self-funded governmental group health plan which, for the most part, is exempt from the requirements of ERISA (the Employee Retirement Income Security Act). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

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 Medical 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 Medical 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 Medical Plan or the care provided to you.
16. Make recommendations regarding the Claims Administrator's Participant rights responsibilities policy.

The Preferred Medical 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 Medical 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 Medical 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

INTRODUCTION....18
Preferred Providers....18
Continuity of Care by a Terminated Provider....19
Financial Responsibility for Continuity of Care Services....19
Submitting a Claim Form....19
Eligibility....19
EFFECTIVE DATE OF COVERAGE....20
MEDICAL CARE BENEFITS....21
Annual Open Enrollment....21
Special Enrollment Event....21
Effective Date for Late Enrollees....21
RENEWAL OF PLAN....22
SERVICES FOR EMERGENCY CARE....22
UTILIZATION REVIEW....22
SECOND MEDICAL OPINION POLICY....22
HEALTH EDUCATION AND HEALTH PROMOTION SERVICES....22
RETAIL-BASED HEALTH CLINICS....22
NURSEHELP 24/7 SM....22
THE CLAIMS ADMINISTRATOR ONLINE....23
BENEFITS MANAGEMENT PROGRAM....23
PRIOR AUTHORIZATION....23
DEDUCTIBLE....25
Calendar Year Deductible (Medical Plan Deductible)....25
Services Not Subject to the Deductible....25
Prior Carrier Deductible Credit....25
Last Quarter Carry Over....25
NO LIFETIME BENEFIT MAXIMUM....25
NO ANNUAL DOLLAR LIMITS ON ESSENTIAL BENEFITS....25
PAYMENT....25
OUT-OF-AREA SERVICES....25
PARTICIPANT'S CALENDAR YEAR OUT-OF-POCKET MAXIMUM....27
PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES)....27
Acupuncture Benefits....28
Allergy Testing and Treatment Benefits....28
Ambulance Benefits....28
Ambulatory Surgery Center Benefits....28
Chiropractic Benefits....28
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Benefits....28
Diabetes Care Benefits....29
Dialysis Centers Benefits....29
Durable Medical Equipment Benefits....30
Emergency Room Benefits....30
Family Planning Benefits....30
Home Health Care Benefits....31
Home Infusion/Home Injectable Therapy Benefits....31
Hospice Program Benefits....32
Hospital Benefits (Facility Services)....34
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits....35
Mental Health and Substance use Disorder Benefits....36
Orthotics Benefits....36
Outpatient Prescription Drug Benefits....37
Outpatient X-ray, Pathology and Laboratory Benefits....37
PKU Related Formulas and Special Food Products Benefits....37
Podiatric Benefits....37
Pregnancy and Maternity Care Benefits....37
Preventive Health Benefits....37
Professional (Physician) Benefits....38
Prosthetic Appliances Benefits....39
Radiological and Nuclear Imaging Benefits....39

TABLE OF CONTENTS

Rehabilitative and Habilitative Benefits (Physical, Occupational and Respiratory Therapy) 39
Skilled Nursing Facility Benefits 40
Speech Therapy Benefits (Rehabilitative and Habilitative Services) 40
Transplant Benefits 40
Special Transplants 40
Principal Limitations, Exceptions, Exclusions and Reductions 41
General Exclusions and Limitations 41
Medical Necessity Exclusion 44
Limitations for Duplicate Coverage 44
Exception for Other Coverage 45
Claims Review 45
Reductions – Third Party Liability 45
Coordination of Benefits 47
TERMINATION OF BENEFITS 48
GROUP CONTINUATION COVERAGE 48
Continuation of Group Coverage 48
Continuation of Group Coverage for Participants on Military Leave 50
GENERAL PROVISIONS 50
Liability of Participants in the Event of Non-Payment by the Claims Administrator 50
Independent Contractors 50
Non-Assignability 50
Plan Interpretation 50
Confidentiality of Personal and Health Information 51
Access to Information 51
Right of Recovery 51
CUSTOMER SERVICE 51
SETTLEMENT OF DISPUTES 52
DEFINITIONS 52
Plan Provider Definitions 52
All Other Definitions 54
NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS 62

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 Medical 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 Participant 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.

Plan Administrator and Plan Sponsor

The Employer is the Plan Administrator and Plan Sponsor.

The Plan Administrator shall retain the authority to delegate its officers and Employees such responsibilities that are imposed by the terms of the Plan s together with authority to control and manage the operation of the Benefit Plan.

The designated party, that sets up a healthcare plan for the benefit of the Employer's Employees. The responsibilities of the Plan Sponsor include determining membership parameters, investment choices and, providing contribution payment.

Program Administrator

The CSAC Excess Insurance Authority is the Program Administrator. The Authority shall have the duty to interpret and construe the Memorandum of Understanding with regard to overall administration of the Program.

Claims Administrator

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.

Each Member Entity which has established a Benefit Plan for its Employees and are signatory to the Memorandum of Understanding shall have the duty and authority to interpret and construe the Benefit Plan it has established on behalf of the Member Entity's Employees subject to the Memorandum with the Authority.

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.

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Summary of Benefits

Group Plan

Preferred Benefit Plan

Preferred 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 participating[3] or non-participating[4] provider
Calendar year medical deductible	*Individual coverage*	$200
	Family coverage	$200: individual $600: family

Calendar Year Out-of-Pocket Maximum[5]

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.

	When using a participating[3] or non-participating[4] provider	
Individual coverage	$1,000	$1,000
Family coverage	$1,000: individual $1,000: family	$1,000: individual $1,000: family

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.

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Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Preventive Health Services[7]				
Annual routine gynecological office visit, including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test, human papillomavirus (HPV) screening tests.	$0		30%	✔
Annual routine physical examination office visit, including the physical examination office visit, routine eye/ear screening for Members through age 18 and pediatric and adult immunizations and the immunization agent.	$0		30%	✔
Colorectal cancer screening Physician Services for Members age 50 and over	$0		30%	✔
Osteoporosis screening for Members age 65 and over or 60 and over if at increased risk	$0		30%	✔
Routine laboratory Services including well baby laboratory Services	$0		30%	✔
Well baby office visits, including well baby examination office visit, pediatric immunizations and the immunization agent, well baby vision and hearing screening	$0		30%	✔
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	20%	✔	30%	✔
Specialist care office visit	20%	✔	30%	✔
Second opinion consultation	$0		$0	
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%	✔

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Other professional services				
Other practitioner office visit	20%	✔	30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	20%	✔
Chiropractic services	20%	✔	30%	✔
Up to 30 visits per member, per calendar year.				
Teladoc consultation	$40/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%	✔
• Vasectomy	20%	✔	30%	✔
• Infertility services	20%	✔	30%	✔
Diagnosis and treatment of cause of Infertility				
Podiatric services	20%	✔	30%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	20%	✔	30%	✔
Midwife Services	20%	✔	20%	✔
Outpatient Hospital (Facility) and Professional (Physician) laboratory/genetic testing and radiology/ultrasound related to pregnancy and maternity care	$0		30%	✔
Physician services for pregnancy termination	$0		Not covered	

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Emergency services				
Emergency room services	20%		20%	
If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room physician services	20%	✔	20%	✔
Urgent care center services	20%	✔	30%	✔
Ambulance services	20%	✔	20%	✔
This payment is for emergency or authorized transport.				
Outpatient facility services				
Ambulatory surgery center	$0		30%	
Outpatient department of a hospital: surgery	$0		30%	
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0		30%	
Inpatient facility services				
Hospital services and stay	$0		30%	
Transplant services				
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.				
• Special transplant facility inpatient services	$0		Not covered	
• Physician inpatient services	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$0		30%	✔
• Outpatient department of a hospital	$0		30%	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$0		30%	✔
• Outpatient department of a hospital	$0		30%	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	$0		30%	✔
• Outpatient department of a hospital	$0		30%	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	$0		30%	✔
• Outpatient department of a hospital	$0		30%	✔

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Rehabilitative and habilitative services				
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.				
Office location	20%	✔	30%	✔
Outpatient department of a hospital	20%	✔	30%	✔
Durable medical equipment (DME)				
DME	20%	✔	30%	✔
Breast pump	$0		30%	✔
Orthotic equipment and devices	20%	✔	30%	✔
Prosthetic equipment and devices	20%	✔	30%	✔
Home health services				
Up to 100 visits per member, per calendar year, by a home health care agency. All visits count towards the limit, including visits during any applicable deductible period, except hemophilia and home infusion nursing visits.				
Home health agency services	20%		20%	
Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.				
Home visits by an infusion nurse	20%		20%	
Home health medical supplies	20%		20%	
Home infusion agency services	20%		20%	
Hemophilia home infusion services	20%		20%	
Includes blood factor products.				

Benefits[6]	Your payment			
	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Skilled nursing facility (SNF) services				
Up to 140 days per member, per benefit period, except when provided as part of a hospice program. All days count towards the limit, including days during any applicable deductible period and days in different SNFs during the calendar year.				
Freestanding SNF	20%	✔	20%	✔
Hospital-based SNF	20%	✔	30%	✔
Hospice program services	20%		20%	
Includes pre-hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.				
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	30%	✔
• Self-management training	20%	✔	30%	✔
Dialysis services	20%	✔	30%	✔
PKU product formulas and special food products	20%	✔	20%	✔
Allergy serum	20%	✔	30%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder benefits are provided through the Claims Administrator.	When using a participating provider[3]	CYD[2] applies	When using a non-participating provider[4]	CYD[2] applies
Outpatient services				
Office visit, including physician office visit - Employee	$0 for visits 1-12		$0 for visits 1-12	
Office visit, including physician office visit - Employee	20% for visits 13-36	✔	30% for visits 13-36	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder benefits are provided through the Claims Administrator.	**When using a participating provider[3]**	**CYD[2] applies**	**When using a non-participating provider[4]**	**CYD[2] applies**
Office visit, including physician office visit - Dependent	50% for visits 1-6		50% for visits 1-6	
Office visit, including physician office visit - Dependent	20% for visits 7-36	✔	30% for visits 7-36	✔
Other outpatient services, including intensive outpatient care and office-based opioid treatment	20%	✔	30%	✔
Partial hospitalization program	$0		30%	
Psychological testing	20%	✔	30%	✔
Inpatient services				
Physician inpatient services	20%	✔	30%	✔
Hospital services	$0		30%	
Residential care	$0		$0	
Up to 90 days per member, per calendar year; 180 days per member, per lifetime for Mental Health.				
Up to 30 days per member, per calendar year; 60 days per member, per lifetime for Substance Use Disorder.				

Prior Authorization

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

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from non-participating providers
- Mental health services, except outpatient office visits
- Hospice program services

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

Notes

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 Calendar Year 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 medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible.

These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This benefit Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

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 EOC. 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 combined Participating Provider 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.

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

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 Member. 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 Member 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 Member 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, access the Claims Administrator's Internet site located at http://www.blueshieldca.com, or call 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.

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 for the Deductibles, Copayments, and 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. 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.

When medical care is received from a Participating Provider, the Plan will apply Benefits using the Allowable Amount. Participating Providers agree to not bill the Member for any charges in excess of the Allowable Amount. The Member pays the Participating Provider Deductible and coinsurance as shown in the Summary of Benefits, plus any charges that are not covered by the Plan and any charges that are otherwise excluded or limited by the Plan.

Except as otherwise specified in this booklet, for care received from a Non-Participating Provider (other than a Hospital/ Outpatient Facility), the Plan will apply benefits based on 90% of the Reasonable and Customary Charge (after the Non-Participating Deductible is satisfied). The Member pays the Non-Participating Provider Deductible and coinsurance as shown in the Summary of Benefits, plus any amounts above the Reasonable and Customary Charge, any charges that are not covered by the Plan and any charges that are excluded or limited by the Plan.

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.

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

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the 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. 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, Member'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 Member'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

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 Member the first day of employment. Your spouse or Domestic Partner and all your Dependent children are eligible at the same time.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under another 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. 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 birth or 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 and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

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

Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are both 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 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 Employer.

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.

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

If a Member fails or refuses to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the plan, he or she will immediately lose eligibility to continue enrollment.

Effective Date of Coverage

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to the Claims Administrator, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If your Dependent is a Late Enrollee, your Dependents' coverage will become effective the earlier of 12 months from the date you made a written request for coverage for your Dependents or at the Employer's 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 or other health insurance, 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 subsequently acquire Dependents as a result of marriage, establishment of domestic partnership, birth, or placement for adoption, you may request enrollment for 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 effective date will be the date of marriage or establishments of domestic partnership;
2. For birth, the effective date will be the date of birth;
3. For a child placed for adoption, the effective date will be

the date the Employee, spouse, or Domestic Partner has the right to control the child's health care.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may update your enrollment to the Preferred Plan. A completed enrollment form must be forwarded to the Claims Administrator within the Open Enrollment Period. Enrollment becomes effective on the date of this Plan immediately following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, 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.

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 Employee, spouse or Domestic Partner has the right to control the child's health care. In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by the Claims Administrator within 31 days. An application may also be submitted electronically, if available. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. 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 within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer's next Open Enrollment Period, or at the time there is a qualified status change.

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.

Medical Care Benefits

The individual's coverage will be effective as described in this booklet.

Annual Open Enrollment

An annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent special enrollment period; or
- during any previous annual Open Enrollment Period; or
- within 60 days after the termination date, if the individual was previously covered under the Plan but elected to terminate the coverage.

To qualify for enrollment during the annual Open Enrollment Period, the Member or Dependent:

- must meet the eligibility requirements described in the Plan, including satisfaction of any applicable waiting period; and
- may not be covered under an alternate medical expense coverage offered by the Employer, unless the annual Open Enrollment Period happens to coincide with a separate Open Enrollment Period established for coverage election.

The effective date for any qualified individual requesting coverage during the annual Open Enrollment Period will be the day immediately following the completion of the annual Open Enrollment Period.

Special Enrollment Event

If you or your Dependent request enrollment after the first period in which you or your Dependent were eligible to enroll but during a special enrollment event due to a family status change (newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees), you or your Dependent will be a special enrollee and will not be considered a Late Enrollee.

If the Employer offers different Benefit options, a Benefit option transfer may also be made on any contribution due date if your request is due to a special enrollment event and you complete the appropriate enrollment form within the time specified for a special enrollment event due to a family status change (newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees).

If a request for contributory coverage is made more than 60 days after the date an individual is eligible but during a special enrollment event due to a family status change, coverage for such individual will become effective as described within in this section.

Effective Date for Late Enrollees

If a late enrollee requests coverage other than during an annual Open Enrollment Period or special enrollment period,

the effective date of coverage for the late enrollee will be the next plan anniversary date, provided on such date:

- the Dependents continue to meet the Plan's definition of Dependent.

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;
5. Employer relocates outside of California;
6. association membership ceases.

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 Provider'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 24/7 SM

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 obtain 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:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) 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 Rehabilitative Services, Skilled Nursing care, and Special Transplant. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant, 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 non-emergency 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, 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.

Deductible

Calendar Year Deductible (Medical Plan Deductible)

The Calendar Year per Member and per Family Deductible amounts are shown on the Summary of Benefits. The Summary of Benefits indicates whether or not the Calendar Year Deductible applies to a particular Covered Service.

There are individual and Family Calendar Year Deductible amounts. The individual Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Deductible within the Family Deductible. This means the Claims Administrator will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met.

Once the respective Deductible is reached, Covered Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

For Covered Services received from Non-Participating Providers, the Member is responsible for the applicable Copayment or Coinsurance and for amounts billed in excess of the Claims Administrator's Allowable Amount. Charges in excess of the Claims Administrator's Allowable Amount do not accrue to the Calendar Year Medical Deductible.

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 a health plan sponsored by your Employer or under an Individual and Family Health Plan (IFP) issued by the Claims Administrator during the same Calendar Year this Plan becomes effective, that amount will be applied to the Deductible required under this Plan.

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

Last Quarter Carry Over

If charges for covered Services received during the last 3 months of the Calendar Year are applied to the Deductible, the Deductible for the next Calendar Year will be reduced by that amount.

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 Member 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.

Participant's Calendar Year Out-of-Pocket Maximum

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

If a benefit plan has any Calendar Year Deductible, it will accumulate toward the applicable Calendar Year Out-of-Pocket Maximum. Once a Member's Out-of-Pocket Maximum has been met*, the Plan will pay 100% of the Allowable Amount for that Member's covered Services for the remainder of that Calendar Year, except as described below. Once the Family Out-of-Pocket Maximum has been met*, the Plan will pay 100% of the Allowable Amount for the Participant's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as described below.

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 maximum Calendar Year Out-of-Pocket Maximum.

*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 these items may cause a Participant's payment responsibility to exceed the maximums.

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

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 Administrator 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 Members will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Member 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 Benefit 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 (surface and air) from one medical facility to another. Ambulance services are required to be provided by a licensed ambulance or a psychiatric transport van.

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 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.

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

2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

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

DIABETES CARE BENEFITS

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 if selected as an optional Benefit by your Employer.

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 Member to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's 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, registered 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 if selected as an optional Benefit by your Employer.);
3. Breast pump rental or purchase is only covered if obtained 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 Provider'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 Member 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 Member is responsible for the Emergency Room Member Copayment plus the appropriate Admitting Hospital Services Member 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.

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. Diagnosis and treatment of cause of Infertility including office visits, laboratory and radiology Services. No Benefits are provided for Services for Infertility treatment related to the harvesting or stimulation of the human ovum, in-vitro fertilization (IVF), artificial insemination, Gamete Intrafallopian Transfer (G.I.F.T.), Zygote Intrafallopian Transfer (ZIFT) procedure, or any other form of assisted fertilization;
3. Intrauterine devices (IUDs), including insertion and/or removal;
4. Implantable contraceptives;

5. Injectable contraceptives when administered by a Physician;
6. Voluntary sterilization (tubal ligation and vasectomy). No Benefits are provided for contraceptives, except as may be provided under the Outpatient prescription drug Benefit supplement if your Employer provides Benefits for Outpatient prescription drugs;
7. Diaphragm fitting procedure.

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 supplemental Benefit for Outpatient Prescription Drugs if selected as an optional Benefit by your Employer.

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 Drug Benefits Supplement if selected as an optional Benefit by your Employer, 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 Rehabilitative 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 Blue Shield.

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.

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

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

Volunteer Services - Services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the 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 Rehabilitative and Habilitative (Physical, Occupational and Respiratory Therapy) Benefits and Speech Therapy Benefits (Rehabilitative 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;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Member as determined by the Plan;

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

3. Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones);
4. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity;
5. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repairor
6. surgical removal of impacted teeth on an Outpatient basis.

No benefits are provided for:

1. services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair), including treatment to alleviate TMJ;
3. dental implants (endosteal, subperiosteal or transosteal);
4. any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
5. alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
6. fluoride treatments except when used with radiation therapy to the oral cavity;
7. non-surgical treatment ((e.g., splint and Physical Therapy) of Temporomandibular Joint Syndrome (TMJ);

8. surgical and arthroscopic treatment of TMJ.

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:

1. 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.
2. 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.
3. Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment
4. 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.
5. Psychological Testing - testing to diagnose a Mental Health Condition when referred by a Participating Provider.
6. 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

No Benefits are provided for Outpatient prescription drugs under this Plan. Please contact your Employer for information on the Outpatient prescription drug Benefits provided through a separate entity other than the Claims Administrator.

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.

See the section on *Radiological and Nuclear Imaging Benefits* for additional diagnostic procedures which require prior authorization by the Claims Administrator.

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

Podiatric Services include office visits and other covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services, including surgical procedures, are customarily provided by a licensed doctor of podiatric medicine. Covered lab and X-ray Services provided in conjunction with this Benefit are described under the Outpatient 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 group health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

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

Preventive Health Benefits

Preventive Health 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 Pre-vention, or the most current version of the Recom-mended 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 Physi-cians;
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 and Substance Abuse 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.

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 offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. 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. A Participating Provider 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 Participating Provider at an extended office hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found online at www.blueshieldca.com or from Customer Service.

16. 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 Outpatient 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 folowing 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 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 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.

Radiological and Nuclear Imaging Benefits

The following radiological and nuclear imaging procedures, when performed on an Outpatient, non-emergency basis, require prior authorization under the Benefits Management Program.

See the Benefits Management Program section for complete information.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and
5. Cardiac diagnostic procedures utilizing nuclear medicine.

Rehabilitative 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 (Rehabilitative 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 Rehabilitative Benefit. See the section on Chiropractic Benefits.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitative/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 Participant per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Speech Therapy Benefits (Rehabilitative 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

Tissue and Kidney Transplants

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Participant is the transplant recipient.

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

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 Participants 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 through the Benefits Management Program, and (3) the recipient of the transplant is a Participant. 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 non-payment if the Claims Administrator determines the service was not a covered service.

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.

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 Rehabilitative Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitative Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. 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 Participant's home;
6. for Outpatient Mental Health Services, except as specifically listed under Mental Health and Substance Use Disorder Benefits;
7. for substance use disorder treatment or rehabilitation on an Inpatient, Partial Hospitalization or Outpatient basis, except as specifically listed under Mental Health and Substance Use Disorder Benefits;
8. for hearing aid instruments, examinations for the appropriate type of hearing aid, device checks, electroacoustic evaluation for hearing aids and other ancillary equipment, except as specifically listed;
9. 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;
10. 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;
11. 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 the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
12. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;
13. 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;
14. 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;
15. 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;

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 Participants 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 testing for intelligence or learning disabilities, or behavioral problems or social skills training/therapy;
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 Participant 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 Special 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 contraceptives, except as specifically included under Family Planning Benefits; oral contraceptives and diaphragms are excluded; no Benefits are provided for contraceptive implants
34. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;
35. 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;
36. for or incident to elective (not Medically Necessary) abortion;
37. incident to bariatric surgery Services;
38. 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;
39. services provided by an individual or entity that:
    - is not appropriately licensed or certified by the state to provide health care services;
    - is not operating within the scope of such license or certification; or
    - does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;

40. for massage therapy that is not Physical Therapy or a component of a multimodality Rehabilitative Services treatment plan;
41. 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;
42. for Outpatient prescription drugs;
43. for Behavioral Health Treatment Benefits;
44. transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van); and
45. not specifically listed as a Benefit. 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.

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 a Participant is eligible for Medicare

1. The Claims Administrator group plan will provide benefits before Medicare in the following situations:
   a. When you the Employee or his/her spouse is eligible for Medicare due to age, if the Employee is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
   b. When the Participant is eligible for Medicare due to disability, if the Employee is actively working for a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
   c. When a Participant is eligible for Medicare solely due to end-stage renal disease during the first 30 months that he or she is 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 the Employee or his/her spouse is eligible for Medicare due to age, if the Employee is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
   b. When the Participant is eligible for Medicare due to disability, if the Employee is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
   c. When the Participant is 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 the Employee is retired and the Employee or his/her spouse is age 65 years or older.

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

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 Participant is injured or becomes ill due to the act or omission of another person (a "third party"), the Claims Administrator shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and the Plan Administrator have an equitable right to restitution, reimbursement or other available remedy to recover amounts the Plan Administrator paid for the Services provided to the Participant on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Participant, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

The Plan Administrator's right to restitution, reimbursement or other available remedy is against any recovery the Participant receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Participant has been "made whole" by the Recovery. The Plan Administrator's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due the Claims Administrator for the Benefits it paid in connection with such injury or illness.

The Participant is required to:

1. Notify the Plan Administrator in writing of any actual or potential claim or legal action which such Participant expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and
3. Agree in writing to reimburse the Plan Administrator for Benefits paid by the Claims Administrator from any Recovery when the Recovery

is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and

4. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan Administrator, in writing, within 10 days after any Recovery has been obtained.

A Participant's failure to comply with 1. through 5. above shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan Administrator.

Further, if the Participant receives Services from a Participating Hospital for such injuries or illness, the Hospital has the right to collect from the Participant 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 Participant for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

IF THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"), THE FOLLOWING THIRD PARTY LIABILITY SECTION APPLIES.

If a Participant'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 Participant 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 Participant'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 Participant or any other person acting on behalf of the Participant 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 Participant 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 Participant or others enrolled through the Participant 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 Participant or on the Participant's behalf, and without regard to whether the Participant 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 Participant, 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 Participant, such as an attorney-client trust account.

The Participant 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 Participant'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.

COORDINATION OF BENEFITS

When a Participant 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 Participant will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are Incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

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

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the Participant for the longer period of time will determine its benefits first, provided that:
   a. a plan covering a Participant as a laid-off or retired Employee, or as a Dependent of that Participant will determine its benefits after any other plan covering that Participant as an Employee, other than a laid-off or retired Employee, or such Dependent; and
   b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

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

If this Plan is the secondary carrier in the order of payments, and 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 pay the benefits that would be due as if it were the primary plan, provided that the covered Participant (1) assigns to the Claims Administrator the right to receive benefits from the other plan to the extent of the difference between the benefits which the Claims Administrator actually pays and the amount that the Claims Administrator would have been obligated to pay 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 Ad-

ministrator 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 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 a Participant's coverage for cause immediately upon written notice to the Participant and the Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to the Employer or the Claims Administrator (see the Cancellation/rescission for Fraud or Intentional Misrepresentations of Material Fact provision);
2. Permitting use of an identification card by someone other than Participant to obtain Services; or
3. Obtaining or attempting to obtain Services under the Plan 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 31 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.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

The Claims Administrator may cancel or rescind coverage for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Participants for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission is a cancellation of coverage that has a retroactive effect. The Claims Administrator will provide written notice to the Employer prior to any rescission.

In the event coverage is rescinded or cancelled, either by the Claims Administrator or the Employer, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice. Rescissions are effective upon at least 30 days advance written notice, retroactive to the date specified in the rescission notice.

Group Continuation Coverage

Continuation of Group Coverage

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

Applicable to Participants when the 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 Participant will be entitled to elect to continue group coverage under this Plan if the Participant 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 Participant if the Qualifying Event had not occurred (including any changes in such coverage).

Under COBRA, a Participant is entitled to benefits if at the time of the qualifying event such Participant 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 Employee:
   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 Employee, spouse, 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):

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

   a. the death of the Employee; or
   b. the termination of the Employee's employment (other than by reason of such Employee's gross misconduct); or
   c. the reduction of the Employee's hours of employment to less than the number of hours required for eligibility; or
   d. the divorce or legal separation of the Employee from the Dependent spouse or termination of the domestic partnership; or
   e. the Employee'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 an Employee 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 Employee 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 Employee's death, termination, or reduction of hours of employment, the Participant's Medicare entitlement or the Employer's filing for reorganization under Title XI, United States Code.

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

If the Participant does not notify the COBRA administrator within 60 days, the Participant's coverage will terminate on the date the Participant 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 Participant to continue group coverage under this Plan.

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

Payment of Dues

Dues for the Participant's continuing coverage shall be 102 percent of the applicable group dues rate, except for the Participant who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

If the Participant 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 Participant's coverage under this Plan would otherwise termi-

nate 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 Participant 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 Participant becomes covered under another group health plan;
4. the Participant becomes entitled to Medicare;
5. the Participant 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 Participants on Military Leave

Continuation of group coverage is available for Participants on military leave if the Participant's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Participants 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 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 and Coinsurance, and 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 or the Claims Administrator but are independent contractors. In no instance shall the Plan or the Claims Administrator 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 Plan and 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 Participant 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 Participant 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 Participant 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 Participants 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 error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the 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 Participants to request an expedited decision. A Participant, Physician, or representative of a Participant may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Participant, or when the Participant is experiencing severe pain. The Claims Administrator shall make a decision and notify the Participant and Physician as soon as possible to accommodate the Participant'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 thera-

pist; 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.

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.

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/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. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider.

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 dieticians; certified nurse midwives; licensed occupational therapists; 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 Participants 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 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 applicable 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 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.

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

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

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

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 Participant.

Copayment — the amount that a Participant 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 Participant 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 Participant 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. an Employee's legally married spouse who is not legally separated from the Employee;

   or,

2. an Employee's Domestic Partner;

   or,

3. a child of, adopted by, or in legal guardianship of the Employee, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Employee, 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 an Employeewho 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 Employee, spouse, or Domestic Partner) are not Dependents unless the Employee, 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 Employee, spouse, or Domestic Partner for support and maintenance;

   b. the Employee, 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 Participant by a registered domestic partnership.

Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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

Durable Medical Equipment — equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes 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).

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

Employee — is the person who, by meeting the Plan's eligibility requirements for Employees, is allowed to choose membership under this Plan for himself or herself and his or her Dependents.

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

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

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

Family — the Employee and all enrolled Dependents.

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.

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.

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

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 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 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 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 insurancewas 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 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 cov-

ered 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 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.

4. For eligible 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 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 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 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 subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for 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 Rehabilitative Services 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.

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 Men-

tal 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) Behavioral Health Treatment

7) 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.

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

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.

Participating Employer — a Participating Employer is a California city or county government. Specific qualifications of a Participating Employer are stipulated in the participation agreement.

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 Medical Benefit Plan Benefit Plan for eligible Employees of the Employer.

Plan Administrator — the designated party that sets up a healthcare plan for the benefit of the Employer's Employees. The responsibilities of the Plan Administrator include determining membership parameters, investment choices and providing contribution payments.

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

Plan Sponsor — the designated party that sets up a healthcare plan for the benefit of the Employer's Employees. The responsibilities of the Plan Sponsor include determining membership parameters, investment choices and providing contribution payments.

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 informa-

tion 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.

Program Administrator — CSAC Excess Insurance Authority.

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

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

Rehabilitative Services — Inpatient or Outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitative 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 Participants 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.

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 Rehabilitative Services 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 Participant 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.

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

For prior authorization of Benefits Management Program Radiological Services: 1-888-642-2583

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

blue of california

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.

Blue Shield of California is an independent member of the Blue Shield Association A49726-REV (10/16)

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' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bííníghah? Doo bííníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hólǫ́. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bííghah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí 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 전화하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում է՞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 հետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

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

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

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

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

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

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

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

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

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