APPLICATION IS HEREBY MADE FOR
A GROUP HEALTH SERVICE CONTRACT TO
Blue Shield of California
(California Physicians' Service)

BY: **San Francisco Electrical Workers Health & Welfare Trust**
720 Market Street, Suite 700
San Francisco, CA 94102

This Contract, number **H11852**, shall be effective **August 1, 2013**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations to the Contractholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

This application is executed in duplicate. **The Contractholder shall sign, date and return this original application page to Blue Shield of California, 50 Beale Street, 22nd Floor, San Francisco, California 94105, Attention: Customer Contract Development.** The Contract shall be retained by the Contractholder. Payment of dues and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

The Contractholder is responsible for communicating any changes to Benefits as set forth in Part IX. Contractholder Responsibility for Distribution and Notification Requirements. Please see this section for important timelines for distribution of information.

It is agreed that this application supersedes any previous application for this Contract.

Dated at _____ (City, State)

this _____ day of _____ 20 _____

_____

(Legal Name of Contractholder)

By _____

Title _____

PLEASE SIGN, DATE AND RETURN THE ORIGINAL APPLICATION PAGE TO BLUE SHIELD OF CALIFORNIA AT THE ABOVE ADDRESS. RETAIN THE CONTRACT.

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

blue of california

blue of california

50 Beale Street
San Francisco, California 94105
(415) 229-5000

GROUP HEALTH SERVICE CONTRACT

BLUE SHIELD OF CALIFORNIA ACCESS+ HMO® HEALTH PLAN

between

San Francisco Electrical Workers Health & Welfare Trust

("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

In consideration of the applications and the timely payment of dues, Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **August 1, 2013**, for a term of one year, subject to the provisions entitled, "Changes: Entire Contract".

Jeffrey W Hermosillo

Jeffrey W. Hermosillo, Senior Vice President, Employer Markets
Blue Shield of California

Group Number: **H11852**

Original Effective Date: **August 1, 2008**

IMPORTANT

No Member has the right to receive the Benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the Group Continuation Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form. Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the Evidence of Coverage and Disclosure Form, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in Part V. Dues, Part VIII. General Provisions, D. Changes: Entire Contract, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

TABLE OF CONTENTS

Page

PART I. INTRODUCTION C-3
PART II. DEFINITIONS C-3
PART III. ELIGIBILITY C-4
A. Employee Eligibility, Waiting Periods and Open Enrollment C-4
B. Associated Employers C-5
C. Termination of Benefits C-5
PART IV. GROUP RENEWAL PROVISIONS C-6
PART V. DUES C-7
PART VI. INTER-PLAN PROGRAMS (BLUECARD® PROGRAM AND OTHERS) C-8
PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD C-10
A. Cancellation Without Cause C-10
B. Cancellation for Non-Payment of Dues C-10
C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact or Failure to Provide Records C-10
D. Grace Period C-10
E. Payment or Refund of Dues Upon Cancellation C-10
F. Termination of Benefits C-11
G. Trust to Provide Subscribers with Notice Confirming Termination of Coverage C-11
PART VIII. GENERAL PROVISIONS C-12
A. Choice of Providers C-12
B. Use of Masculine Pronoun C-12
C. Workers' Compensation C-12
D. Changes: Entire Contract C-12
E. Statutory Requirements C-12
F. Legal Process C-13
G. Time of Commencement or Termination C-13
H. Records and Information to be Furnished C-13
I. Inquiries and Complaints C-13
J. Confidentiality C-13
K. Termination of a Plan Provider Contract C-13
L. ERISA Plan Administrator C-13
PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS C-14
A. Obtaining Declinations or Waivers of Coverage C-14
B. Distribution of Summary of Benefits and Coverage (SBC) C-14
C. Distribution of Member ID Cards and Evidence of Coverage and Disclosure Form Booklets C-14
D. Notification of Cancellation to Subscribers C-15
E. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices C-15
F. Notification of Individual Conversion Plan Option C-16
EVIDENCE OF COVERAGE AND DISCLOSURE FORM C-17
Refer to the Table of Contents in the Evidence of Coverage and Disclosure Form
The Evidence of Coverage and Disclosure Form includes the following optional Benefits/riders:
Outpatient Prescription Drugs
Substance Abuse Condition Benefits
Residential Care for Substance Abuse Condition Benefits

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the Definitions section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

Employee - an individual who is an "Active member" or a "Retiree member" as defined under the rules and regulations of the Trust.

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the Eligibility section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Each such individual determined eligible for coverage under the rules and regulations of the Trust on the effective date of this Contract is eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the first of the month following the completion of ninety (90) days of continuous service in the employ of the Trust; or as determined by the Trust, whichever is applicable.

   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.

2. The date of eligibility of a former Employee, who has been re-employed, shall be determined pursuant to the terms of the Trust's rules and regulations.

3. The Trust agrees to offer health Benefits coverage to all eligible Employees during the initial enrollment period and distribute information as set forth in Part IX. Contractholder Responsibility for Distribution and Notification Requirements. In addition, the Trust agrees to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or at the Trust's next open enrollment period, whichever is earlier unless the Employee meets the criteria specified in paragraph 1. of the definition of Late Enrollee. Blue Shield will not consider applications for earlier effective dates.

4. An Employee may transfer enrollment for himself or his Dependent(s) from another group health plan sponsored by the Trust to the health plan covered by this Contract only during the open enrollment period in July of each year. The effective date of Benefits for such Employee and Dependent(s) shall be the first day of each subsequent August. Submission of evidence of acceptability is not required when application is made during this open enrollment period.

5. The Trust shall timely report any additions or terminations of Employees or Dependents so that retroactive Dues adjustments are avoided and claims are not paid for ineligible individuals. However, if the Trust determines that it has made an administrative error in the processing of eligibility for an Employee or Dependent, Blue Shield will accept the retroactive changes subject to the following limitations:

   a. Blue Shield will accept enrollment of the Employee or Dependent retroactively for a maximum of 90 days, as long as Dues are paid by the Trust for the entire retroactive enrollment period. If an Employee or Dependent is retroactively enrolled pursuant to this, and the Employee or Dependent received covered health care Services during that retroactive period, Blue Shield will reimburse the Employee for payments made for covered Services received in accordance with the rules of the Evidence of Coverage and Disclosure Form, minus the Member's Copayments as stated in the Evidence of Coverage and Disclosure Form;

   b. Blue Shield will accept termination/disenrollment of the Employee or Dependent retroactive for a maximum of 90 days and will refund appropriate Dues paid for the retroactive termination period. In such case, Blue Shield reserves the right to request refund from the Employee for any payments made for services rendered during the retroactive termination period. In making a request for retroactive termination or disenrollment, the Contractholder shall comply with all applicable state and federal law, including, but not limited to, the Patient Protection & Affordable Care Act and any related regulations.

(H11852 / A.1.a.,b.,2.,3.-del, 4. & 5.)

PART III. ELIGIBILITY

B. Associated Employers

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(list of associated Employers)

None

C. Termination of Benefits

In addition to the provisions contained in the Termination of Benefits section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

1. The Benefits of a Subscriber shall cease on the first day of the month following the month in which the Subscriber retires, is pensioned, leaves voluntarily or is dismissed from the employ of the Contractholder or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:

    a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Dues for that Subscriber shall continue coverage in force in accordance with the Trust's policy regarding such coverage; or,

    b. if the Trust is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Dues for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The covered Trust is solely responsible for notifying Employees of the availability and duration of family leaves.

2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31st day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written application for the addition of the Dependent is submitted to and received by Blue Shield prior to the 31st day following the effective date of coverage.

PART IV. GROUP RENEWAL PROVISIONS

A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract

The Trust shall be notified by Blue Shield of California of its intent to renew this Group Health Service Contract at least 120 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in Part V. Dues, Paragraph D., or in Part VIII. General Provisions, Paragraph D. Changes: Entire Contract.

B. Renewal of the Group Health Service Contract

Blue Shield will renew this Group Health Service Contract at the option of the Contractholder except in the following instances:

1. the Contractholder violates a material contract provision relating to Trust or other group contribution or group participation rates by the Contractholder or Trust;
2. the Contractholder fails to pay the required Dues as specified under Part V. Dues;
3. the Contractholder commits fraud or other intentional misrepresentation of material fact;
4. the Contractholder relocates outside of California;
5. Blue Shield ceases to offer a plan type purchased by the Contractholder;
6. Blue Shield ceases to offer health benefit plans in the state (withdrawal of all products).

(H11852 / A. & B.1.)

PART V. DUES

A. Dues

Monthly Dues

H11852 - 000/CBA/ER1:

Subscriber and all Dependents	$1,510.53

H11852 - CB2/ER2:

Subscriber	$749.86
Additional for one Dependent	$677.95
Additional for two or more Dependents	$1,418.97

H11852 - CC0:

Subscriber	$824.85
Additional for one Dependent	$745.74
Additional for two or more Dependents	$1,560.86

B. When and Where Payable

1. The first month's Dues must be paid to Blue Shield by the effective date of this Contract and subsequent Dues shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Dues payment has been received by Blue Shield.

2. Dues for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Dues for Employees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

3. All Dues are payable by the Trust to Blue Shield of California. The payment of any Dues shall not maintain the Benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in Part V. F.

C. The terms of this Contract or the Dues payable therefore may be changed from time to time as set forth in Part VIII., D. Changes Entire Contract.

D. The Trust shall remit to Blue Shield the amount specified in Part V. A. ("the base Dues"). If a State or any other taxing authority imposes upon Blue Shield a tax or license fee which is levied upon or measured by the base Dues or by the gross receipts of Blue Shield or any portion of either, then Blue Shield may amend the Contract to increase the base Dues by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice which shall not be earlier than the date of the imposition of such tax or license fee, by mailing a postage prepaid notice of the amendment to the Trust at its address of record with Blue Shield at least 60 days before the effective date of the amendment.

E. If Benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under Part V. D., the Dues charge therefore may be made, or the Dues credit therefore may be given, as of the effective date of such change.

F. A grace period of 31 days to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing, other than those due on the effective date of this Contract during which period this Contract shall continue in force, but the Trust shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Dues shall be in accordance with Part VII. B.

PART VI. INTER-PLAN PROGRAMS (BLUECARD® PROGRAM AND OTHERS)

Out-of Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a member accesses Covered Services outside California, Puerto Rico and U.S. Virgin Islands the claim for those services may be processed through one of these Inter-Plan Programs and presented to Blue Shield for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to members under this agreement are described generally below.

When a member accesses Covered Services outside of California, Puerto Rico and U.S. Virgin Islands he may obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from non-participating health care providers. Blue Shield's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when members access covered health care services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the member liability on claims for covered health care services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the health care provider's billed covered charges or the negotiated price made available to Blue Shield by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's health care provider contracts. The negotiated price made available to Blue Shield by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases; or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Blue Shield is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining a member's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Blue Shield would then calculate the member liability in accordance with applicable law.

PART VI. INTER-PLAN PROGRAMS (BLUECARD® PROGRAM AND OTHERS)

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Non-Participating Health Care Providers Outside Blue Shield Service Area

When Covered Services, other than Emergency Services, are received from non-participating health care providers outside of California, Puerto Rico and U.S. Virgin Islands the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and the payment Blue Shield will make for the covered services as set forth in this paragraph.

Claims for Covered Emergency Services are paid based on the Allowable Amount as defined in the Evidence of Coverage and Disclosure Form.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The Trust may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

B. Cancellation for Non-Payment of Dues

Blue Shield may cancel this Contract for non-payment of Dues. If Dues are not received when due, coverage will end 31 days after the date for which Dues are due. The Trust will be liable for all Dues accrued while this Contract continues in force including those accrued during the 31-day grace period. In such case, a Notice Confirming Termination of Coverage will be mailed to the Trust by Blue Shield. A new application for coverage will be required by the Trust and a new contract will be issued only upon demonstration that the Trust meets all underwriting requirements at the time of application.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact or Failure to Provide Records

Blue Shield may cancel or rescind this Contract for fraud or intentional misrepresentation of material fact by the Trust; or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Trust) may, at the discretion of Blue Shield, result in the cancellation or rescission, respectively, of this Contract or the coverage of Employees or Dependents who have committed said fraud or intentional misrepresentation of material fact. This Contract may also be cancelled for failure to provide Blue Shield with records and information in accordance with state and federal law. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

D. Grace Period

The Trust shall be entitled to a grace period of 31 days for payment of Dues, as described in Part V. F. hereof. If during a Dues grace period written notice is given by the Trust to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Trust or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Trust shall be liable to Blue Shield for the full month's payment of Dues if discontinuance of coverage occurs on or after the 15th of the month. If discontinuance of coverage occurs prior to the 15th of the month then Dues payment will be waived and refunded to the group.

E. Payment or Refund of Dues Upon Cancellation

In the event of cancellation, the Trust shall promptly pay any earned Dues which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Trust the amount of prepaid Dues, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

(H11852 / A., B., C., D. & E.)

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

F. Termination of Benefits

No Benefits shall be provided for Services rendered after the effective date of cancellation, except as specifically provided in the Group Continuation Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form.

In the event this Contract is canceled for any reason, including but not limited to for non-payment of Dues, no further Benefits will be provided after cancellation unless the Member is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of Benefits in accordance with the Extension of Benefits section of the Evidence of Coverage and Disclosure Form.

G. Trust to Provide Subscribers with Notice Confirming Termination of Coverage

If this Contract is rescinded, or cancelled by either party, the Trust shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Trust shall promptly mail a copy of Blue Shield's Notice Confirming Termination of Coverage to each Subscriber and provide Blue Shield proof of such mailing and the date thereof. The Trust must also inform each Subscriber regarding their right to transfer to a Blue Shield individual conversion plan.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

A. Choice of Providers

The Plan has established a network of primary care and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Services to Members. A Member must obtain or receive approval for all Covered Services from his Personal Physician. Each Subscriber must select a Personal Physician for himself and each of his Dependents from the list of Personal Physicians in the HMO Physician and Hospital Directory. The Physician and Hospital Directory will be given to Members at the time of enrollment. A Member's Personal Physician will be accessible to the Member on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements to assure coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by all Plan Hospitals. The list of Providers in the Physician and Hospital Directory includes the location and phone numbers of all Personal Physicians, Plan Hospitals, and Participating Hospice Agencies in the Personal Physician Service Area. Members should contact Member Services for information on Plan Non-Physician Health Care Practitioners in their Personal Physician Service Area.

B. Use of Masculine Pronoun

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. Workers' Compensation

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation insurance.

D. Changes: Entire Contract

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Trust or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract, the Dues payable therefor, and the Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment and annual Copayment maximum amounts, may be changed from time to time. Blue Shield will provide at least 60 days' written notice of any such change, and these shall not become effective until at least 60 days after written notice of such change is delivered or mailed to the Trust's last address as shown on the records of Blue Shield. Benefits for Services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

Notice of changes in Benefits, and any documents that may be delivered to the Trust or the Trust's representative for the purpose of informing members of the details of their coverage under this Contract, will be distributed by the Trust or his representative as set forth in Part IX. Contractholder Responsibility for Distribution and Notification Requirements.

E. Statutory Requirements

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and applicable Centers for Medicare and Medicaid Services ("CMS") requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

PART VIII. GENERAL PROVISIONS

F. Legal Process

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

G. Time of Commencement or Termination

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

H. Records and Information to be Furnished

The Trust shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Dues and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Trust identification number and Trust size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

I. Inquiries and Complaints

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to the Plan at the address or telephone number indicated on page GC-1 of this Contract. (See also the Member Services section of the Evidence of Coverage and Disclosure Form.)

J. Confidentiality

The Contractholder and Blue Shield shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Plan to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, the Plan may provide aggregate, encrypted or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder or Blue Shield receives, maintains or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder and Blue Shield shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA") and Health Information Technology for Economic and Clinical Health ("HITECH") Act provisions on security and privacy.

K. Termination of a Plan Provider Contract

1. Blue Shield shall provide written notice to the Trust within a reasonable period of time of any termination or breach of Contract of a Plan Provider if such termination or breach may materially affect the Trust or its Subscribers.
2. Upon termination of a Plan Provider Contract, Blue Shield shall be liable for Benefits rendered by such provider to an eligible Member (other than for Copayments) until the authorized Services being rendered to the Member by the former Plan Provider are completed, unless Blue Shield makes reasonable and medically appropriate provision for the assumption of such Benefits by another Plan Provider.

L. ERISA Plan Administrator

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder has various distribution of notices and Member materials and other notification requirements under this Group Health Service Contract. Some of the major Contractholder distribution and notification requirements are summarized below; however, this is a summary only and is not to be construed as an all-inclusive list.

A. Obtaining Declinations or Waivers of Coverage

All eligible Employees will be offered health benefits coverage during the initial and subsequent enrollment periods. If an Employee elects to decline or waive coverage, the Trust is responsible for obtaining the Employee's signed acknowledgment of receipt of an explicit written notice in bold type specifying that failure to elect coverage during the open enrollment period permits the Plan to impose an exclusion from coverage for a period of 12 months or at the Trust's next open enrollment period, whichever is earlier, unless the Employee meets the criteria specified in paragraph 1. of the definition of Late Enrollee as set forth in the Evidence of Coverage and Disclosure Form.

B. Distribution of Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) will be issued by the Plan for all eligible Employees and Dependents. The Trust is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The Trust will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The Trust shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the Trust does not distribute paper SBCs, then the Trust will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the Trust's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the Trust to the Subscriber and any Dependents no later than 60 days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the Trust fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the Trust, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the Trust agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

C. Distribution of Member ID Cards and Evidence of Coverage and Disclosure Form Booklets

1. Member ID Cards

Membership cards will be issued by the Plan for all Subscribers and will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions.

2. Evidence of Coverage and Disclosure Form Booklets

An Evidence of Coverage and Disclosure Form (EOC) which summarizes the Benefits of this Contract and how to obtain covered Services will be issued by the Plan for all Subscribers. The Plan will send the EOC to the Contractholder, and, the Contractholder is responsible for distributing the EOC to Subscribers whether in printed, hardcopy or electronic form.

EOCs will be provided to the Contractholder in electronic form (such as by Compact Disk (CD) or posted on Blue Shield's Trust website) or in paper hard copy form. If the Contractholder receives the EOC in electronic form, the Contractholder is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the EOC after it is provided to the Contractholder. If the Contractholder receives the EOC in hard copy form, the Contractholder will notify Subscribers that printed hard copies of the EOC are available and will promptly distribute to Subscribers.

(H11852 / A. & B.)

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Employees of the Contractholder; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with Blue Shield's instructions for accessing the EOC from the Blue Shield website.

If the Contractholder posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit Employees of the Contractholder to download and print a complete and accurate copy of the EOC. The Contractholder will notify Employees enrolled with Blue Shield that the EOC for their plan is available to review, download and print from the Contractholder's intranet site and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site.

The Contractholder will provide a hard copy of the EOC to an Employee upon request. If Blue Shield receives an inquiry from an Employee of the Contractholder regarding obtaining a copy of the EOC, Blue Shield will refer that individual to the Contractholder's human resources benefits staff with instructions that a copy of the EOC is available from the Contractholder on request. The Contractholder has the option to request a supply of hard copies of the EOC in an amount not to exceed 10% of the total Subscriber count at no additional charge.

In the event Blue Shield reasonably concludes that the Contractholder is either using the electronic EOC in a matter not permitted by this agreement or is not providing Subscribers with access to the EOC in accordance herewith, then Blue Shield will print copies of the EOC, and the Contractholder will cooperate with Blue Shield to ensure that printed copies of the EOC are timely provided to all Employees of the Contractholder enrolled with Blue Shield. The Contractholder agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the EOC documents.

D. Notification of Cancellation to Subscribers

If this Contract is rescinded, or canceled by either party, the Trust shall notify the Subscribers. If rescinded or canceled by Blue Shield, the Trust shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof. The Trust must also inform each Subscriber regarding their right to transfer to a Blue Shield individual conversion plan.

E. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended or the California Continuation Benefits Replacement Act [Cal-COBRA]. See the Group Continuation Coverage and Extension of Benefits sections of the Evidence of Coverage and Disclosure Form for additional information.

1. COBRA

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations.

To the extent required by COBRA, and upon timely receipt of dues and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

The Contractholder is solely responsible for all aspects of the administration of Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder, in the event that federal continuation of

coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 [COBRA], as amended, apply to the Contractholder, are as set forth below:

a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.

b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.

c. The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Trust's (Contractholder's) filing for reorganization under Title XI, United States Code.

d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.

e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and the COBRA law.

f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.

g. Contractholder or its COBRA administrator will provide notification of conversion rights or other continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.

i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

2. Cal-COBRA

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber’s termination or reduction in hours of employment within 30 days of the Qualifying Event.

F. Notification of Individual Conversion Plan Option

The Contractholder is solely responsible for notifying Employees of the availability, terms and conditions of the Individual Conversion Plan within 15 days of termination of this Contract's coverage. (See the Individual Conversion Plan section of the Evidence of Coverage and Disclosure Form.)

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

An Evidence of Coverage and Disclosure Form booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this Evidence of Coverage and Disclosure Form and any applicable Supplements and are included as part of this Contract.

Note: In the Evidence of Coverage and Disclosure Form, references to "you" or "your" shall mean the eligible Subscriber and/or Dependent of this Plan. References to "we" or "us" shall mean the Plan and/or Blue Shield of California.

Access+ HMO®

Combined Evidence of Coverage and Disclosure Form

San Francisco Electrical Workers Health & Welfare Trust

Effective Date: August 1, 2013

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan.

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

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

PLEASE NOTE

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

IMPORTANT

No person has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the 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 group contract.

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

This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health Plan Contract must be consulted to determine the exact terms and conditions of coverage. The Group Health Service Contract is available from the San Francisco Electrical Workers Health and Welfare Trust or a copy can be furnished upon request. The Trust is familiar with this health Plan, and you may also direct questions concerning coverage or specific Plan provisions to the Blue Shield Member Services Department.

The Blue Shield Access+ HMO Health Plan

Member Bill of Rights

As a Blue Shield Access+ HMO Plan Member, you have the right to:

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

The Blue Shield Access+ HMO Health Plan

Member Responsibilities

As a Blue Shield Access+ HMO Plan Member, you have the responsibility to:

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

Table of Contents

Title	Page
Access+ HMO Summary of Benefits	5
Introduction to the Blue Shield Access+ HMO Health Plan	13
Choice of Physicians and Providers	13
How to Use Your Health Plan	15
Eligibility	22
Effective Date of Coverage	23
Renewal of Group Health Service Contract	24
Prepayment Fee	24
Plan Changes	25
Plan Benefits	25
Principal Limitations, Exceptions, Exclusions and Reductions	37
Termination of Benefits and Cancellation Provisions	44
Group Continuation Coverage and Individual Conversion Plan	46
General Provisions	49
Member Services	51
Grievance Process	51
Definitions	53
Notice of the Availability of Language Assistance Services	60
Supplement A — Outpatient Prescription Drug Benefits	61
Supplement B — Substance Abuse Condition Benefits	67
Supplement C — Residential Care for Substance Abuse Condition Benefits	69

HMO Summary of Benefits

What follows is a summary of your Benefits and the Copayments applicable to the Benefits of your Plan. A more complete description of your Benefits is contained in the Plan Benefits section. Please be sure to read that section and the exclusions and limitations in the Principal Limitations, Exceptions, Exclusions and Reductions section for a complete description of the Benefits of your Plan.

You should know that all Benefits described in this summary and throughout this Evidence of Coverage and Disclosure Form apply only when provided or authorized as described herein, except in an Emergency or as otherwise specified.

Should you have any questions about your Plan, please call the Member Services Department at the number provided on the back page of this booklet.

Note: See the end of this Summary of Benefits for important benefit footnotes.

Summary of Benefits[1] **Access+ HMO**

Member Calendar Year Deductible[2] (Medical Plan Deductible)	Deductible Responsibility
Calendar Year Medical Deductible There is no calendar year deductible under this plan.	None

Member Maximum Calendar Year Copayment Responsibility[3]	Member Maximum Calendar Year Copayment
Calendar Year Copayment Maximum	$2,000 per Member $4,000 per Family with two Family members $6,000 for a Family with three or more Family members

Member Maximum Lifetime Benefits	Maximum Blue Shield Payment
Lifetime Benefit Maximum There is no lifetime benefit limit under this plan.	No maximum

Benefit	Member Copayment
Access+ Specialist Benefits Note: See the Choice of Physicians and Providers and How to Use Your Health Plan sections for more information and for a list of services which are not covered under this Benefit. Your Medical Group or IPA must be an Access+ Provider in order for you to use this Benefit. Refer to the HMO Physician and Hospital Directory or call Member Services at the number provided on the last page of this booklet to determine whether a Medical Group or IPA is an Access+ Provider.	
Conventional X-rays, lab, diagnostic tests	You pay nothing
Office visit, examination or other consultation with a Plan Specialist in the same Medical Group or IPA as the Personal Physician without a referral from your Personal Physician Note: See Professional (Physician) Benefits for specialist services when you have a referral from your Personal Physician	$30 per visit
Allergy Testing and Treatment Benefits	
Allergy serum purchased separately for treatment	50%
Office visits (includes visits for allergy serum injections)	$25 per visit
Ambulance Benefits	
Emergency or authorized transport	You pay nothing
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.	
Ambulatory Surgery Center Outpatient surgery facility Services	You pay nothing
Ambulatory Surgery Center Outpatient surgery Physician Services (billed as part of Ambulatory Surgery Center Outpatient surgery facility Services)	You pay nothing
Clinical Trial for Cancer Benefits	
Clinical trial for cancer Services Covered Services for Members who have been accepted into an approved clinical trial for cancer when prior authorized by the Plan. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in this Summary of Benefits.	You pay nothing
Diabetes Care Benefits	
Devices, equipment and supplies	20%
Diabetes self-management training provided by a Physician in an office setting	$25 per visit
Diabetes self-management training provided by a registered dietician or registered nurse that are certified diabetes educators	$25 per visit
Durable Medical Equipment Benefits[4]	
Breast pump	You pay nothing
Other Durable Medical Equipment	You pay nothing

Benefit	Member Copayment
Emergency Room Benefits	
Emergency room Physician Services Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and Services would not be covered.	You pay nothing
Emergency room Services not resulting in admission Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and the Services would not be covered.	$100 per visit
Emergency room Services resulting in admission (Billed as part of Inpatient Hospital Services)	$100 per admission
Family Planning and Infertility Benefits Note: Copayments listed in this section are for Outpatient Physician Services only. If Services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the appropriate facility Benefit in this Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), intrauterine device (IUD), and tubal ligation.	
Counseling and consulting (Including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	You pay nothing
Diaphragm fitting procedure	You pay nothing
Elective abortion	$100 per surgery
Implantable contraceptives	You pay nothing
Infertility Services Diagnosis and treatment of cause of Infertility (in vitro fertilization and artificial insemination not covered)	50%
Injectable contraceptives	You pay nothing
Insertion and/or removal of intrauterine device (IUD)	You pay nothing
Intrauterine device (IUD)	You pay nothing
Tubal ligation	You pay nothing
Vasectomy	$50 per surgery
Home Health Care Benefits[4]	
Home health care agency Services (including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist) Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers.	You pay nothing
Medical supplies and laboratory Services	You pay nothing

Benefit	Member Copayment
Home Infusion/Home Injectable Therapy Benefits	
Hemophilia home infusion Services provided by a Hemophilia Infusion Provider and prior authorized by the Plan.	You pay nothing
Hemophilia therapy home infusion nursing visit provided by a Hemophilia Infusion Provider and prior authorized by the Plan (Nursing visits are not subject to the Home Health Care Calendar Year visit limitation.)	You pay nothing
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency[5] (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit if selected as an optional Benefit by the Trust, and are described in a Supplement included with this booklet.	You pay nothing
Home visits by an infusion nurse[5] Home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation	You pay nothing
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program. All Hospice Program Benefits must be prior authorized by the Plan and must be received from a Participating Hospice Agency.	
24-hour Continuous Home Care	You pay nothing
General Inpatient care	You pay nothing
Inpatient Respite Care	You pay nothing
Pre-hospice consultation	You pay nothing
Routine home care	You pay nothing
Hospital Benefits (Facility Services)	
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year facility Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year facility Deductible has not been met.	You pay nothing
Inpatient Services[4] Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care.	$100 per admission
Inpatient Services to treat acute medical complications of detoxification	$100 per admission
Outpatient dialysis Services	You pay nothing
Outpatient Services for surgery and necessary supplies	$50 per surgery
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	You pay nothing
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity. (Be sure to read the Plan Benefits section for a complete description.)	
Inpatient Hospital Services	$100 per admission
Office location	$25 per visit
Outpatient department of a Hospital	$50 per surgery

Benefit	Member Copayment
Mental Health Access+ Specialist Benefits	
Office visit, examination or other consultation for Mental Health Conditions with a MHSA Participating Provider without a referral from the MHSA Note: See the Mental Health and Substance Abuse paragraphs in the How to Use Your Health Plan section for more information. Psychological testing and written evaluation are not covered under this Benefit.[6]	$30 per visit
Mental Health Benefits[6, 7] All non-Emergency Services must be arranged through the MHSA	
Inpatient Hospital Services	You pay nothing
Behavioral Health Treatment - home or other setting (non-institutional)	You pay nothing
Behavioral Health Treatment - office location	$25 per visit
Inpatient Professional (Physician) Services	You pay nothing
Outpatient Mental Health Services, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT)	You pay nothing
Outpatient Partial Hospitalization	You pay nothing[8]
Psychological testing	You pay nothing
Psychosocial support through LifeReferrals 24/7	You pay nothing
Orthotics Benefits	
Office visits	$25 per visit
Orthotic equipment and devices	You pay nothing
Outpatient Prescription Drug Benefits Outpatient Prescription Drug coverage if selected as an optional Benefit by the Trust, is described in a Supplement included with this booklet.	
Outpatient X-Ray, Pathology and Laboratory Benefits	
Mammography and Papanicolaou test	You pay nothing
Outpatient X-ray, pathology and laboratory	You pay nothing
PKU Related Formulas and Special Food Products Benefits	
PKU Related Formulas and Special Food Products	You pay nothing
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Plan Benefits section. When covered, Services will pay as any other surgery as noted in this Summary of Benefits.	
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	$100 per admission
Prenatal and postnatal Physician office visits (including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy)	You pay nothing
Preventive Health Benefits	
Preventive Health Services See the description of Preventive Health Services in the Definitions section for more information.	You pay nothing

Benefit	Member Copayment
Professional (Physician) Benefits	
Injectable medications Note: Also see Allergy Testing and Treatment Benefits in this Summary of Benefits	You pay nothing
Inpatient Physician Services Inpatient Hospital and Skilled Nursing Facility Services by Physicians, including the Services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist	You pay nothing
Internet based consultations	$10 per consultation
Outpatient Physician Services, other than an office setting	You pay nothing
Physician home visits	$50 per visit
Physician office visits including visits for surgery, chemotherapy, radiation therapy, diabetic counseling, asthma self-management training, mammography and Papanicolaou test, audiometry examinations, when performed by a Physician or by an audiologist at the request of a Physician, and second opinion consultations when authorized by the Plan Note: For mammography and Papanicolaou test, a woman may self-refer to an OB/GYN or family practice Physician in the same Medical Group/IPA as her Personal Physician. Physical Therapy benefits are not provided under this Benefit. See below under Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy).	$25 per visit
Prosthetic Appliances Benefits	
Office visits[4]	$25 per visit
Prosthetic equipment and devices	You pay nothing
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:	
Office location	$25 per visit
Outpatient department of a Hospital	$25 per visit
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services.	$100 per admission
Skilled Nursing Facility rehabilitation unit for Medically Necessary days. Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year facility Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year facility Deductible has not been met.	You pay nothing

Benefit	Member Copayment
Skilled Nursing Facility Benefits[4]	
Services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year facility Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year facility Deductible has not been met.	You pay nothing
Speech Therapy Benefits Speech Therapy Services by a licensed speech pathologist or a certified speech therapist in the following settings:	
Office location	$25 per visit
Outpatient department of a Hospital	$25 per visit
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	$100 per admission
Skilled Nursing Facility rehabilitation unit for Medically Necessary days. Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year facility Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year facility Deductible has not been met.	You pay nothing
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin.	
Hospital Services	$100 per admission
Professional (Physician) Services	You pay nothing
Transplant Benefits - Special Note: Blue Shield requires prior authorization from Blue Shield's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield. Special Transplant Benefits for transplant of human heart, lung, heart and lung in combination, human bone marrow transplants, pediatric human small bowel transplants, pediatric and adult human small bowel and liver transplants in combination.	
Facility Services in a Special Transplant Facility	$100 per admission
Professional (Physician) Services	You pay nothing
Urgent Care Benefits Note: See the How to Use Your Health Plan section for more information.	
Urgent care while in your Personal Physician's Service Area not rendered or referred by your Personal Physician or at an urgent care clinic when not instructed by your Personal Physician or assigned Medical Group/IPA	Not covered
Urgent care while in your Personal Physician's Service Area rendered or referred by your Personal Physician (includes Services rendered in an urgent care center when instructed by your Personal Physician or assigned Medical Group/IPA)[9]	$25 per visit
Urgent Services outside your Personal Physician Service Area Medically Necessary Out-of-Area Follow-up Care is covered.[10]	$50 per visit

Summary of Benefits
Footnotes:

[1] All Benefits must be provided or authorized by your Personal Physician and/or the Medical Group/IPA except in an Emergency or as otherwise specified.
Unless otherwise specified, Copayments are calculated based on Allowed Charges.

[2] If your Plan includes a Plan Deductible as shown on the Summary of Benefits, before the Plan provides Benefit payments for the covered facility Services to which the Deductible applies, the Deductible must be satisfied once during the Calendar Year by or on behalf of each Member separately. Payments applied to your Calendar Year Deductible accrue towards the Member maximum Calendar Year Copayment.

[3] The Member maximum Calendar Year Copayment applies to all covered Services except for: Durable Medical Equipment; Access+ Specialist office visits including visits for Mental Health Services; Internet based consultations; and, the following optional Benefits: Outpatient prescription drugs; additional Infertility Benefits; chiropractic Services; acupuncture Services; and, vision plan and dental plan Benefits, if covered under this Plan.

[4] For care received by a Participating Hospice Agency, see the Hospice Program Benefits section.

[5] Home infusion injectable medications require prior authorization by the Plan and must be obtained from Home Infusion Agencies. See Home Infusion/Home Injectable Therapy Benefits in the Plan Benefits section for details. See the Outpatient Prescription Drug Benefits Supplement for coverage of home self-administered injectable medication.

[6] The MHSA is a specialized health care service plan contracted by the Plan to administer all Mental Health Services.

[7] No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage is selected as an optional Benefit by the Trust. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

[8] For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.

[9] Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

[10] Up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits. Blue Shield may direct the member to receive the additional follow-up care from the Personal Physician.

Note: Copayments and charges for Services not accruing to the Member maximum Calendar Year Copayment continue to be the Member's responsibility after the Calendar Year Copayment maximum is reached.

Note: All Services except those meeting the Emergency and Urgent Services requirements must have prior approval by the Personal Physician, Medical Group/IPA or MHSA, including those the Member obtains after the maximum Calendar Year Copayment has been met. The Member will be responsible for payment of services that are not authorized, those that are not an Emergency or covered Urgent Service procedure, or Mental Health Services not authorized by the MHSA. Members must obtain Services from the Plan Providers that are authorized by their Personal Physician. For urgent care while in the Personal Physician Service Area, Members must first call the Personal Physician. However, Members may go directly to an urgent care center when the assigned Medical Group/IPA has provided instructions about obtaining care from an urgent care clinic in the Personal Physician Service Area. See How to Use Your Health Plan.

The Blue Shield Access+ HMO Health Plan

Combined Evidence of Coverage and Disclosure Form

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

INTRODUCTION TO THE BLUE SHIELD ACCESS+ HMO HEALTH PLAN

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

By choosing this Health Maintenance Organization (HMO), you've selected some significant differences from not only the other health care coverage provided by Blue Shield, but also from that of most other health plans.

Unlike some HMOs, the Access+ HMO offers you a health Plan with a wide choice of Physicians, Hospitals and Non-Physician Health Care Practitioners. Access+ HMO Members may also take advantage of special features such as Access+ Specialist and Access+ Satisfaction. These features are described fully in this booklet.

You will be able to select your own Personal Physician from the Blue Shield HMO Physician and Hospital Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Each of your eligible Family members may select a different Personal Physician.

Note: If your Plan has a per Member Calendar Year Deductible requirement for facility Services, as listed on the Summary of Benefits, then the Calendar Year Deductible must be satisfied for those Services to which it applies before the Plan will provide Benefit payments for those covered Services.

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

All covered Services must be provided by or arranged through your Personal Physician, except for the following:

- Services received during an Access+ Specialist visit,
- OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Personal Physician,
- Urgent care provided in your Personal Physician Service Area by an urgent care clinic when instructed by your assigned Medical Group/IPA,
- Emergency Services, or
- Mental Health Services.*

*See the Mental Health Services paragraphs in the How to Use Your Health Plan section for information.

Note: A decision will be rendered on all requests for prior authorization of services as follows:

- for Urgent Services and in-area urgent care, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.

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

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

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

If you have any questions regarding the information, you may contact us through our Member Services Department at the number provided on the last page of this booklet.

CHOICE OF PHYSICIANS AND PROVIDERS

SELECTING A PERSONAL PHYSICIAN

A close Physician-patient relationship is an important ingredient that helps to ensure the best medical care. Each Member is therefore required to select a Personal Physician at the time of enrollment. This decision is an important one because your Personal Physician will:

1. Help you decide on actions to maintain and improve your total health;
2. Coordinate and direct all of your medical care needs;
3. Work with your Medical Group/IPA to arrange your referrals to Specialty Physicians, Hospitals and all other

health Services, including requesting any prior authorization you will need;

4. Authorize Emergency Services when appropriate;
5. Prescribe those lab tests, X-rays and Services you require;
6. If you request it, assist you in obtaining prior approval from the Mental Health Service Administrator (MHSA) for Mental Health Services*; and,

   *See the Mental Health Services paragraphs in the How to Use Your Health Plan section for information.

7. Assist you in applying for admission into a Hospice Program through a Participating Hospice Agency when necessary.

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

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

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you must submit a written application as explained in the Eligibility section of this Evidence of Coverage and Disclosure Form.

ROLE OF THE MEDICAL GROUP OR IPA

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

Your designated Medical Group/IPA (or Blue Shield when noted on your identification card) ensures that a full panel of Specialists is available to provide for your health care needs and helps your Personal Physician manage the utilization of your health Plan Benefits by ensuring that referrals are directed to Providers who are contracted with them. Medical Groups/IPAs also have admitting arrangements with Hospitals contracted with Blue Shield in their area and some have special arrangements that designate a specific Hospital as "in network." Your designated Medical Group/IPA works with your Personal Physician to authorize Services and ensure that that Service is performed by their in network Provider.

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

CHANGING PERSONAL PHYSICIANS OR DESIGNATED MEDICAL GROUP OR IPA

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

Once your Personal Physician change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Personal Physician and Access+ Specialist visits. Once your Medical Group/IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new Medical

Group/IPA, even if you remain with the same Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician or Medical Group/IPA.

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

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

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

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

Continuity of Care by a Terminated Provider

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

Continuity of Care for New Members by Non-Contracting Providers

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

Relationship With Your Personal Physician

The Physician-patient relationship you and your Personal Physician establish is very important. The best effort of your Personal Physician will be used to ensure that all Medically Necessary and appropriate professional Services are provided to you in a manner compatible with your wishes.

If your Personal Physician recommends procedures or treatments which you refuse, or you and your Personal Physician fail to establish a satisfactory relationship, you may select a different Personal Physician. Member Services can assist you with this selection.

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

Repeated failures to establish a satisfactory relationship with a Personal Physician may result in your no longer meeting the eligibility and enrollment requirements for the Plan. However, such an event will only occur after you have been given access to other available Personal Physicians and have been unsuccessful in establishing a satisfactory relationship. Any such change in your eligibility will take place in accordance with written procedures established by Blue Shield and only after written notice to the Member which describes the unacceptable conduct provides the Member with an opportunity to respond and warns the Member of the possibility of no longer remaining eligible to be covered under the Plan.

How to Use Your Health Plan

Use of Personal Physician

At the time of enrollment, you will choose a Personal Physician who will coordinate all Covered Services. You must contact your Personal Physician for all health care needs including preventive Services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological (OB/GYN) Physician Services, Access+ Specialist, and Mental Health Services), admission into a Hospice Program through a Participating Hospice Agency, Emergency Services, Urgent Services and for hospitalization.

The Personal Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care Services and requesting any needed prior authorization. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Personal Physician or

the MHSA and self-arranged appointments to an Access+ Specialist or for OB/GYN Services. Because your Physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the Physician. Some offices may advise you that a fee (not to exceed your Copayment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Personal Physician for any reason, you must contact Member Services at the number provided on the last page of this booklet, Monday through Friday, between 8 a.m. and 5 p.m. to select a Personal Physician to obtain Benefits.

OBSTETRICAL/GYNECOLOGICAL (OB/GYN) PHYSICIAN SERVICES

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

Obstetrical and gynecological Services are defined as:

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

It is important to note that services by an OB/GYN or family practice Physician outside of the Personal Physician's Medical Group or IPA without authorization will not be covered under this Plan. Before making the appointment, the Member should call the Member Services Department at the number provided on the last page of this booklet to confirm that the OB/GYN or family practice Physician is in the same Medical Group/IPA as her Personal Physician.

The OB/GYN Physician Services are separate from the Access+ Specialist feature described below.

REFERRAL TO SPECIALTY SERVICES

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

To obtain referral for specialty Services, including lab and X-ray, you must first contact your Personal Physician. If the Personal Physician determines that specialty Services are Medically Necessary, the Physician will complete a referral form and request necessary authorization. Your Personal Physician will designate the Plan Provider from whom you will receive Services.

When no Plan Provider is available to perform the needed Service, the Personal Physician will refer you to a non-Plan Provider after obtaining authorization. This authorization procedure is handled for you by your Personal Physician. Specialty Services are subject to all of the benefit and eligibility provisions, exclusions and limitations described in this booklet. You are responsible for contacting Blue Shield to determine that services are Covered Services, before such services are received.

SECOND MEDICAL OPINION

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

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

ACCESS+ SPECIALIST

You may arrange an office visit with a Plan Specialist in the same Medical Group or IPA as your Personal Physician without a referral from your Personal Physician, subject to the limitations described below. Access+ Specialist office visits are available only to Members whose Personal Physicians belong to a Medical Group or IPA that participates as an Access+ Provider. Refer to the HMO Physician and Hospital Directory or call Blue Shield Member Services at the number provided on the last page of this booklet to determine whether a Medical Group or IPA is an Access+ Provider.

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

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

Note: When you receive a referral from your Personal Physician to obtain services from a specialist, you are responsible for the Copayment listed in the Summary of Benefits for Professional (Physician) Benefits.

Note: For Access+ Specialist visits for Mental Health Services, see the following Mental Health Services paragraphs.

The Access+ Specialist visit includes:

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

An Access+ Specialist visit does not include:

1. Any services which are not covered or which are not Medically Necessary;
2. Services provided by a non-Access+ Provider (such as podiatry and Physical Therapy), except for the X-ray and laboratory Services described above;
3. Allergy testing;
4. Endoscopic procedures;
5. Any diagnostic imaging including CT, MRI, or bone density measurement;
6. Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics;
7. Infertility Services;
8. Emergency Services;
9. Urgent Services;
10. Inpatient Services, or any Services which result in a facility charge, except for routine X-ray and laboratory Services;
11. Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician;
12. OB/GYN Services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician;
13. Internet based consultations.

NURSEHELP 24/7 AND LIFEREFERRALS 24/7

If you are unsure about what care you need, you should contact your Physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by 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.

NurseHelp 24/7 and LifeReferrals 24/7 programs provide Members with no charge, confidential telephone support for

information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

These programs include:

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

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

MENTAL HEALTH SERVICES

Blue Shield of California has contracted with an MHSA to underwrite and deliver all Mental Health Services through a unique network of Mental Health Participating Providers. (See Mental Health Service Administrator under the Definitions section for more information.) All Non-Emergency Mental Health Services, except for Access+ Specialist visits, must be arranged through the MHSA. Members do not need to arrange for Mental Health Services through their Personal Physician. (See 1. Prior Authorization paragraphs below.)

All Mental Health Services, except for Emergency or Urgent Services, must be provided by an MHSA network Participating Provider. MHSA Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. Members may contact the MHSA directly for information on, and to select an MHSA Provider by calling 1-877-263-8827. Your Personal Physician may also contact MHSA to obtain information regarding MHSA network Participating Providers for you.

Mental Health Services received from a Provider who does not participate in the MHSA Participating Provider network will not be covered, except as stated herein, and all charges for these services will be the Member's responsibility. This limitation does not apply with respect to Emergency Services. In addition, when no MHSA Participating Provider is available to perform the needed Service, the MHSA will refer you to a non-Plan Provider and authorize Services to be received.

For complete information regarding Benefits for Mental Health Services, see Mental Health Benefits in the Plan Benefits section.

1. Prior Authorization

All Non-Emergency Mental Health Services must be prior authorized by the MHSA. For prior authorization of Mental Health Services, the Member should contact the MHSA at 1-877-263-8827.

Failure to receive prior authorization for Mental Health Services as described, except for Emergency and Urgent Services, will result in the Member being totally responsible for all costs for these services.

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

- for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.

2. Access+ Specialist visits for Mental Health Services

The Access+ Specialist feature is available for all Mental Health Services except for psychological testing and written evaluation which are not covered under this Benefit.

The Member may arrange for an Access+ Specialist office visit for Mental Health Services without a referral from the MHSA, as long as the Provider is an MHSA Participating Provider. Refer to the Blue Shield of California Behavioral Health Provider Directory or call the MHSA Member Services at 1-877-263-8827 to determine the MHSA Participating Providers. Members will be responsible for the Copayment listed in the Summary of Benefits for each Access+ Specialist visit for Mental Health Services. This Copayment is in addition to any Copayments that you may incur for specific Benefits as described in the Summary of Benefits. Each follow-up office visit for Mental Health Services which is not referred or authorized by the MHSA is a separate Access+ Specialist visit and requires a separate Copayment.

3. Psychosocial Support through LifeReferrals 24/7

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

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

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

EMERGENCY SERVICES

Members who reasonably believe that they have an emergency medical condition which requires an emergency response

are encouraged to appropriately use the "911" emergency response system where available.

Members should go to the closest Plan Hospital for Emergency Services whenever possible.

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

An emergency means a 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. If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

INPATIENT, HOME HEALTH CARE, HOSPICE PROGRAM AND OTHER SERVICES

The Personal Physician is responsible for obtaining prior authorization before you can be admitted to the Hospital or a Skilled Nursing Facility, including Subacute Care admissions, except for Mental Health Services which are described in the previous Mental Health Services paragraphs. The Personal Physician is responsible for obtaining prior authorization before you can receive home health care and certain other Services or before you can be admitted into a Hospice Program through a Participating Hospice Agency. If the Personal Physician determines that you should receive any of these Services, he or she will request authorization. Your Personal Physician will arrange for your admission to the Hospital, Skilled Nursing Facility, or a Hospice Program through a Participating Hospice Agency as well as for the provision of home health care and other Services.

Note: For Hospital admissions for mastectomies or lymph node dissections, the length of Hospital stays will be determined solely by the Member's Physician in consultation with the Member. For information regarding length of stay for maternity or maternity related Services, see Pregnancy and Maternity Care Benefits in the Plan Benefits section for information relative to the Newborns' and Mothers' Health Protection Act.

URGENT SERVICES

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

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

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

(Urgent care) While in your Personal Physician Service Area

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

Outside of California

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

Out-of-Area Follow-up Care is covered and services may be received through the BlueCard® Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

Within California

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

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

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

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

INTER-PLAN PROGRAMS

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

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

BLUECARD PROGRAM

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

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your 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 for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because they will not be applied retroactively to claims already paid.

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

Claims for Covered Emergency Services are paid based on the Allowed Charges as defined in this booklet.

Claims for Emergency and Out-of-Area Urgent Services

1. Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record for payment to the Plan, within 1 year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. In the event covered medical transportation Services are obtained in such an emergency situation, the Blue Shield Access+ HMO shall pay the medical transportation provider directly.

2. Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating BlueCard Program provider, you must submit a complete claim with the Urgent Service record for payment to the Plan, within 1 year after the first provision of Urgent Ser-

vices for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Urgent Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. If the Plan determines that the services would not have been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

MEMBER CALENDAR YEAR DEDUCTIBLE

The following section only applies if your Plan has a Calendar Year Deductible requirement for facility Services as listed on the Summary of Benefits.

The Calendar Year Deductible is shown in the Summary of Benefits. The Calendar Year Deductible applies only to facility charges for Inpatient Hospital Services, Skilled Nursing Facility Services, ambulatory surgery center Services and Outpatient Hospital surgery Services.

Before the Plan provides Benefit payments for the covered facility Services listed below, the Deductible must be satisfied once during the Calendar Year by or on behalf of each Member separately. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan. The Deductible applies to the following covered facility Services:

1. Inpatient Hospital Services;
2. Skilled Nursing Facility Services;
3. Ambulatory surgery center Services; and,
4. Outpatient Hospital Surgery Services.

After the Calendar Year Deductible is satisfied for those Services to which it applies, the Plan will provide Benefit payments for those covered Services.

The Deductible is based on Allowed Charges.

Payments applied to your Calendar Year Deductible accrue towards the Member maximum Calendar Year Copayment.

NO MEMBER MAXIMUM LIFETIME BENEFITS

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

NO ANNUAL DOLLAR LIMIT ON ESSENTIAL BENEFITS

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

MEMBER MAXIMUM CALENDAR YEAR COPAYMENT

Your maximum Copayment responsibility each Calendar Year for Covered Services is shown in the Summary of Benefits.

For all Plans, once a Member's maximum responsibility has been met*, the Plan will pay 100% of Allowed Charges for that Member's covered Services for the remainder of that Calendar Year, except as described below. Additionally, for Plans with a Member and a Family maximum responsibility, once the Family maximum responsibility has been met*, the Plan will pay 100% of Allowed Charges for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as described below.

*Note: Certain Services are not included in the calculation of the maximum Calendar Year Copayment. These items are shown on the Summary of Benefits.

Note that Copayments and charges for Services not accruing to the Member maximum Calendar Year Copayment continue to be the Member's responsibility after the Calendar Year Copayment maximum is reached.

If your Plan has a per Member Calendar Year Deductible requirement for facility Services, as listed on the Summary of Benefits, payments applied to your Calendar Year Deductible accrue towards the Member maximum Calendar Year Copayment.

Note: It is your responsibility to maintain accurate records of your Copayments and to determine and notify Blue Shield when the Member maximum Calendar Year Copayment responsibility has been reached.

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

LIABILITY OF SUBSCRIBER OR MEMBER FOR PAYMENT

It is important to note that all Services except for those meeting the Emergency and out-of-Service Area Urgent Services requirements, Access+ Specialist visits, Hospice Program Services received from a Participating Hospice Agency after the Member has been accepted into the Hospice Program, OB/GYN Services by an obstetrician/gynecologist or family practice Physician who is in the same Medical Group/IPA as the Personal Physician, and all Mental Health Services, must have prior authorization by the Personal Physician

or Medical Group/IPA. The Member will be responsible for payment of services that are not authorized or those that are not an Emergency or covered out-of-Service Area Urgent service procedures. (See the previous Urgent Services paragraphs for information on receiving Urgent Services out of the Service Area but within California.) Members must obtain Services from the Plan Providers that are authorized by their Personal Physician or Medical Group/IPA and, for all Mental Health Services, from MHSA Participating Providers. Hospice Services must be received from a Participating Hospice Agency.

If your condition requires Services which are available from the Plan, payment for services rendered by non-Plan Providers will not be considered unless the medical condition requires Emergency or Urgent Services.

LIMITATION OF LIABILITY

Members shall not be responsible to Plan Providers for payment for Services if they are a Benefit of the Plan. When Covered Services are rendered by a Plan Provider, the Member is responsible only for the applicable Deductible/Copayments, except as set forth in the Third Party Liability section. Members are responsible for the full charges for any non-Covered Services they obtain.

If a Plan Provider ceases to be a Plan Provider, you will be notified if you are affected. The Plan will make every reasonable and medically appropriate provision to have another Plan Provider assume responsibility for Services to you. You will not be responsible for payment (other than Copayments) to a former Plan Provider for any authorized Services you receive. Once provisions have been made for the transfer of your care, services of a former Plan Provider are no longer covered.

UTILIZATION REVIEW

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

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

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

PLAN SERVICE AREA

The Plan Service Area of this Plan is identified in the HMO Physician and Hospital Directory. You and your eligible Dependents must live or work in the Plan Service Area identified in those documents to enroll in this Plan and to maintain eligibility in this Plan.

ELIGIBILITY

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

If you are an Employee and reside or work in the Plan Service Area, you are eligible for coverage as a Subscriber the day following the date you complete the applicable waiting period established by the Trust. Your spouse or Domestic Partner and all your Dependent children who live or work in the Plan Service Area are eligible at the same time. (Special arrangements may be available for Dependents who are full-time students, Dependents of Subscribers who are required by court order to provide coverage, and Dependents and Subscribers who are long-term travelers. Please contact your Member Services Department to request an Away From Home Care® (AFHC) Program Brochure which explains these arrangements including how long AFHC coverage is available. This brochure is also available at https://www.blueshieldca.com for HMO Members.)

When you do not enroll yourself or your Dependents during the initial enrollment period and later apply for coverage, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of, 12 months from the date of application for coverage or at the Trust's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

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

Newborn infants of the Subscriber, spouse or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber'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 Blue Shield 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:

a. to continue coverage of a newborn or child placed for adoption;

b. to add a spouse after marriage or add a Domestic Partner after establishing a domestic partnership;

c. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;

d. to add yourself and spouse after marriage;

e. to add yourself and your 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 eligible to be Subscribers, 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 from the Member's Personal Physician of such disabling condition. Blue Shield or the Trust 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 Trust or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than 2 years after the initial certification and then annually thereafter.

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

2. If a Member commits any of the following acts, they will immediately lose eligibility to continue enrollment:

   a. Abusive or disruptive behavior which:

      (1) threatens the life or well-being of Plan personnel, or providers of Services;

      (2) substantially impairs the ability of Blue Shield to arrange for Services to the Member; or

      (3) substantially impairs the ability of providers of Services to furnish Services to the Member or to other patients.

   b. Failure or refusal to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the Plan.

3. A Member will also lose eligibility under the Plan, upon 30 days' written notice, if they are unable to establish a satisfactory Physician-patient relationship after following the procedures in the Relationship with Your Personal Physician section;

4. Trust eligibility – the Trust must meet specified Trust eligibility, participation and contribution requirements to be eligible for this group Plan. See the Trust for further information.

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 the Trust.

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

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of, 12 months from the date you made a written request for coverage or at the Trust's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

If you declined coverage for yourself and your Dependents during the initial enrollment period because you or your Dependents were covered under another employer health plan, 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 Blue Shield written evidence of loss of coverage.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of marriage, establishment of domestic partnership, birth or placement for adoption, you may request enrollment for yourself and your Dependents within 31 days. The effective date of

enrollment for both you and your Dependents will depend on how you acquire your Dependent(s):

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

Once each Calendar Year, the Trust may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another health plan sponsored by the Trust to the Access+ HMO. A completed enrollment form, which also indicates the choice of Personal Physician, must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the first day of the month 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 Subscriber, spouse or Domestic Partner has the right to control the child's health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield within 31 days. 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 Trust's next Open Enrollment Period.

If the Member is receiving Inpatient care at a non-Plan facility when coverage becomes effective, the Plan will provide Benefits only for as long as the Member's medical condition prevents transfer to a Plan facility in the Member's Personal Physician Service Area, as approved by the Plan. Unauthorized continuing or follow-up care in a non-Plan facility or by non-Plan Providers is not a Covered Service.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with the Trust, 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.

RENEWAL OF GROUP HEALTH SERVICE CONTRACT

Blue Shield of California will offer to renew the Group Health Service Contract except in the following instances:

1. non-payment of Dues (see Termination of Benefits and Cancellation Provisions section);
2. fraud, misrepresentations or omissions;
3. failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4. termination of plan type by Blue Shield;
5. the Trust relocates outside of California;
6. association membership ceases.

All groups will renew subject to the above.

PREPAYMENT FEE

The monthly Dues for you and your Dependents are indicated in the Trust's group Contract. The initial Dues are payable on the effective date of the group Contract, and subsequent Dues are payable on the same date (called the transmittal date) of each succeeding month. Dues are payable in full on each transmittal date and must be made for all Subscribers and Dependents.

All Dues required for coverage for you and your Dependents will be handled through the Trust, and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group Contract up to the date immediately preceding the next transmittal date, but not thereafter.

The Dues payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. The Trust will receive notice from the Plan of any changes in Dues at least 60 days prior to the change. The Trust will then notify you immediately.

Note: This paragraph does not apply to a Member who is enrolled under a Contract where monthly Dues automatically increase, without notice, the first day of the month following

an age change that moves the Member into the next higher age category.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, and annual Copayment maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days' written notice of any such change.

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

PLAN BENEFITS

The Plan Benefits available to you under the Plan are listed in this section. The Copayments and Deductible for these Services, if applicable, are in the Summary of Benefits.

The Services and supplies described here are covered only if they are Medically Necessary and, except for Mental Health Services, are provided, prescribed, or authorized by your Personal Physician or Medical Group/IPA. Your Personal Physician will also designate the Plan Provider from whom you must obtain authorized Services and will assist you in applying for admission into a Hospice Program through a Participating Hospice Agency. All Mental Health Services must be authorized by the MHSA and provided by an MHSA Participating Provider, unless otherwise authorized by the MHSA. The Plan will not pay charges incurred for services without authorization, except for OB/GYN Services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Personal Physician, Access+ Specialist visits, Hospice Services obtained through a Participating Hospice Agency after you have been admitted into the Hospice Program, and Emergency or Urgent Services obtained in accordance with the How to Use Your Health Plan section.

The determination of whether services are Medically Necessary or are an emergency or urgent will be made by the Medical Group/IPA or by the Plan. This determination will be based upon a review that is consistent with generally accepted medical standards, and will be subject to grievance in accordance with the procedures outlined in the Grievance Process section.

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.

The following are the basic health care Services covered by the Blue Shield Access+ HMO without charge to the Member, except for Deductible/Copayments where applicable, and as set forth in the Third Party Liability section. The Deductible/Copayments are listed in the Summary of Benefits. These Services are covered when Medically Necessary, and when provided by the Member's Personal Physician or other Plan Provider or authorized as described herein, or received according to the provisions described under Obstetrical/Gynecological (OB/GYN) Physician Services, Access+ Specialist, and Mental Health Benefits. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions set forth in this booklet.

You are responsible for paying a minimum charge (Deductible/Copayment) to the Physician or provider of Services at the time you receive Services. The specific Deductible/Copayments, as applicable, are listed in the Summary of Benefits.

ALLERGY TESTING AND TREATMENT BENEFITS

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

AMBULANCE BENEFITS

The Plan will pay for ambulance Services as follows:

1. Emergency Ambulance Services. Emergency ambulance Services for transportation to the nearest Hospital which can provide such emergency care only if a reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance Services.
2. Non-Emergency Ambulance Services. Medically Necessary ambulance Services to transfer the Member from a non-Plan Hospital to a Plan Hospital or between Plan facilities when in connection with authorized confinement/admission and use of the ambulance is authorized.

AMBULATORY SURGERY CENTER BENEFITS

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

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

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

as described herein. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

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

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

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

CLINICAL TRIAL FOR CANCER BENEFITS

Benefits are provided for routine patient care for a Member whose Personal Physician has obtained prior authorization and who has been accepted into an approved clinical trial for cancer provided that:

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

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

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

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

An approved clinical trial is limited to a trial that is:

1. Approved by one of the following:
   a. one of the National Institutes of Health;
   b. the federal Food and Drug Administration, in the form of an investigational new drug application;
   c. the United States Department of Defense;
   d. the United States Veterans Administration;

   or
2. Involves a drug that is exempt under federal regulations from a new drug application.

DIABETES CARE BENEFITS

1. Diabetic Equipment

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

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

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 Supplement.

2. Diabetes Self-Management Training

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

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. When authorized as Durable Medical Equipment, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

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

1. Rental charges for Durable Medical Equipment in excess of purchase price are not covered;
2. Routine maintenance or repairs, even if due to damage, are not covered;
3. Environmental control equipment, generators, and self-help/educational devices are not covered;
4. No benefits are provided for backup or alternate items;
5. 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: See the Outpatient Prescription Drug Supplement for Benefits for asthma inhalers and inhaler spacers.);
6. Breast pump rental or purchase is only covered if obtained from a designated Plan Provider in accordance with Blue Shield medical policy. For further information call Member Services or go to http://www.blueshieldca.com.

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

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

EMERGENCY ROOM BENEFITS

1. Emergency Services. Members who reasonably believe that they have an emergency medical or Mental Health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the Personal Physician or the MHSA by phone within 24 hours of the commencement of the Emergency Services, or as soon as it is medically possible for the Member to provide notice. 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. The Emergency Services Copayment does not apply if the Member is admitted directly to the Hospital as an Inpatient from the emergency room.
2. Continuing or Follow-up Treatment. If you receive Emergency Services from a Hospital which is a non-Plan Hospital, follow-up care must be authorized by Blue Shield or it may not be covered. If, once your Emergency medical condition is stabilized, and your treating health care provider at the non-Plan Hospital believes that you require additional Medically Necessary Hospital Services, the non-Plan Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital Services by the non-Plan Hospital. If Blue Shield determines that you may be safely transferred to a Hospital that is contracted with the Plan and you refuse to consent to the transfer, the non-Plan Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for Services provided to you once your Emergency condition is stable. Also, if the non-Plan Hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Plan Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan Hospital, you should contact Blue Shield at the telephone number on your identification card.

FAMILY PLANNING AND INFERTILITY BENEFITS

1. Family Planning Counseling, including Physician office visits for diaphragm fitting and injectable contraceptives.
2. Intrauterine device (IUD), including insertion and/or removal. No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.
3. Infertility Services. Infertility Services, except as excluded in the Principal Limitations, Exceptions, Exclusions and Reductions section, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose and treat the cause of Infertility. Any services related to the harvesting or stimulation of the

human ovum (including medications, laboratory and radiology service) are not covered.

4. Tubal Ligation.
5. Elective Abortion.
6. Vasectomy.
7. Implantable contraceptives.
8. Injectable contraceptives when administered by a Physician.
9. Diaphragm fitting procedure.

HOME HEALTH CARE BENEFITS

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the Personal Physician, and authorized. Visits by home health care agency providers are limited to a combined visit maximum during any Calendar Year as shown in the Summary of Benefits.

Intermittent and part-time home visits by a home health agency to provide Skilled Nursing Services 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 the professional Services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan, and related laboratory Services 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 Benefit or under the supplemental Benefit for Outpatient Prescription Drugs.

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

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

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

1. Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency. Note: For Services related to hemophilia, see item 2. below. Services include home infusion agency Skilled Nursing Services, parenteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary, FDA approved injectable medications when prescribed by the Personal Physician and prior authorized, and when provided by a Home Infusion Agency.

This Benefit does not include medications, drugs, insulin, insulin syringes or Specialty Drugs covered under the supplemental Benefit for Outpatient Prescription Drugs, and Services related to hemophilia which are covered as 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).

2. Hemophilia home infusion products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All Services must be prior authorized by the Plan and must be provided by a 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 Member Services 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 Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in 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 Plan Benefits section.

This Benefit does not include:

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

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

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

*Services and certain drugs may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), the Outpatient Prescription Drug Benefit, or as described elsewhere in this Plan Benefits 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 Plan Provider's certification and the admission must receive prior approval from Blue Shield. Note: Members with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-Hospice consultative visit from a Participating Hospice Agency. Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Members can continue to receive Covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate Plan Provider. Member Copayments when applicable are paid to the Participating Hospice Agency.

Note: Hospice services provided by a non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies. If Blue Shield prior authorizes Hospice Program Services from a non-contracted Hospice, the Member's Copayment for these Services will be the same as the Copayments for Hospice Program Services when received and authorized by a Participating Hospice Agency.

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

1. Pre-Hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified Health Aide Services, and Homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical Social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Members to the extent that these needs are not met by the Personal Physician.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical Therapy, Occupational Therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain Activities of Daily Living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that 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 5 consecutive days at a time.

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

DEFINITIONS

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

Continuous Home Care – home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided

for more than half of the Period of Care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the Services are covered as routine home care rather than Continuous Home Care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL BENEFITS (FACILITY SERVICES)

The following Hospital Services customarily furnished by a Hospital will be covered when Medically Necessary and authorized:

1. Inpatient Hospital Services include:

    a. Semi-private room and board, unless a private room is Medically Necessary;

    b. General nursing care, and special duty nursing when Medically Necessary;

    c. Meals and special diets when Medically Necessary;

    d. Intensive care Services and units;

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

    f. Hospital ancillary Services including diagnostic laboratory, X-ray Services and therapy Services;

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

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

    i. Administration of blood, blood plasma including the cost of blood, blood plasma, and in-Hospital blood processing;

    j. Radiation therapy, chemotherapy, and renal dialysis;

    k. Subacute Care;

    l. 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 7 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;

    m. 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;

    n. Medically Necessary Inpatient skilled nursing Services, including Subacute Care. Note: These Services are limited to the day maximum as shown in the Summary of Benefits during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether in a Hospital or a Skilled Nursing Facility;

    o. Rehabilitation when furnished by the Hospital and authorized.

    p. Medically Necessary Services in connection with 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 and Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Surgery must be authorized as described herein. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

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

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

        (2) Surgery to reform or reshape skin or bone;

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

        (4) Hair transplantation; and

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

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

Note: See Hospice Program Benefits in the Plan Benefits section for Inpatient Hospital Services provided under the hospice program Services Benefit.

2. Outpatient Hospital Services:

   a. Services and supplies for treatment (including dialysis, radiation and chemotherapy) or surgery in an Outpatient Hospital setting.

   b. Services for general anesthesia and associated facility charges in connection with dental procedures when performed in a Hospital Outpatient setting because of an underlying medical condition or clinical status and the Member is under the age of 7 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.

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

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

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

      (2) Surgery to reform or reshape skin or bone;

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

      (4) Hair transplantation; and

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

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

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

Hospital and professional Services provided for conditions of the teeth, gums, or jaw joints and jaw bones, including adjacent tissues are a Benefit only to the extent that these Services 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 non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

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

5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones);

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

7. Dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

This Benefit does not include:

1. Services performed on the teeth, gums (other than tumors 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. Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

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

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

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

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

MENTAL HEALTH BENEFITS

Blue Shield of California's MHSA administers and delivers the Plan's Mental Health Benefits. All Non-Emergency Mental Health Services must be arranged through the MHSA. Also, all Non-Emergency Mental Health Services must be prior authorized by the MHSA. For prior authorization for Mental Health Services, Members should contact the MHSA at 1-877-263-9952.

All Mental Health Services must be obtained from MHSA Participating Providers. (See the How to Use Your Health Plan section, the Mental Health Services paragraphs for more information.)

Benefits are provided for the following Medically Necessary covered Mental Health Conditions, subject to applicable Deductible/Copayments and charges in excess of any Benefit maximums. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit description below, and to the Principal Limitations, Exceptions, Exclusions and Reductions set forth in this booklet.

No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage has been selected as an optional Benefit by the Trust, in which case an accompanying Supplement provides the Benefit description, limitations and Copayments. Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

1. Inpatient Services

Benefits are provided for Inpatient Hospital and professional Services in connection with hospitalization for the treatment of Mental Health Conditions. All Non-Emergency Mental Health Services must be prior authorized by the MHSA and obtained from MHSA Participating Providers. Residential care is not covered.

Note: See Hospital Benefits (Facility Services) in the Plan Benefits section for information on Medically Necessary Inpatient detoxification.

2. Outpatient Services

Benefits are provided for Outpatient facility and office visits for Mental Health Conditions.

3. Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT) Services

Benefits are provided for Hospital and professional Services in connection with Partial Hospitalization, Intensive Outpatient Care and ECT for the treatment of Mental Health Conditions.

4. Psychological Testing

Psychological testing is a covered Benefit when the Member is referred by an MHSA Provider, the procedure is prior authorized by the MHSA and when provided to diagnose a Mental Health Condition.

5. Psychosocial Support through LifeReferrals 24/7

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

6. Behavioral Health Treatment

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

ORTHOTICS BENEFITS

Medically necessary Orthoses for Activities of Daily Living are covered, including the following:

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

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

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

Benefits for Medically Necessary Orthoses are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized appliances equally appropriate for a condition, this Plan will provide Benefits based on the most cost effective appliance. Routine maintenance is not

covered. No Benefits are provided for backup or alternate items.

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.

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

Outpatient X-Ray, Pathology and Laboratory Benefits

1. Laboratory, X-ray, Major Diagnostic Services. All Outpatient diagnostic X-ray and clinical laboratory tests and Services, including diagnostic imaging, electrocardiograms, and diagnostic clinical isotope Services.
2. Genetic Testing and Diagnostic Procedures. Genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Blue Shield of California medical policy.

Note: See Pregnancy and Maternity Care Benefits in the Plan Benefits section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

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. These Benefits must be prescribed or ordered by the appropriate health care professional.

Pregnancy and Maternity Care Benefits

The following pregnancy and maternity care is covered subject to the exclusions listed in the Principal Limitations, Exceptions, Exclusions and Reductions section:

1. Prenatal and postnatal Physician office visits and delivery, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.

Note: See Outpatient X-ray, Pathology and Laboratory Benefits in the Plan Benefits section for information on coverage of other genetic testing and diagnostic procedures.

2. Inpatient Hospital Services. Hospital Services for the purposes of a normal delivery, routine newborn circumcision,* Cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth.
3. Outpatient routine newborn circumcision.*

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

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

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

Preventive Health Benefits

Preventive Health Services, as defined, are covered.

Professional (Physician) Benefits (other than for Mental Health Benefits which are described elsewhere in this Plan Benefits section.)

1. Physician Office Visits. Office visits for examination, diagnosis, and treatment of a medical condition, disease or injury, including Specialist office visits, second opinion or other consultations, office surgery, Outpatient chemotherapy and radiation therapy, diabetic counseling, audiometry examinations when performed by a Physician or by an audiologist at the request of a Physician, and OB/GYN Services from an obstetrician/gynecologist or family practice Physician who is within the same Medical Group/IPA as the Personal Physician. Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
2. Home Visits. Medically Necessary home visits by Plan Physician.
3. Inpatient Medical and Surgical Physician Services. Physicians' Services in a Hospital or Skilled Nursing Facility for examination, diagnosis, treatment and consultation including the Services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist. Inpatient professional Services are covered only when Hospital and Skilled Nursing Facility Services are also covered.
4. Internet Based Consultation. Medically Necessary consultations with Internet Ready Physicians via the Blue

Shield approved Internet portal. Internet based consultations are available only to Members whose Personal Physicians (or other Physicians to whom you have been referred for care within your Personal Physician's Medical Group/IPA) have agreed to provide Internet based consultations via the Blue Shield approved Internet portal ("Internet Ready"). Refer to the On-Line Physician Directory to determine whether your Physician is Internet Ready and how to initiate an Internet based consultation. This information can be accessed at http://www.blueshieldca.com.

5. Injectable medications approved by the Food and Drug Administration (FDA) are covered for the Medically Necessary treatment of medical conditions when prescribed or authorized by the Personal Physician or as described herein. Insulin and Home Self-Administered Injectables will be covered if the Member's Trust provides supplemental Benefits for prescription drugs through the supplemental Benefit for Outpatient Prescription Drugs.

6. Medically Necessary Services in connection with 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 and 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. Surgery must be authorized as described herein. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

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

   - 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.

PROSTHETIC APPLIANCES BENEFITS

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

Medically Necessary Prostheses for Activities of Daily Living are covered, including the following:

1. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

Routine maintenance is not covered. Benefits do not include wigs for any reason or any type of speech or language assistance devices except as specifically provided above. See the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices. No benefits are provided for backup or alternate items.

Benefits are provided for contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia following cataract surgery when no intraocular lens has been implanted. Note: These contact lenses will not be covered under your Blue Shield Access+ HMO health Plan if the Trust provides supplemental Benefits for vision care that cover contact lenses through a vision plan purchased through Blue Shield of California. There is no coordination of benefits between the health Plan and the vision plan for these Benefits.

Note: For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services), and Professional (Physician) Benefits in the Plan Benefits section. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy are covered as a surgical professional Benefit.

REHABILITATION BENEFITS (PHYSICAL, OCCUPATIONAL AND RESPIRATORY THERAPY)

Rehabilitation Services include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy pursuant to a written treatment plan, and when rendered in the Provider's office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in Speech Therapy Benefits in the Plan Benefits section. Medically Necessary Services will be authorized for an initial treatment period and any addition-

al subsequent Medically Necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is Medically Necessary.

Note: See Home Health Care Benefits in the Plan Benefits section for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

SKILLED NURSING FACILITY BENEFITS

Subject to all of the Inpatient Hospital Services provisions, Medically Necessary skilled nursing Services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. This Benefit is limited to a combined day maximum as shown in the Summary of Benefits during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether in a Hospital or a Skilled Nursing Facility. Custodial care is not covered.

Note: For information concerning hospice program Benefits see Hospice Program Benefits in the Plan Benefits section.

SPEECH THERAPY BENEFITS

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

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

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

Except as specified above and as stated under Home Health Care Benefits, no Outpatient Benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See Home Health Care Benefits in the Plan Benefits section for information on coverage for Speech Therapy Services rendered in the home, including visit limits. See Hospital Benefits (Facility Services) in the Plan Benefits section for information on Inpatient Benefits and Hospice Program Benefits in the Plan Benefits section for hospice program Services.

TRANSPLANT BENEFITS – CORNEA, KIDNEY OR SKIN

Hospital and professional Services provided in connection with human organ transplants are a Benefit to the extent that they are:

1. Provided in connection with the transplant of a cornea, kidney, or skin, when the recipient of such transplant is a Member;
2. Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

Transplant Benefits - Special

Blue Shield will provide Benefits for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from Blue Shield's Medical Director and (3) the recipient of the transplant is a Subscriber or Dependent. The following conditions are applicable:

1. Blue Shield reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding Benefits based on (a) the medical circumstances of each patient and (b) consistency between the treatment proposed and Blue Shield medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.
2. The following procedures are eligible for coverage under this provision:
    a. Human heart transplants;
    b. Human lung transplants;
    c. Human heart and lung transplants in combination;
    d. Human kidney and pancreas transplants in combination;
    e. Human liver transplants;
    f. 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;
    g. Pediatric human small bowel transplants;
    h. Pediatric and adult human small bowel and liver transplants in combination.

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

URGENT SERVICES BENEFITS

To receive urgent care within your Personal Physician Service Area, call your Personal Physician's office or follow instructions given by your assigned Medical Group/IPA in accordance with the How to Use Your Health Plan section.

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

Inside California

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

Outside California or the United States

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

Note: Up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits. Blue Shield may direct the Member to receive the additional follow-up care from the Personal Physician.

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, 7 days a week. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in Claims for Emergency and Out-of-Area Urgent Services in the How to Use Your Health Plan section. See BlueCard Program in the How to Use Your Health Plan section for additional information.

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

PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Experimental or Investigational in Nature except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits in the Plan Benefits section;
2. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits in the Plan Benefits section;
3. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;
4. for any services whatsoever relating to the diagnosis or treatment of any Substance Abuse Condition, unless the Trust has purchased substance abuse coverage as an optional Benefit, in which case an accompanying Supplement

provides the Benefit description, limitations and Copayments;

5. performed in a Hospital by Hospital officers, residents, interns and others in training;
6. 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;
7. for Cosmetic Surgery or any resulting complications, except that Medically Necessary Services to treat complications of Cosmetic Surgery (e.g., infections or hemorrhages) will be a Benefit, but only upon review and approval by a Blue Shield Physician 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;
8. incident to an organ transplant, except as provided under Transplant Benefits in the Plan Benefits section;
9. for convenience items such as telephones, TVs, guest trays, and personal hygiene items;
10. for transgender or gender dysphoria conditions, including but not limited to intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
11. 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 (G.I.F.T.) 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 and Maternity Care Benefits under a Blue Shield of California health plan;
12. for or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for medically necessary treatment of medical complications;
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 provided under Home Health Care Benefits, Speech Therapy Benefits, and Hospice Program Benefits in the Plan Benefits section;
14. for routine foot care including callus, corn paring or excision and toenail trimming (except as may be provided through a Participating Hospice Agency); treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot; for special footwear (e.g., non-custom made or over-the-counter shoe inserts or arch supports) except as specifically provided under Orthotics Benefits and Diabetes Care Benefits in the Plan Benefits section;
15. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided under Prosthetic Appliances Benefits in the Plan Benefits section, and video-assisted visual aids or video magnification equipment for any purpose);
16. for hearing aids;
17. for Dental Care or services incident to the treatment, prevention, or relief of pain or dys-

function 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 in the Plan Benefits section;

18. 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 Hospital Benefits (Facility Services) and Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits in the Plan Benefits section;
19. for or incident to reading, vocational, educational, recreational, art, dance or music therapy; weight control or exercise programs, nutritional counseling except as specifically provided for under Diabetes Care Benefits in the Plan Benefits section. This exclusion shall not apply to Medically Necessary Services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
20. for learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to Medically Necessary Services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
21. for or incident to acupuncture, except as specifically provided;
22. for spinal manipulation and adjustment, except as specifically provided under Professional (Physician) Benefits (other than for Mental Health Benefits) in the Plan Benefits section;
23. for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of Benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges;
24. in connection with private duty nursing, except as provided under Hospital Benefits (Facility Services), Home Health Care Benefits**,** Home Infusion/Home Injectable Therapy Benefits, and Hospice Program Benefits in the Plan Benefits section;
25. for rehabilitation services except as specifically provided under Hospital Benefits (Facility Services), Home Health Care Benefits**,** and Rehabilitation Benefits in the Plan Benefits section;
26. 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 Drug Supplement or Home Infusion/Home Injectable Therapy Benefits in the Plan Benefits section;
27. for transportation services other than provided under Ambulance Benefits in the Plan Benefits section;
28. for unauthorized non-Emergency Services;
29. not provided by, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician, Emergency Services or Urgent Services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section,

when specific authorization has been obtained in writing for such Services as described herein, for Mental Health Services which must be arranged through the MHSA or for Hospice Services received by a Participating Hospice Agency;

30. performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;

31. for orthopedic shoes, except as provided under Diabetes Care Benefits in the Plan Benefits section, home testing devices, environmental control equipment, generators, exercise equipment, self help/educational devices, or for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistance devices, except as provided under Prosthetic Appliances Benefits in the Plan Benefits section, vitamins, and comfort items;

32. for physical exams required for licensure, employment, or insurance unless the examination corresponds to the schedule of routine physical examinations provided under Preventive Health Benefits in the Plan Benefits section, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;

33. for penile implant devices and surgery, and any related services except for any resulting complications and Medically Necessary Services as provided under Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services), and Professional (Physician) Benefits in the Plan Benefits section;

34. for home testing devices and monitoring equipment except as specifically provided in Durable Medical Equipment Benefits in the Plan Benefits section;

35. for or incident to sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

36. 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 Durable Medical Equipment Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, and Diabetes Care Benefits in the Plan Benefits section;

37. 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;

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

39. for prescription or non-prescription food and nutritional supplements, except as under PKU Related Formulas and Special Food Products Benefits and Home Infusion/Home Injectable Therapy Benefits in the Plan Benefits section, and except as provided through a hospice agency;
40. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits in the Plan Benefits section;
41. for services provided by an individual or entity that is not licensed, certified, or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification, or state authorization, except as specifically stated herein;
42. for massage therapy performed by a massage therapist;
43. not specifically listed as a benefit.

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

MEDICAL NECESSITY EXCLUSION

All Services must be Medically Necessary. The fact that a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude Benefits for services which are not Medically Necessary.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

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

When your Blue Shield group plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield group plan may be lower but will not exceed the Medicare allowed amount. Your Blue Shield 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 Blue Shield group plan will pay the reasonable value or Blue Shield's Allowed Charges 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 Blue Shield group plan will pay the reasonable value or Blue Shield's Allowed Charges 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 Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowed Charges).

Contact the Member Services department at the telephone number shown at the end of this document if you have any questions about how Blue Shield coordinates your group plan benefits in the above situations.

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS AND SERVICES REVIEW

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

REDUCTIONS - THIRD PARTY LIABILITY

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

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

The Member is required to:

1. Notify Blue Shield, the Member's designated Medical Group or the IPA in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and
4. Provide a lien calculated in accordance with California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield and the Member's designated Medical Group or Independent Practice Association, in writing, within 10 days after any Recovery has been obtained.

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

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

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

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

COORDINATION OF BENEFITS

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

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of, or reimbursement for, Hospital or medical expenses, such person will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any Calendar Year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit value or amount payable by each plan separately.

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

The following rules determine the order of benefit payments:

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

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the Dependent child of a person whose date of birth (excluding year of birth), occurs earlier in a Calendar Year, shall determine its benefits before a plan which covers the Dependent child of a person whose date of birth (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Notwithstanding (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

a. a plan covering a patient as a laid-off or retired employee, or as a Dependent of such an employee, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such Dependent; and,

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

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

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

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

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

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

TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

TERMINATION OF BENEFITS

Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Group Health Service Contract is discontinued, (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the Trust, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Trust (see Cancellation for Non-Payment of Dues - Notices), or (4) the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment, or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

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

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see the Trust about possibly continuing group coverage. Also, see the Group Continuation Coverage and Individual Conversion Plan section for information on continuation of coverage.

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

If application is not made for a newborn or a child placed for adoption 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.

If the Subscriber no longer lives or works in the Plan Service Area, coverage will be terminated for him and all his Dependents. If a Dependent no longer lives or works in the Plan Service Area, then that Dependent's coverage will be terminated. (Special arrangements may be available for Dependents who are full-time students or do not live in the Subscriber's home. Please contact the Member Services Department to request an Away From Home Care® Program Brochure which explains these arrangements.)

Additionally, the Plan may terminate coverage of a Member for cause immediately upon written notice for the following:

1. Material information that is false or misrepresented information provided on the enrollment application or given to the group or the Plan; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;
2. Permitting a non-Member to use a Member identification card to obtain Services and Benefits; or
3. Obtaining or attempting to obtain Services or Benefits under the Group Health Service Contract by means of

false, materially misleading, or fraudulent information, acts or omissions.

The Plan may also terminate coverage of a Member for cause upon 31 days written notice for the following:

1. Inability to establish a satisfactory Physician-patient relationship after following the procedures under Relationship with Your Personal Physician in the Choice of Physicians and Providers section;
2. Failure to pay any Copayment or supplemental charge.

REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS

If you had been making contributions toward coverage for you and your Dependents and voluntarily cancelled such coverage, you may apply for reinstatement. You or your Dependents must wait until the earlier of, 12 months from the date of application or at the Trust's next Open Enrollment Period to be reinstated. Blue Shield will not consider applications for earlier effective dates.

CANCELLATION WITHOUT CAUSE

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

CANCELLATION FOR NON-PAYMENT OF DUES - NOTICES

Blue Shield may cancel this group Contract for non-payment of Dues.

If the Trust fails to pay the required Dues when due, coverage will end 31 days after the date for which Dues are due. The Trust will be liable for all Dues accrued while this Plan continues in force including those accrued during the 31-day grace period.

Blue Shield of California will mail the Trust a Notice Confirming Termination of Coverage. The Trust must provide you with a copy of the Notice Confirming Termination of Coverage.

In addition, Blue Shield of California will send you a HIPAA certificate which will state the date on which your coverage terminated, the reason for the termination, and the number of months of creditable coverage which you have. The certificate will also summarize your rights for continuing coverage on a guaranteed issue basis under HIPAA and on Blue Shield of California's conversion plan. For more information on conversion coverage and your rights to HIPAA coverage, please see the paragraph on Availability of Blue Shield of California Individual Plans.

CANCELLATION/RESCISSION FOR FRAUD OR INTENTIONAL MISREPRESENTATIONS OF MATERIAL FACT

Blue Shield may cancel or rescind the group Contract for fraud or intentional misrepresentation of material fact by the Trust, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative.

If you are hospitalized or undergoing treatment for an ongoing condition and the group Contract is cancelled for any reason, including non-payment of Dues, no Benefits will be provided unless you obtain an Extension of Benefits.

Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Trust) may, at the discretion of Blue Shield, result in the cancellation or rescission, respectively, of this Plan or the coverage of Employees or Dependents who committed said fraud or intentional misrepresentation of material fact. Cancellations are effective on receipt or on such later date as specified in the cancellation notice. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

In the event the Contract is rescinded or cancelled, either by Blue Shield or the Trust, it is the Trust's responsibility to notify you of the rescission or cancellation.

RIGHT OF CANCELLATION

If you are making any contributions toward coverage for yourself or your Dependents, you may cancel such coverage to be effective at the end of any period for which Dues have been paid.

If the Trust does not meet the applicable eligibility, participation and contribution requirements of the group contract, Blue Shield of California will cancel this Plan after 30 days' written notice to the Trust.

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

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

See the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision for termination for fraud or intentional misrepresentations of material fact.

GROUP CONTINUATION COVERAGE AND INDIVIDUAL CONVERSION PLAN

GROUP CONTINUATION COVERAGE

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

Applicable to Members when the Subscriber's Trust (Contractholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Trust should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member will be entitled to elect to continue group coverage under this Plan if the Member would lose coverage otherwise because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

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

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

Qualifying Event

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

1. With respect to the Subscriber:
    a. the termination of employment (other than by reason of gross misconduct); or
    b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

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

    a. the death of the Subscriber; or
    b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
    c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
    d. the divorce or legal separation of the Dependent spouse from the Subscriber or termination of the domestic partnership; or
    e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
    f. a Dependent child's loss of Dependent status under this Plan.
3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, when the Trust files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. Such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees:

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

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

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

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

2. With respect to Cal-COBRA enrollees:

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

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

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

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

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

Duration and Extension of Continuation of Group Coverage

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

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

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

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under 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 Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

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

Payment of Dues

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

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

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

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

Effective Date of the Continuation of Coverage

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

Termination of Continuation of Group Coverage

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

1. discontinuance of this Group Health Service Contract (if the Trust continues to provide any group benefit plan for Employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Trust or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which dues were paid;
3. the Member becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member no longer resides in Blue Shield's Service Area;
6. the Member commits fraud or deception in the use of the Services of this Plan.

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

Continuation of Group Coverage for Members on Military Leave

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

Availability of Blue Shield of California Individual Plans

Blue Shield's Individual Plans described at the beginning of this section may be available to Members whose group coverage, COBRA or Cal-COBRA coverage is terminated or expires while covered under this group Plan.

Individual Conversion Plan

Continued Protection

Regardless of age, physical condition or employment status, you may continue Blue Shield protection when you retire, leave the job or become ineligible for group coverage. If you have held group coverage for 3 or more consecutive months, you and your enrolled Dependents may apply to transfer to an individual conversion health plan then being issued by Blue Shield. The Trust is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of termination of the Contract's coverage.

An application and first Dues payment for the conversion plan must be received by Blue Shield within 63 days of the date of termination of your group coverage. However, if the group Contract is replaced by the Trust with similar coverage under another contract within 15 days, transfer to the individual conversion health plan will not be permitted. You will not be permitted to transfer to the individual conversion plan under any of the following circumstances:

1. You failed to pay amounts due the Plan;
2. You were terminated by the Plan for good cause or for fraud or misrepresentation;
3. You knowingly furnished incorrect information or otherwise improperly obtained the Benefits of the Plan;
4. You are covered or eligible for Medicare;
5. You are covered or eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; and,
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in your group Plan.

An individual conversion health Plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for Dependent coverage under the group Plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse or Domestic Partner of a Subscriber, if their marriage or domestic partnership has terminated;

5. Dependents, when continuation of coverage under COBRA and/or Cal-COBRA expires, or is terminated.

When a Dependent reaches the limiting age for coverage as a Dependent, or if a Dependent becomes ineligible for any of the other reasons given above, it is your responsibility to inform Blue Shield. Upon receiving notification, Blue Shield will offer such Dependent an individual conversion health plan for purposes of continuous coverage.

GUARANTEED ISSUE INDIVIDUAL COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and under California law, you may be entitled to apply for certain of Blue Shield's individual health plans on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons if you meet the other eligibility requirements, you live or work in Blue Shield's Service Area and you agree to pay all required Dues). You may also be eligible to purchase similar coverage on a guaranteed issue basis from any other health plan that sells individual coverage for hospital, medical or surgical benefits. Not all Blue Shield individual plans are available on a guaranteed issue basis under HIPAA. To be eligible, you must meet the following requirements:

- You must have at least 18 or more months of creditable coverage.
- Your most recent coverage must have been group coverage (COBRA and Cal-COBRA are considered group coverage for these purposes).
- You must have elected and exhausted all COBRA and/or Cal-COBRA coverage that is available to you.
- You must not be eligible for nor have any other health insurance coverage, including a group health plan, Medicare or Medi-Cal.
- You must make application to Blue Shield for guaranteed issue coverage within 63 days of the date of termination from the group plan.

If you elect Conversion Coverage or other Blue Shield individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Member Services representative at the telephone number noted on your ID Card.

EXTENSION OF BENEFITS

If a person becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the group Contract terminates, Blue Shield will extend the Benefits of this Plan, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) the date the covered person is no longer Totally Disabled; (2) 12 months from the date the group Contract terminated; (3) the date on which the covered person's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the person without limitation as to the Totally Disabling condition.

Written certification of the Member's Total Disability should be submitted to Blue Shield by the Member's Personal Physician as soon as possible after the Group Health Service Contract terminates. Proof of continuing Total Disability must be furnished by the Member's Personal Physician at reasonable intervals determined by Blue Shield.

GENERAL PROVISIONS

PUBLIC POLICY PARTICIPATION PROCEDURE

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

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

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

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

Please follow the following procedure:

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

GRACE PERIOD

After payment of the first Dues, the Contractholder is entitled to a grace period of 31 days for the payment of any Dues due. During this grace period, the Contract will remain in force. However, the Contractholder will be liable for payment of Dues accruing during the period the Contract continues in force.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

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

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services Department at the number provided on the last page of this booklet, or by accessing Blue Shield of California's Internet site located at http://www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

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

NON-ASSIGNABILITY

Benefits of this Plan are not assignable.

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

FACILITIES

The Plan has established a network of Physicians, Hospitals, Participating Hospice Agencies and Non-Physician Health Care Practitioners in your Personal Physician Service Area.

The Personal Physician(s) you and your Dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the Plan network provide access to 24-hour Emergency Services. The list of the Hospitals, Physicians and Participating Hospice Agencies in your Personal Physician Service Area indicates the location and phone numbers of these Providers. Contact Member Services at the number provided on the last page of this booklet for information on Plan Non-Physician Health Care Practitioners in your Personal Physician Service Area.

For Urgent Services when you are within the United States, you simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, 7 days a week. For Urgent Services when you are outside the United States, you can call collect 1-804-673-1177 24 hours a day. We will identify the BlueCard Program provider closest to you. Urgent Services when you are outside the U.S. are available through the BlueCard Worldwide Network. For Urgent Services when you are within California, but outside of your Personal Physician Service Area, you should, if possible, contact Blue Shield Member Services at the number listed on the last page of this booklet in accordance with the How to Use Your Health Plan section. For urgent care Services when you are within your Personal Physician Service Area, contact your Personal Physician or follow instructions provided by your assigned Medical Group/IPA.

INDEPENDENT CONTRACTORS

Plan Providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield of California conducts a process of credentialing and certification of all Physicians who participate in the Access+ HMO Network. However, in no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or

providing Services, including any Physician, Hospital, or other provider or their employees.

PAYMENT OF PROVIDERS

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

If you want to know more about this payment system, contact Member Services at the number listed on the last page of this booklet.

PLAN INTERPRETATION

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of the Contract, to determine the Benefits of the Contract, and determine eligibility to receive Benefits under the Contract. Blue Shield shall exercise this authority for the benefit of all persons entitled to receive Benefits under the Contract.

ACCESS+ SATISFACTION

You may provide Blue Shield with feedback regarding the service you receive from Plan Physicians. If you are dissatisfied with the service provided during an office visit with a Plan Physician, you may contact Member Services to request a refund of your office visit Copayment, as shown in the Summary of Benefits under Professional (Physician) Services.

MEMBER SERVICES

For all Services other than Mental Health

If you have a question about Services, providers, Benefits, how to use your Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call Blue Shield's Member Services Department at the number listed on the last page of this booklet.

The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free TTY number, 1-800-241-1823.

You also may write to the Blue Shield Member Services Department as noted on the last page of this booklet.

Member Services can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Members to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Member Services Department at the number listed on the last page of this booklet.

For all Mental Health Services

For all Mental Health Services, Blue Shield of California has contracted with the Plan's MHSA. The MHSA should be contacted for questions about Mental Health Services, MHSA Participating Providers, or Mental Health Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-8827

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

The MHSA can answer many questions over the telephone.

Note: The MHSA has established a procedure for our Members to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the number listed above.

GRIEVANCE PROCESS

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

For all Services other than Mental Health

Members, a designated representative, or a provider on behalf of the Member may contact the Member Services Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Plan at the telephone number as noted on the last page of this booklet. If the telephone inquiry to Member Services does not resolve the question or issue to the Member's

satisfaction, the Member may request a grievance at that time, which the Member Services Representative will initiate on the Member's behalf.

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

Blue Shield will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

For all Mental Health Services

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

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

1-877-263-8827

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

The MHSA will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

Note: If the Trust's health Plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.

EXTERNAL INDEPENDENT MEDICAL REVIEW

If your grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting Provider in whole or in part on the grounds that the service is not Medically Necessary or is Experimental/Investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is Experimental/Investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Member Services. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the Service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Member Services.

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan **at the number provided on the last page of this booklet** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential

legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

DEFINITIONS

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

Access+ Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the Access+ HMO Plan and for Mental Health Services, an MHSA Participating Provider.

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

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

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

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.

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

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

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

Close Relative — the spouse, Domestic Partner, child, brother, sister, or parent of a Subscriber or Dependent.

Contractholder – is San Francisco Electrical Workers Health & Welfare Trust.

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

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

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

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board or meet the Activities of Daily Living (which may include nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Physician); or care furnished to a Member who is mentally or physically disabled, and:

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,
2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

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.

Dental Care and Services — Services or treatment on or to the teeth or gums whether or not caused by Accidental Injury, including any appliance or device applied to the teeth or gums.

Dependent —

1. a Subscriber's legally married spouse who is not legally separated from the Subscriber:

   or,

2. a Subscriber's Domestic Partner;

   or,

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

and who has been enrolled and accepted by the Plan as a Dependent and has maintained membership in accordance with the Contract.

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

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

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

   b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the Trust's or Blue Shield's request; and

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

      (1) within 24 months after the month when the Dependent would otherwise have been terminated; and

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

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

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

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

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

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

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

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

Dues — the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

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

Emergency Services — Services 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.

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

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

Family — the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued by the Plan to the Contractholder that establishes the Services Members are entitled to receive from the Plan.

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

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

Hospital — either (1.), (2.) or (3.) below:

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

Independent Practice Association (IPA) — a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members. For all Mental Health Services, this definition includes the MHSA.

Infertility — the Member must be actively trying to conceive and has either:

1. the presence of a demonstrated bodily malfunction recognized by a licensed Physician as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
4. failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (the initial six cycles are not a benefit of this Plan); or
5. three or more pregnancy losses.

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

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

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent will not be considered a Late Enrollee if any of the conditions listed under (1.), (2.), (3.), (4.), (5.), (6.) or (7.) below is applicable:

1. The eligible Employee or Dependent meets all of the following requirements (a.), (b.), (c.) and (d.):
    a. The Employee or Dependent was covered under another employer health benefit plan at the time he was offered enrollment under this Plan;
    b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if he was covered under another employer health plan, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee;
    c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce, or termination of a domestic partnership; and
    d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and the eligible Employee elects this Plan during an Open Enrollment Period; or
3. A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon

presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
6. For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or
7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Medical Group — an organization of Physicians who are generally located in the same facility and provide Benefits to Members. For all Mental Health Services, this definition includes the MHSA.

Medical Necessity (Medically Necessary) —

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

    Inpatient services which are not Medically Necessary include hospitalization:

    a. for diagnostic studies that could have been provided on an Outpatient basis;
    b. for medical observation or evaluation;
    c. for personal comfort;
    d. in a pain management center to treat or cure chronic pain; or
    e. for Inpatient rehabilitation that can be provided on an Outpatient basis.
5. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

Member — either a Subscriber or Dependent.

Mental Health Condition — for the purposes of this Plan, means those conditions listed in the "Diagnostic & Statistical Manual of Mental Disorders Version IV" (DSM4), except as stated herein, and no other conditions. Mental Health Conditions include Severe Mental Illnesses and Serious Emotional Disturbances of a Child, but do not include any services relating to the following:

1. Diagnosis or treatment of Substance Abuse Conditions;
2. Diagnosis or treatment of conditions represented by V Codes in DSM4;
3. Diagnosis or treatment of any conditions listed in DSM4 with the following codes:

    294.8, 294.9, 302.80 through 302-90, 307.0, 307.3, 307.9, 312.30 through 312.34, 313.9, 315.2, 315.39 through 316.0.

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

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

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

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

Open Enrollment Period — that period of time set forth in the Contract during which eligible individuals and their Dependents may transfer from another health benefit plan sponsored by the Employer to the Blue Shield Access+ HMO 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.

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

Outpatient — an individual receiving Services under the direction of a Plan Provider, but not as an Inpatient.

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

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

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

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

Personal Physician Service Area — that geographic area served by your Personal Physician's Medical Group or IPA.

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

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

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

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

Note: This definition does not apply to Mental Health Services. For Participating Providers for Mental Health Services, see the Mental Health Service Administrator (MHSA) Participating Providers definitions above.

Plan Non-Physician Health Care Practitioner — a health care professional who is not a Physician and has an agreement with one of the contracted IPAs, Medical Groups, Plan Hospitals or Blue Shield to provide Covered Services to Members when referred by a Personal Physician. For all Mental Health Services, this definition includes MHSA Participating Providers.

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

Plan Service Area — that geographic area served by the Plan.

Plan Specialist — a Physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide Covered Services to Members either according to an authorized referral by a Personal Physician, or according to the Access+ Specialist program, or for OB/GYN Physician Services. For all Mental Health Services, this definition includes MHSA Participating Providers.

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

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

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

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

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

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

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

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

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

Rehabilitation — Inpatient or Outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy. Benefits for Speech Therapy are described in Speech Therapy Benefits in the Plan Benefits section.

Residential Care — services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for Acute Care or Skilled Nursing Services. This definition does not apply to services rendered under the Hospice Program Benefit.

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

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

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

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

    a. As a result of the mental disorder the child has substantial impairment in at least 2 of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;

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

Services — includes Medically Necessary health care services and Medically Necessary supplies furnished incident to those services.

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

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

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

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified

health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;

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

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

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

Subscriber — an individual who satisfies the eligibility requirements of the Contract, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Contract.

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

Total Disability —

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

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

Trust — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 Employees and that is actively engaged in business or service, in which a bona fide Trust-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.

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

This combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of the Blue Shield Access+ HMO Plan.

Should you have any questions, please call the Blue Shield of California Member Services Department at the number provided on the last page of this booklet.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

Supplement A — Outpatient Prescription Drug Benefits

Summary of Benefits

Member Calendar Year Brand Name Drug Deductible	Deductible Responsibility	
	Participating Pharmacy	**Non-Participating Pharmacy**
Per Member There is no Brand Name Drug Deductible requirement.	$0	

Benefit	Member Copayment	
	Participating Pharmacy	**Non-Participating Pharmacy[1]**
Retail Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	$15 per prescription	Not covered
Formulary Brand Name Drugs	$30 per prescription	Not covered
Non-Formulary Brand Name Drugs	Not covered	Not covered
Mail Service Prescriptions		
Contraceptive Drugs and Devices[2]	$0 per prescription	Not covered
Formulary Generic Drugs	$30 per prescription	Not covered
Formulary Brand Name Drugs	$60 per prescription	Not covered
Non-Formulary Brand Name Drugs	Not covered	Not covered
Specialty Pharmacies		
Specialty Drugs	20% of the Blue Shield contracted rate up to a maximum of $100 per prescription	Not covered

[1] Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency, including Drugs for emergency contraception. See the Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy section for details.

[2] If a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost for the Brand Name contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization to be covered without a Copayment.

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

Outpatient Prescription Drug Benefits

The following prescription drug Benefit is separate from the Health Plan coverage. The Calendar Year maximum Co-payments and the Coordination of Benefits provision do not apply to this Outpatient Prescription Drug Benefits Supplement; however, the general provisions and exclusions of the Health Plan contract shall apply.

Benefits are provided for Outpatient prescription Drugs which meet all of the requirements specified in this supplement, are prescribed by the Member's Personal Physician, are obtained from a Participating Pharmacy, and are listed in the Drug Formulary. Drug coverage is based on the use of Blue Shield's Outpatient Drug Formulary, which is updated on an ongoing basis by Blue Shield's Pharmacy and Therapeutics Committee. A Non-Formulary Drug may be covered but only through the prior authorization process described herein. Select Drugs and Drug dosages and most Specialty Drugs require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield.

Coverage for selected Drugs may be limited to a specific quantity as described in "Limitation on Quantity of Drugs that may be Obtained per Prescription or Refill".

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year.

A Non-Formulary Drug may be covered only if prior authorized by Blue Shield. Your Physician may request prior authorization. For instructions regarding obtaining prior authorization, see the section entitled Prior Authorization Process for Non-Formulary Drugs later in this supplement.

Members may call Blue Shield Member Services at the number listed on their Blue Shield Identification Card to inquire if a specific drug is included in the Formulary. Member Services can also provide Members with a printed copy of the Formulary. Members may also access the Formulary through the Blue Shield of California web site at http://www.blueshieldca.com.

Definitions

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

Diabetic Drugs and Supplies — medications and supplies used in the treatment and monitoring of diabetes. These medications may be administered orally or by injection and supplies may include lancets, lancet puncture devices, and blood and urine testing strips and test tablets.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (5) contraceptive Drugs and devices,(6) smoking cessation Drugs which require a prescription, (7) inhalers and inhaler spacers for the management and treatment of asthma.

Note: No prescription is necessary to purchase the items shown in (2), (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — a comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs. Benefits are provided for Formulary Drugs. Unless prior authorization has been received from Blue Shield, Non-Formulary Drugs are not covered.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Brand Name Drug equivalent.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Unless prior authorization has been received from Blue Shield, Non-Formulary Drugs are not covered.

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

Participating Pharmacy — a pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members. Note: The Mail Service Pharmacy is a Participating Pharmacy.

To select a Participating Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Member Services number on your Blue Shield Identification Card.

Specialty Drugs — Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancer, and other conditions that are difficult

to treat with traditional therapies. Specialty Drugs are listed in Blue Shield's Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy and Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

Specialty Pharmacy Network — select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs.

To select a Specialty Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Member Services number on your Blue Shield Identification Card.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain Drugs at a Participating Pharmacy, the Member must present his Blue Shield Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Blue Shield Identification Card will be denied.

Benefits are provided for Specialty Drugs only when obtained from a Blue Shield Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Specialty Drugs that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.

The Member is responsible for paying the Formulary Generic Drug Copayment for each prescription Formulary Generic Drug. The pharmacist will collect from the Member the Copayment at the time the Drugs are obtained.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand Name contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Name Drug Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Participating Pharmacy at the time the Drug is obtained, until the Brand Name Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices).

If the Member requests a Brand Name Drug when a Generic Drug equivalent is available, and the Brand Name Drug Deductible has been satisfied (when applicable), the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

If the prescribing Physician requests a Brand Name Drug when a Generic Drug equivalent is available, the Member is responsible for paying the applicable Brand Name Drug Copayment.

The Member is responsible for paying 100% of the cost of Drugs not listed on the Blue Shield Prescription Drug Formulary, unless prior authorization has been obtained.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency.

When Drugs are obtained at a Non-Participating Pharmacy for a covered emergency, including Drugs for emergency contraception, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services - Emergency Claims, P. O. Box 7168, San Francisco, CA 94120. The Member will be reimbursed the purchase price of covered prescription Drug(s) minus the Brand Name Drug Deductible for Brand Name Drugs (when applicable) and any applicable Copayment(s). Claim forms may be obtained from the Blue Shield Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

For the Member's convenience, when Drugs have been prescribed for a chronic condition he may obtain the Drug through Blue Shield's Mail Service Prescription Drug Program. The Member should submit the applicable Mail Service Copayment, an order form and his Blue Shield Member number to the address indicated on the mail order envelope. Members should allow 14 days to receive the Drug. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

The Member is responsible for the Mail Service Formulary Generic Drug Prescription Drug Copayment for each prescription Drug.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand Name contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy contracted rate.

If this Outpatient Prescription Drug Benefit has a Brand Name Deductible, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Brand Name Drug to the Mail Service Pharmacy prior to your prescription being sent to you, until the Brand Name Drug Deductible is satisfied (not applicable to contraceptive Drugs and devices). To obtain the Participating Pharmacy contracted rate amount, please contact the Mail Service Pharmacy at 1-866-346-7200. The TTY telephone number is 1-866-346-7197.

If the Member requests a Mail Service Brand Name Drug when a Mail Service Generic Drug is available, and the Brand Name Drug Deductible has been satisfied (when applicable), the Member is responsible for the difference between the contracted rate for the Mail Service Brand Name Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

If the prescribing Physician requests a Mail Service Brand Name Drug when a Mail Service Generic Drug equivalent is available, the Member is responsible for paying the applicable Mail Service Brand Name Drug Copayment.

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

A Non-Formulary Drug may be covered only if prior authorized by Blue Shield. Select Formulary Drugs and most Specialty Drugs may also require prior authorization for Medical Necessity. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compound drugs are covered only if the requirements listed under the Exclusions section of this Supplement are met. If a compounded medication is approved for coverage, the Formulary Brand Name Drug Copayment applies. Your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within 5 business days or within 72 hours for an expedited review.

Prior authorization decisions are based upon the following:

1. The requested Drug, dose, and/or quantity are safe and Medically Necessary for the specified use.
2. Formulary alternative(s) have failed or are inappropriate.
3. Treatment is stable and a change to an alternative may cause immediate harm.
4. Drugs recommended as initial treatment have been tried and failed or are inappropriate.
5. Relevant clinical information supports the use of the requested medication over Formulary Drug alternatives.

Limitation on Quantity of Drugs that may be Obtained per Prescription or Refill

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment will be assessed for each 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.
3. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

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

1. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage and Drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible;

2. Any drug provided or administered while the Member is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Evidence of Coverage and Disclosure Form);
3. Take home drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits (Facility Services) and Skilled Nursing Facility Benefits sections of your Evidence of Coverage and Disclosure Form);
4. Non-Formulary Drugs, except as prior authorized by Blue Shield, as described herein;
5. Drugs except as specifically listed as covered under this Outpatient Prescription Drug Benefits Supplement, which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
6. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
7. Drugs that are considered to be experimental or investigational;
8. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections of your Evidence of Coverage and Disclosure Form). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
9. Blood or blood products (see the Hospital Benefits (Facility Services) section of your Evidence of Coverage and Disclosure Form);
10. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
11. Dietary or Nutritional Products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections of your Evidence of Coverage and Disclosure Form);
12. Injectable drugs which are not self-administered, and all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, and Family Planning Benefits sections of the health plan;
13. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
14. Drugs when prescribed for smoking cessation purposes (over the counter or by prescription), except to the extent that smoking cessation prescription Drugs are specifically listed as covered under the "Drug" definition in this benefit description;
15. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) require a Physician's prescription, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: refer to your medical Benefits for coverage of other contraceptive methods;
16. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), and, (3) it is being prescribed for an FDA-approved indication;
17. Replacement of lost, stolen or destroyed prescription Drugs;
18. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to a Member enrolled in a Hospice Program through a Participating Hospice Agency;

19. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
20. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.
21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

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

Supplement B — Substance Abuse Condition Benefits

Summary of Benefits

Benefit	Member Copayment[1]
Benefits are provided for Services for Substance Abuse Conditions (including Partial Hospitalization[2]) as described in this supplement.	
Hospital Facility Services	
Inpatient Services	Your Plan's Hospital Benefits (Facility Services), Inpatient Services Copayment
Outpatient Services	Your Plan's Hospital Benefits (Facility Services), Outpatient Services, Services for illness or injury Copayment
Partial Hospitalization[2]	Your Plan's Ambulatory Surgery Center Benefits Copayment applies per Episode
Professional (Physician)Services	
Inpatient Services	Your Plan's Professional (Physician) Benefits, Inpatient Physician Benefits Copayment
Outpatient Services	Your Plan's Professional (Physician) Benefits, office visit Copayment

1 The Copayments below are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.

2 Partial Hospitalization/Day Treatment Program is a treatment program that may be free-standing or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

In addition to the Benefits described in your Evidence of Coverage and Disclosure Form, your Plan provides coverage for Substance Abuse Condition Services as described in this supplement All Services must be Medically Necessary. Residential care is not covered. For a definition of Substance Abuse Condition, see the Definitions section of your Evidence of Coverage and Disclosure Form. All Non-Emergency Substance Abuse Condition Services must be obtained from an MHSA Participating Provider.

This supplemental Benefit does not include Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification, which are covered as part of the medical Benefits of your health Plan and not considered to be treatment of the Substance Abuse Condition itself.

Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver Mental Health Services as well as the Substance Abuse Condition Services described in this supplement. These Services are provided through a separate network of MHSA Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide substance abuse Services to Blue Shield Subscribers. A Blue Shield Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your Copayment, as payment-in-full for covered substance abuse Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain substance abuse Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for substance abuse Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. For questions about these Substance Abuse Condition Benefits, or for assistance in selecting an MHSA Participating Provider, Members should call the MHSA at 1-877-263-9952.

Prior authorization by the MHSA is required for all Non-Emergency Substance Abuse Condition Services.

Prior to obtaining the Substance Abuse Condition Services, you or your Physician must call the MHSA at 1-877-263-9952 to obtain prior authorization.

Failure to obtain prior authorization or to follow the recommendations of the MHSA or Blue Shield for Non-Emergency

Substance Abuse Condition Services will result in non-payment of services by Blue Shield.

Benefits are provided for Medically Necessary Services for Substance Abuse Condition as defined in your Evidence of Coverage and Disclosure Form, and as specified in this supplement.

This Benefit is subject to the general provisions, limitations and exclusions listed in your Evidence of Coverage and Disclosure Form.

Supplement C — Residential Care for Substance Abuse Condition Benefits

Summary of Benefits

Benefit	Member Copayment[2]
Benefits are provided for Services for Substance Abuse Conditions in a Residential Substance Abuse program up to a maximum of 100 days per Calendar Year as described in this supplement[1,3,4,5]	
Substance Abuse Condition Benefits	
Residential Care for Substance Abuse Condition Services – Facility Services	Your Plan's Hospital Benefits (Facility Services), Inpatient Medically Necessary skilled nursing Services including Subacute Care Copayment[5]
Residential Care for Substance Abuse Condition Services – Physician Services	Your Plan's Professional (Physician) Benefits, Inpatient Physician Services Copayment[5]

1 Residential Care Substance Abuse program Benefits may only be purchased if you have purchased the Substance Abuse Condition Benefits Supplement.

2 The Copayments below are subject to the Deductible, Member Maximum Calendar Year Copayment Responsibility and other applicable provisions of your Plan.

3 Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver the Substance Abuse Condition Services described in this supplement. Prior authorization by the MHSA is required for admittance into a Residential Care Substance Abuse program. Inpatient Residential Care Substance Abuse services received from a provider who does not participate in the MHSA Participating Provider network are not covered and all charges for these services will be the Member's responsibility.

4 Residential Care Substance Abuse Condition Benefits are provided in a licensed facility that provides structured 24-hour residential services designed to promote treatment and maintain recovery from the recurrent use of alcohol, drugs, and/or related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

5 For these Services, Benefits are provided up to a maximum of 100 days per Calendar Year per Member for all Services combined. Note: The number of days starts counting on the first day regardless of whether the Deductible has been met or not.

In addition to the Benefits described in your Evidence of Coverage and Disclosure Form, your Plan provides coverage for Residential Care Substance Abuse Condition Services as described in this supplement. All Services must be Medically Necessary. For a definition of Substance Abuse Condition, see the Definitions section of your Evidence of Coverage and Disclosure Form. All Residential Care Substance Abuse Condition Services must be obtained from a MHSA Participating Provider.

This supplemental Benefit does not include Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification, which are covered as part of the medical Benefits of your health Plan and not considered to be treatment of the Substance Abuse Condition itself.

Blue Shield of California has contracted with a Mental Health Service Administrator (MHSA) to administer and deliver Mental Health Services as well as the Residential Care Substance Abuse Condition Services described in this supplement. These Services are provided through a separate network of MHSA Participating Providers.

Note that MHSA Participating Providers are only those providers who participate in the MHSA network and have contracted with the MHSA to provide substance abuse Services to Blue Shield Subscribers. A Blue Shield Preferred/Participating Provider may not be a MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your Copayment, as payment-in-full for covered substance abuse Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your

advantage to obtain substance abuse Services from MHSA Participating Providers.

It is your responsibility to ensure that the provider you select for Residential Substance Abuse Condition Services is a MHSA Participating Provider. MHSA Participating Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. For questions about these Residential Care Substance Abuse Condition Benefits, or for assistance in selecting a MHSA Participating Provider, Members should call the MHSA at 1-877-263-9952.

Prior authorization by the MHSA is required for all Residential Care Substance Abuse Condition Services.

Prior to obtaining the Residential Care Substance Abuse Condition Services, you or your Physician must call the MHSA at 1-877-263-9952 to obtain prior authorization.

Failure to obtain prior authorization or to follow the recommendations of the MHSA or Blue Shield for Residential Care Substance Abuse Condition Services will result in nonpayment of services by Blue Shield.

This Benefit is subject to the general provisions, limitations and exclusions listed in your Evidence of Coverage and Disclosure Form.

Handy Numbers

If your family has more than one Blue Shield HMO Personal Physician, list each family member's name with the name of his or her Physician.

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Important Numbers:

Hospital _____

Pharmacy _____

Police Department _____

Ambulance _____

Poison Control Center _____

Fire Department _____

General Emergency _____ *911* _____

Access+ HMO Member Services Department
See last page of this booklet) _____

For information contact Blue Shield of California.

Members may call Blue Shield's Member Services Department toll free: 1-800-642-6155

For Mental Health Services and information, call the MHSA: 1-877-263-8827

The hearing impaired may call Member Services through Blue Shield's toll-free TTY number: 1-800-241-1823

Please direct correspondence to:

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