Added Advantage POS℠

Combined Evidence of Coverage and Disclosure Form

Walnut Valley Unified School District

Effective Date: January 1, 2012

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 for review through your Employer or a copy can be furnished upon request. Your Employer 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 at the number listed on the last page of this booklet.

The Blue Shield Added Advantage POS Health Plan
Member Bill of Rights

As a Blue Shield POS 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 Blue Shield POS 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 or grievances about the Blue Shield POS or the care provided to you.
18. Participate in establishing Public Policy of the Blue Shield POS Health Plan, 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 Added Advantage POS Health Plan
Member Responsibilities

As a Blue Shield POS Plan Member, you have the responsibility to:

1. Carefully read all Blue Shield POS Health Plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out-of-pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield POS Health Plan 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 POS Health 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 Inpatient Mental Health Services.

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Added Advantage POS
Summary of Benefits

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

All Level I Benefits ("HMO Plan" level of Benefits) described in this summary apply only when provided or authorized as described herein, except in an emergency or as otherwise specified. Services received without prior authorization by your Personal Physician and/or the Blue Shield HMO may be covered under Level II or Level III ("Preferred Plan" and "Non Preferred Plan" level of Benefits) of your Plan.

Should you have any questions about your Plan, please call the Blue Shield Member Services Department at the number listed on the last page of this booklet, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

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

Summary of Benefits

Added Advantage POS Plan

Member Calendar Year Deductible (Medical Plan Deductible)	Deductible Responsibility		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Calendar Year Deductible	None	$350 per Member / $700 per Family[4]	

Member Maximum Calendar Year Copayment Responsibility	Member Maximum Calendar Year Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Calendar Year Copayment Maximum	$1,000 per Member / $2,000 per Family[5]	$2,000 per Member / $4,000 per Family[6]	$5,000 per Member / $10,000 per Family[7]

Member Maximum Lifetime Benefits	Maximum Blue Shield Payment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Lifetime Benefit Maximum	No maximum	No maximum	

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Preadmission Review and Prior Authorization	Automatic	See the Benefits Management Program section for additional and reduced payments[8]	See the Benefits Management Program section for additional and reduced payments[8]
Allergy Testing and Treatment Benefits			
Allergy serum purchased separately for treatment	50%	50%	50%
Office visits (includes visits for allergy serum injections)	$15 per visit	10%	30%
Ambulance Benefits			
Emergency or authorized transport[9]	$50	10% of billed charges	10% of billed charges
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	$50 per surgery	10%	30% (Blue Shield payment not to exceed $245 per Member per day)
Ambulatory Surgery Center Outpatient Surgery Physician Services (For Level 1, billed as part of Ambulatory Surgery Center Outpatient Surgery facility Services)	You pay nothing	10%	30%

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Bariatric Surgery Benefits All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county. **Bariatric Surgery Benefits for residents of designated counties in California**[10] All bariatric surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See Bariatric Surgery Benefits in the Plan Benefits section for a list of designated counties.			
Hospital Inpatient Services	You pay nothing	10%	Not covered[10]
Hospital Outpatient Services	$50 per surgery	10%	Not covered[10]
Physician Services	You pay nothing	10%	Not covered[10]
Bariatric Surgery Benefits for residents of non-designated counties in California			
Hospital Inpatient Services	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)[10]
Hospital Outpatient Services	$50 per surgery	10%	30% (Blue Shield payment not to exceed $245 per Member per day)[10]
Physician Services	You pay nothing	10%	30%[10]
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 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	Not covered	Not covered

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Diabetes Care Benefits			
Devices, equipment and supplies	50%	50%	50%
Diabetes self-management training provided by a Physician in an office setting	$15 per visit	10%	30%
Diabetes self-management training provided by a registered dietician or registered nurse who are certified diabetes educators	$15 per visit	10%	30%
Dialysis Center Benefits			
Dialysis Services Preservice review is required for all dialysis Services under Levels II and III Note: Dialysis Services may also be obtained from a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits	You pay nothing	10%	30% (Blue Shield payment not to exceed $210 per Member per day)
Durable Medical Equipment Benefits[11]			
Durable Medical Equipment	50%	50%	50%
Emergency Room Benefits			
Emergency room Physician Services	You pay nothing	10%[12]	10%[12]
Emergency room Services not resulting in admission	$100 per visit	$100 per visit	$100 per visit
Emergency room Services resulting in admission (billed as part of Inpatient Hospital Services) Note: For Emergency ambulance Services, see the Ambulance Benefits section of this Summary of Benefits.	You pay nothing	10%	10% (Blue Shield payment not to exceed $540 per Member per day)

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
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.			
Counseling and consulting (including Physician office visits for diaphragm fitting or injectable contraceptives)	You pay nothing	Not covered	Not covered
Diaphragm fitting procedure	You pay nothing	Not covered	Not covered
Elective abortion	$100 per surgery	50%	50%
Infertility Services Diagnosis and treatment of cause of Infertility (in vitro fertilization and artificial insemination not covered)	50%	Not covered	Not covered
Injectable contraceptives when administered by a Physician	$25 per injection	Not covered	Not covered
Insertion and/or removal of intrauterine device (IUD)	$15 per visit	Not covered	Not covered
Intrauterine device (IUD)	50%	Not covered	Not covered
Tubal ligation In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services for a delivery/abdominal surgery.	$100 per surgery	50%	50%
Vasectomy	$75 per surgery	50%	50%

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Home Health Care Benefits			
Home health care agency Services[11] including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist for up to a total of 100 visits by home health care agency providers per Member per Calendar Year combined for all levels	$15 per visit	10%	Not covered[13]
Medical supplies and laboratory Services to the extent the Benefits would have been provided had the Member remained in the Hospital or Skilled Nursing Facility	You pay nothing	10%	Not covered[13]
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	10%	Not covered
Hemophilia therapy home infusion nursing visits 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.)	$15 per visit	10%	Not covered
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency[14] Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit if selected as an optional Benefit by your Employer, and are described in a Supplement included with this booklet.	You pay nothing	10%	Not covered[13]
Home visits by an infusion nurse (home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation)	$15 per visit	10%	Not covered[13]

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Hospice Program Benefits All Hospice Program Benefits must be prior authorized by Blue Shield and received from a Participating Hospice Agency[15]			
24-hour Continuous Home Care	You pay nothing	Not covered	Not covered
General Inpatient care	You pay nothing	Not covered	Not covered
Inpatient Respite Care	You pay nothing	Not covered	Not covered
Pre-hospice consultation	You pay nothing	Not covered	Not covered
Routine home care	You pay nothing	Not covered	Not covered
Hospital Benefits (Facility Services)			
Inpatient Medically Necessary skilled nursing Services including Subacute Care[16]	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Inpatient Services[11] including semi-private room and board, operating room, intensive cardiac care units, general nursing care, Subacute Care, drugs, medications, oxygen, blood and blood plasma. All bariatric surgery Services must be prior authorized in writing. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Inpatient Services to treat acute medical complications of detoxification	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Outpatient dialysis Services	You pay nothing	10%	30% (Blue Shield payment not to exceed $210 per Member per day)
Outpatient Services for surgery and necessary supplies	$50 per surgery	10%	30% (Blue Shield payment not to exceed $245 per Member per day)
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy, treatment and necessary supplies	You pay nothing	10%	30% (Blue Shield payment not to exceed $245 per Member per day)

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Medical Treatment of 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	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Office location	$15 per visit	10%	30%
Outpatient department of a Hospital	$50 per surgery	10%	30% (Blue Shield payment not to exceed $245 per person per day)

Mental Health Benefits All Level I Non-Emergency Services must be referred or authorized by the Mental Health Services Administrator (MHSA)[17]			
Benefit	**Member Copayment**		
	Level I Care referred or authorized by the MHSA and provided by MHSA Participating Providers for "HMO Plan" level of Benefits	**Level II** There are no separate benefit payments under Level II as all covered Services from MHSA Participating Providers are paid under Level I when referred or authorized and under Level III when not referred or authorized	**Level III**[3] Member use of MHSA Non-Participating Providers and Services from MHSA Participating Providers that are not referred or authorized by the MHSA for Non-Preferred Plan level of Benefits
Mental Health Benefits[18] **All Level I (HMO) non-Emergency Services must be arranged through the MHSA**			
Inpatient Hospital Services	You pay nothing		30% (Blue Shield payment not to exceed $420 per Member per day)[19]
Inpatient Professional (Physician) Services	You pay nothing		30%[19]
Outpatient Mental Health Services, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT)[19]	$15 per visit		30%[19]
Outpatient Partial Hospitalization Note: All non-Emergency Services must be prior authorized by the MHSA.	$50 per episode of care[20]		30% (Blue Shield payment not to exceed $245 per Member per day)[19,20]
Psychological testing	You pay nothing		30%
Psychosocial support through LifeReferrals 24/7	You pay nothing		You pay nothing

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Orthotics Benefits			
Office visits	$15 per visit	10%	30%
Orthotic equipment and devices	You pay nothing	10%	30%
Outpatient Prescription Drug Benefits			
Outpatient Prescription Drug coverage if selected as an optional Benefit by your Employer, is described in a Supplement included with this booklet			
Outpatient X-ray, Pathology and Laboratory Benefits			
Mammography and Papanicolaou test	You pay nothing	10%	30%
Outpatient X-ray, pathology and laboratory	You pay nothing	10%	30% (Blue Shield payment not to exceed $245 per Member per day)
PKU Related Formulas and Special Food Products Benefits			
PKU related formulas and Special Food Products Note: The above Services must be prior authorized by Blue Shield.	You pay nothing	10%	10%
Pregnancy and Maternity Care Benefits			
All necessary Inpatient Hospital Services for normal delivery, Cesarean section and complications of pregnancy	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
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 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.	You pay nothing	10%	30%

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Preventive Health Benefits			
Preventive Health Services Note: See the description of Preventive Health Services in the Definitions section for more information	You pay nothing	Not covered	Not covered
Professional (Physician) Benefits			
Injectable medications Note: Also see Allergy Testing and Treatment Benefits in this Summary of Benefits.	You pay nothing	10%	30%
Inpatient Physician Services Inpatient Hospital and Skilled Nursing Facility Services by Physicians including the Services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist. All bariatric surgery Services must be prior authorized in writing. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.	You pay nothing	10%	30%
Internet based consultations	$10 per consultation	Not covered	Not covered
Outpatient Physician Services, other than an office setting	You pay nothing	10%	30%
Physician home visits	$25 per visit	10%	30%
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, Chiropractic and Respiratory Therapy).	$15 per visit	10%	30%

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Prosthetic Appliances Benefits			
Office visits	$15 per visit	10%	30%
Prosthetic equipment and devices (except those provided to restore and achieve symmetry incident to a mastectomy, which are covered under Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services), and Professional (Physician) Benefits in the Plan Benefits section, and specified devices following a laryngectomy, which are covered under Physician Services surgical Benefits)[11]	You pay nothing	10%	30%
Rehabilitation Benefits (Physical, Occupational, Chiropractic and Respiratory Therapy) Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:			
Office location	$15 per visit	10%	30%
Outpatient department of a Hospital	$15 per visit	10%	30% (Blue Shield payment not to exceed $245 per Member per day)
Rehabilitation unit of a Hospital for Medically Necessary days (in an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services)	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Skilled Nursing Facility rehabilitation unit for Medically Necessary days	You pay nothing	10%	10%[21]
Note: Under Levels II and III, there is a combined 12-visit per Member Calendar Year maximum for all Outpatient Physical Therapy Covered Services provided by any provider and all Covered Services provided by a chiropractor. Physical Therapy provided under Home Health Care Benefits and Inpatient Rehabilitation Services in the rehabilitation unit of a Hospital are not subject to the visit maximum under Levels II and III combined.			

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Skilled Nursing Facility Benefits			
Services by a free-standing Skilled Nursing Facility Inpatient Services in a free-standing facility including Subacute Care, and other necessary Services and supplies for up to 100 days per Calendar Year combined for all levels[11,16]	You pay nothing	10%	10%[21]
Speech Therapy Benefits Speech Therapy Services by a licensed speech pathologist or certified speech therapist in the following settings:			
Office location	$15 per visit	10%	30%
Outpatient department of a Hospital	$15 per visit	10%	30% (Blue Shield payment not to exceed $245 per Member per day)
Rehabilitation unit of a Hospital for Medically Necessary days (in an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services)	You pay nothing	10%	30% (Blue Shield payment not to exceed $420 per Member per day)
Skilled Nursing Facility rehabilitation unit for Medically Necessary days Note: Under Levels II and III, all Outpatient Speech Therapy Services must be prior authorized by Blue Shield.	You pay nothing	10%	10%[21]
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin and Services to obtain the human organ transplant			
Hospital Services	You pay nothing	10%	30%
Professional (Physician) Services	You pay nothing	10%	30%

Benefit	Member Copayment		
	Level I[1] Care by or authorized by Personal Physician for "HMO Plan" level of Benefits	**Level II**[2] Member use of Blue Shield Participating Providers for "Preferred Plan" level of Benefits	**Level III**[3] Member use of non-Blue Shield Participating Provider for "Non-Preferred Plan" level of Benefits
Transplant Benefits - Special			
Facility Services in a Special Transplant Facility	You pay nothing	Not covered	Not covered
Professional (Physician) Services Note: Blue Shield requires prior written 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 transplants of human heart, lung, heart and lung in combination, liver, kidney and pancreas in combination, human bone marrow transplants, pediatric human small bowel transplants, pediatric and adult human small bowel and liver transplants in combination, and Services to obtain the human transplant material	You pay nothing	Not covered	Not covered
Urgent Care Benefits			
Urgent care while in your Personal Physician 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	10%	30%
Urgent care while in your Personal Physician Service Area rendered or referred by your Personal Physician (includes Services rendered in an urgent care clinic when instructed by your Personal Physician or assigned Medical Group/IPA)	$15 per visit	10%	30%
Urgent Services outside your Personal Physician Service Area Medically Necessary Out-of-Area Follow-up Care is covered. Note: See the Obtaining Medical Care section for more information.	$50 per visit[22]	10%	30%

Summary of Benefits

Footnotes

[1] All Benefits must be provided or authorized by the Blue Shield HMO Personal Physician and/or the Medical Group/IPA or the MHSA, except for OB/GYN Services from an obstetrician/gynecologist or family practice Physician who is within the same Medical Group/IPA as the Personal Physician. Unless otherwise specified, Copayments under Level I are calculated based on Allowed Charges.

[2] Blue Shield Preferred Providers agree to accept predetermined allowable charges for their Services. Unless otherwise specified, Copayments under Level II are calculated based on the Allowable Amount.

[3] Subscribers are responsible for Copayments and portions of fees in excess of allowable charges for Services provided by Non-Preferred Providers and MHSA Non-Participating Providers. Unless otherwise specified, Copayments under Level III are calculated based on the Allowable Amount.

Note: For Services obtained from MHSA Participating Providers that are not referred or authorized by the MHSA, Subscribers are responsible for Copayments and may also be responsible for portions of fees in excess of allowable charges.

[4] The Calendar Year Deductible does not apply to covered travel expenses for bariatric surgery Services. Also, the Calendar Year Deductible does not accrue to the maximum Calendar Year Copayment.

[5] The Member maximum Calendar Year Copayment under Level I includes all covered Services except for: Outpatient routine newborn circumcision, Durable Medical Equipment, Internet based consultations, and covered travel expenses for bariatric surgery Services, and except for the following optional Benefits: Outpatient prescription drugs, additional Infertility Benefits, chiropractic Services, acupuncture Services, and vision plan and dental plan Benefits. See the Maximum Calendar Year Copayment Responsibility section, Level I (HMO Plan Level of Benefits) for a detailed description and explanation of Member responsibilities.

[6] The Calendar Year Deductible and covered travel expenses for bariatric surgery Services are not included in the calculations for the Member maximum Calendar Year Copayment responsibility under Level II.

[7] Covered Services from any combination of Preferred and Non-Preferred Providers accrue to the Member maximum Calendar Year Copayment responsibility under Level III. The Calendar Year Deductible is not included in the calculations for the Member maximum Calendar Year Copayment responsibility under Level III.

[8] No additional or reduced payments will be assessed in situations of maternity admissions for which the length of stay is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a Cesarean section. (See Pregnancy and Maternity Care Benefits in the Plan Benefits section for information relative to the Newborns' and Mothers' Health Protection Act.)

[9] All non-emergency ambulance service Benefits will be determined in accordance with the Plan and will be subject to the Deductibles and Copayments described herein.

[10] Bariatric surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. See the Definitions section and the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Plan Benefits for complete information and for a list of designated counties.

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

[12] Emergency Services, as defined, will be covered at the Level I Copayment. Please note that if retrospective review determines the Service was not an Emergency Service, Benefits will be determined in accordance with the Plan (for Level II or Level III Benefits) and will be subject to the Deductibles and Copayments described therein. For Services obtained for non-emergency conditions as described above, the Member will be responsible for payment of the dollar Copayment for each Hospital Outpatient emergency room visit that does not result in a direct admission to the Hospital as an Inpatient, in addition to the Inpatient Hospital Copayment (Level II or Level III) of the Allowable Amount.

[13] Services by Non-Participating Home Health Agencies and Non-Participating Home Infusion Agencies are not covered unless prior authorized by Blue Shield. When authorized by Blue Shield, these Non-Participating Agencies will be reimbursed at a rate determined by Blue Shield and the agency and your Copayment will be the Participating Agency Copayment.

[14] Home infusion injectable medications require prior authorization by Blue Shield 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 Drugs Benefit Supplement for coverage of home self-administered injectable medications.

[15] Covered Hospice Services must be prior authorized by Blue Shield and must be received from Blue Shield Participating Hospice Agencies. If Blue Shield prior authorizes Hospice Services from a non-contracted Hospice Agency, the Member's Copayment for these Services will be the same as the Copayment for Services from a Participating Hospice Agency.

[16] Skilled nursing Services are limited to 100 days per Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This 100-day maximum for skilled nursing Services is a combined maximum between Hospital and Skilled Nursing Facilities.

[17] The MHSA is a specialized health care service plan contracted by Blue Shield of California to administer all Mental Health Services.

[18] No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage is selected as an optional Benefit by your Employer. 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.

[19] For Level III, all Inpatient Mental Health Services, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient electroconvulsive therapy Services (except for Emergency and Urgent Services) must be prior authorized by the MHSA.

[20] 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.

[21] For Services by freestanding Skilled Nursing Facilities (nursing homes), which are Other Providers, you are responsible for all charges above the Allowable Amount.

[22] For Level I Services outside of California or the United States, Out-of-Area Follow-up Care is covered through any provider or through the BlueCard® Program participating provider network. However, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits or for care that involves a surgical or other procedure or inpatient stay. For Level I Services outside your Personal Physician Service Area but within California, Member Services will assist the patient in receiving Out-of-Area Follow-up Care through a Blue Shield Plan Provider. To receive Level I Services, Blue Shield HMO may direct the patient to receive follow-up Services from the Personal Physician. Under Level I, 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 clinic when the assigned Medical Group/IPA has provided instructions about obtaining care from an urgent care clinic in the Personal Physician Service Area. See Obtaining Medical Care.

The Blue Shield Added Advantage POS 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 ADDED ADVANTAGE POS HEALTH PLAN

Your interest in the Blue Shield Added Advantage POS Health Plan is truly appreciated. Blue Shield has served Californians for over 60 years, and we look forward to serving your health care coverage needs.

By choosing this Plan, you've selected some significant differences from not only the health care coverage provided by Blue Shield, but also from other health care coverage offered by other health plans. With the Blue Shield POS Plan, you have the opportunity to be an active participant in your own health care. Working with the Plan, we'll help you make a personal commitment to maintain and, where possible, improve your health. 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.

Unlike some other health plans, the Blue Shield POS Plan offers you a health Plan with a wide choice of Physicians, Hospitals and Non-Physician Health Care Practitioners. You will have 3 Benefit options [called "Levels"] to choose from when obtaining medical care. The choice you make at the time you need medical care will determine your out-of-pocket costs.

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

- for Level 1, 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.

YOUR PERSONAL PHYSICIAN

Under the Blue Shield POS Plan, each Member will have a Personal Physician. You select your own Personal Physician from your Blue Shield HMO Physician and Hospital Directory of general practitioners, family practitioners, internists, obstetricians/gynecologists, and pediatricians. Each of your eligible family members must also select a Personal Physician. If you do not select a Personal Physician, Blue Shield will designate a Personal Physician for you.

Under the Plan, deciding whether to obtain your medical care from or through your Personal Physician will determine the level of Benefits you receive and your out-of-pocket cost.

THREE LEVELS OF BENEFITS
(Other than Benefits for Mental Health Services which are described in the Obtaining Medical Care section)

The following three Benefit levels (or options) are available under the Blue Shield POS Plan when you seek medical care:

Level I

Level I is the "HMO Plan" level of Benefits. Using it provides you with the highest level of Benefits — i.e., full Plan Benefits at the lowest out-of-pocket cost to you. You will be covered under Level I only when care is provided by (1) your Personal Physician, (2) any provider authorized by your Personal Physician or (3) any provider for Emergency Services as defined in the Plan Benefits section. You will only be responsible for the Level I Copayments of the Plan.

To determine whether a Level I 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 Level I 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.

Level II

Level II is the "Preferred Plan" level of Benefits. Using it provides you with the second highest level of Benefits. Benefits under Level II are provided when you choose to receive your medical care from a Blue Shield Participating Provider. Referral or authorization by your Personal Physician is not required, but Services are subject to the prior authorization requirements of the Benefits Management Program. You will be responsible for the Level II Deductibles and Copayments of the Plan. However, you will not be required to pay any difference between the Participating Provider's actual charges and Blue Shield's Allowable Amount, except as set forth in the section on Reductions – Third Party Liability.

To determine whether a Level II provider is a Preferred Provider, consult the Blue Shield Physician 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 Level II Preferred Provider's status may change. It is your obligation to verify whether the provider you choose is a Preferred Provider, in case there have been any changes since your directory was published.

Level III

Level III is the non-Preferred Plan level of Benefits. You may choose any provider who is not a Blue Shield Participating Provider at a higher out-of-pocket cost to you. Services are subject to the prior authorization requirements of the Benefits Management Program and you will be responsible for the Level III Deductibles and Copayments of the Plan (which are higher than under Level I or Level II), and any payments as set forth in the section on Reductions – Third Party Liability.

When Services are rendered by a non-Blue Shield Participating Provider, you are also responsible for any difference between the provider's actual charges and the Allowable Amount.

Please review this booklet, which summarizes the general provisions and operation of your Plan.

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

CHOICE OF PERSONAL PHYSICIAN

SELECTING A PERSONAL PHYSICIAN

A close Physician-to-patient relationship helps to ensure you receive 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 is responsible for providing primary care and coordinating or arranging for referral to other health care Services as necessary. More specifically, 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 any lab tests, X-rays and other medical Services you require.
6. If you request it, assist you in obtaining prior approval from the Mental Health Service Administrator (MHSA) for Inpatient Mental Health Services*; and

   *See the Mental Health Services paragraphs in the Obtaining Medical Care 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 Blue Shield HMO Personal Physician at the time of enrollment, Blue Shield will designate a Personal Physician for you and notify you. This designation will remain in effect until you advise Blue Shield of your selection of a different Personal Physician. To select a Personal Physician, contact the Blue Shield Member Services Department at the number listed on the last page of this booklet, Monday through Friday, between 8 a.m. and 5 p.m.

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or placement for adoption but always within 31 days from the date of birth or adoption. You may designate a pediatrician as the Personal Physician for your child. The Personal Physician selected for the month of birth must be in the same Medical Group or IPA as the mother's Personal Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Personal Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If you do not select a Personal Physician within 31 days following the birth or placement for adoption, the Plan will designate a Personal Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Personal Physician for the child after the month of birth or placement for adoption, see the section below on "Changing Personal Physicians". 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 Plan Service Area and Eligibility section of this Evidence of Coverage and Disclosure Form.

ROLE OF THE MEDICAL GROUP OR IPA

Most Blue Shield 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 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 spe-

cial 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 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 Blue Shield Member Services Department at the number provided on the last page of this booklet or submitting a Member Change Request Form to the Blue Shield 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 your 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. 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. Blue Shield 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, while obtaining HMO Plan (Level I) Benefits, 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 Blue Shield 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

(Applies to Level I and Level II only)

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.

Financial Responsibility for Continuity of Care Services

(Does not apply to Level I)

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

Relationship with your Personal Physician

Your Personal Physician seeks to provide Medically Necessary and appropriate professional Services 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 termination of your coverage, but only after you have been given access to other avail-

able Personal Physicians and have been unsuccessful in establishing a satisfactory relationship. Any such termination 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 termination.

OBTAINING MEDICAL CARE

(For all levels, for all Mental Health Services see the Mental Health Services paragraphs later in this section)

LEVEL I: USE OF PERSONAL PHYSICIAN

To receive Level I Benefits, you must obtain or arrange for health care through your Personal Physician including preventive Services, routine health problems, consultation with Plan Specialists, admission into a Hospice Program through a Participating Hospice Agency, Urgent Services and hospitalization.

You should cancel any scheduled appointment 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 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.

All Services, except those meeting the Emergency and Urgent Services requirements below, must have prior approval by the Personal Physician, Medical Group/IPA to receive the highest level of Benefits under Level I. The Member will be responsible for payment of Services under Level II or Level III for those Services that are not authorized or those that are not an emergency or covered Urgent Services.

INTERNET BASED CONSULTATIONS

(Benefits are provided only under Level I)

Benefits are provided under Level I for Internet based consultations. Internet based consultations are Medically Necessary consultations with Internet Ready Physicians via 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"). (For more information, see Professional (Physician) Benefits under the Plan Benefits section.)

OBSTETRICAL/GYNECOLOGICAL (OB/GYN) PHYSICIAN SERVICES

(Benefits are provided only under Level I)

Under Level I, a female Member may arrange for obstetrical and/or gynecological (OB/GYN) Services by an obstetrician/gynecologist or family practice Physician who is 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 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/IPA without authorization will not be covered under Level I. Before making the appointment, the Member should call the Member Services Department at the number listed 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.

REFERRAL TO SPECIALTY SERVICES

To receive specialty Services (including X-rays and laboratory tests) under Level I, you must have the specialty Services provided or arranged by your Personal Physician. You will generally be referred 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 Obtaining Medical Care section for information regarding how to access care. The Plan Specialist or Plan Non-Physician Health Care Practitioner will provide a report to your Personal Physician.

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 ba-

sis, 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 listed at the back of this booklet.

In referring you for specialty Services, your Personal Physician will discuss with you what treatment options are best for you. If the Personal Physician determines that specialty Services are Medically Necessary, your Personal Physician will notify Blue Shield, request necessary authorization, and designate the particular specialist from whom you will receive the specialty Services.

When no HMO Plan Provider is available to perform the needed service, the Personal Physician will refer you to a non-HMO Plan Provider after obtaining authorization. This authorization procedure is handled for you by your Personal Physician.

Referral by a Personal Physician, however, does not guarantee coverage for referral services. The eligibility provisions, exclusions, and limitations for the particular Services under the Blue Shield POS Plan will still apply.

LEVEL II: USE OF BLUE SHIELD PARTICIPATING PROVIDERS

Under Level II, you may choose to receive covered medical Services, including second medical opinions, from any Blue Shield Participating Provider without referral or authorization by your Personal Physician, subject to the prior authorization requirements of the Benefits Management Program.

LEVEL III: USE OF NON-BLUE SHIELD PARTICIPATING PROVIDERS

Under Level III, you may choose to receive covered medical Services, including second medical opinions, from a non-Blue Shield Participating Provider without referral or authorization by your Personal Physician, subject to the prior authorization requirements of the Benefits Management Program.

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.

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 an unexpected 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; or (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, your Services will not be covered under Level I. Benefits will be determined under Level II or Level III, subject to the applicable Deductibles and Copayments.

INPATIENT, HOME HEALTH CARE, HOSPICE PROGRAM AND OTHER SERVICES UNDER LEVEL I

The Personal Physician is responsible for obtaining prior authorization before you are admitted to the Hospital or a Skilled Nursing Facility or receive home health care and certain other Services or before you can be admitted into a Hospice Program through a Participating Hospice Agency under Level I of the Plan. If the Personal Physician determines that you should receive any of these Services, he or she will request authorization. If Blue Shield determines that the requested Service is Medically Necessary, then your Personal Physician will arrange for your admission to the Hospital or Skilled Nursing Facility, including Subacute Care admissions, or to a Hospice Program through a Participating Hospice Agency, as well as for the provision of home health care and other Services. See the Benefits Authorizations for Requirements for Level II and Level III Benefits section for information.

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.

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.) Or you can call Member Services at the telephone number listed on your identification card.

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

These programs include:

NurseHelp 24/7 - Members may call a registered nurse toll free via1-877-304-0504, 24 hours a day, to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

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

MENTAL HEALTH SERVICES

Blue Shield of California has contracted with a MHSA to underwrite and deliver all Mental Health Services through a separate network of Mental Health Participating Providers. (See Mental Health Service Administrator under the Definitions section for more information.)

Level I: Use of MHSA Participating Providers When Referred or Authorized by the MHSA

For Level I, Members should contact the MHSA by calling 1-877-263-9952 to arrange for all Non-Emergency Mental Health Services. Level I Services must be referred or authorized by the MHSA and provided by an MHSA Participating Provider. Members do not need to arrange for Mental Health Services through their Personal Physician.

MHSA Participating 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 calling1-877-263-9952. Your Personal Physician may also contact MHSA to obtain information regarding MHSA Participating Providers for you.

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

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.

Level III: Use of MHSA Non-Participating Providers and Use of MHSA Participating Providers that are not Referred or Authorized by the MHSA

Under Level III, you may choose to receive certain covered Mental Health Services from a Provider who does not participate in the MHSA Participating Provider network or from an MHSA Participating Provider without referral or authorization from the MHSA.

Prior authorization for all Non-Emergency Inpatient Mental Health Services is still required under Level III. See the Benefits Management Program, the Mental Health Services paragraphs, for complete information.

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.

LEVEL I URGENT SERVICES WHILE TRAVELING

The Blue Shield POS Plan provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside 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 exist-

ing medical condition, for which treatment can not 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 POS Plan 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, which 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.

Level I: Follow-up Services

Level I Out-of-Area Follow-up Care is covered and may be provided 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. To receive Level I Services, Blue Shield may direct the patient to receive the additional follow-up Services from the Personal Physician.

When a BlueCard Program provider is available, Level I Services should be obtained from a participating provider, when possible.

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 listed 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.

Benefits will be determined in accordance with the requirements of the Plan, subject to the applicable Deductibles and Copayments.

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 HMO is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield HMO 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 HMO. 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.

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 by the Plan to Blue Shield, 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 Blue Shield. If the services are not preauthorized, Blue Shield will review the claim retrospectively for coverage. If Blue Shield 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 prospectively authorized, the services will not be covered under Level I and Blue Shield will notify the Member of that determination. Blue Shield will notify the Member of its determination within 30 days from receipt of the claim. The services will be covered under Level II or Level III subject to the applicable Deductibles, Copayments and requirements of the Plan. In the event covered medical transportation Services are obtained in such an emergency situation, the Plan 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 Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Urgent Services, unless the claim was submitted as soon as rea-

sonably 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. Blue Shield will notify the Member of its determination within 30 days from receipt of the claim.

If the Services are determined to be not covered as Urgent Services under Level I, they will be covered under Level II or III subject to the applicable Deductibles, Copayments and requirements of the Plan.

BENEFITS AUTHORIZATION REQUIREMENTS FOR LEVEL II AND LEVEL III BENEFITS*

None of this section applies if you are receiving Benefits from or through your Personal Physician under Level I.

*For Outpatient Mental Health Services, see the Mental Health Services paragraphs in the "Obtaining Medical Care" section.

BENEFITS MANAGEMENT PROGRAM

Blue Shield has established the Benefits Management Program to assist you, your Dependents, or provider in identifying the most appropriate and cost-effective course of treatment for which certain Benefits will be provided under this health Plan and for determining whether the Services are Medically Necessary. However, you, your Dependents and provider make the final decision concerning treatment. The Benefits Management Program includes: prior authorization review for certain services, preadmission review, emergency admission notification, Hospital Inpatient review, discharge planning, and case management if determined to be applicable and appropriate by Blue Shield.

Certain portions of the Benefits Management Program also contain Additional or Reduced Payment requirements for either not contacting Blue Shield or not following Blue Shield's recommendations. Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in reduced payment or non-payment if Blue Shield determines the service was not a covered Service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefits Management Program also apply to your Dependents.

Blue Shield requires prior authorization for selected Inpatient and Outpatient Services, supplies, and Durable Medical Equipment; all home health care, home infusion/home injectable services, and PKU related formulas and Special Food Products; and admission into an approved Hospice Program. Preadmission review is required for all Inpatient Hospital and Skilled Nursing Facility Services (except for Emergency Services*).

*See the paragraph entitled Emergency Admission Notification later in this section for notification requirements.

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

PRIOR AUTHORIZATION

For services and supplies listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a Covered Service and may also receive a recommendation for an alternative Service. Failure to contact Blue Shield as described below or failure to follow the recommendations of Blue Shield for Covered Services will result in a reduced payment per procedure as described in the section entitled Additional and Reduced Payments for Failure to Use the Benefits Management Program.

For Services other than those listed in the sections below, you, your Dependents or provider should consult the Plan Benefits section of this booklet to determine whether a service is covered.

> You or your Physician must call the Customer Service telephone number indicated on the back of the Member's identification card for prior authorization for the Services listed in this section except for PKU related formulas and Special Food Products described in item 11. below and for the Mental Health Condition Services listed in item 16. below.

Blue Shield requires prior authorization for the following services:

1. Admission into an approved Hospice Program as specified under Hospice Program Services in the Plan Benefits section.

2. Clinical Trial for Cancer.

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

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for Hospice Program Benefits and Clinical Trial for Cancer Benefits above will result in non-payment of services by Blue Shield.

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

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

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

4. Home Health Care Benefits from Non-Preferred Providers.
5. Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers.
6. Durable Medical Equipment Benefits, including but not limited to motorized wheelchairs, insulin infusion pumps, and CPAP (Continuous Positive Air Pressure) machines.
7. Surgery services which may be considered to be Cosmetic in nature rather than Reconstructive (e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in appearance. The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the Plan Benefits section.
8. Arthroscopic surgery of the temporomandibular joint (TMJ) services.
9. Dialysis services as specified under the Dialysis Centers Benefits and Hospital Benefits (Facility Services) in the Plan Benefits section.
10. Hemophilia home infusion products and services.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for:

injectable drugs administered in the physician office setting,

Home Health Care Benefits from Non-Preferred Providers,

Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers,

Durable Medical Equipment Benefits,

cosmetic surgery services,

arthroscopic surgery of the TMJ services,

dialysis services, and

hemophilia home infusion products and supplies

as described above may result in non-payment of services by Blue Shield.

11. PKU related formulas and Special Food Products.

    Call 1-800-444-0402 (in Northern California) or 1-800-213-3465 (in Southern California) for prior authorization for these services.
12. All bariatric Surgery.
13. Outpatient speech therapy services (see the benefit description in the Plan Benefits section).
14. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).
15. Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT) Services for the treatment of Mental Health Conditions.

    For prior authorization of Intensive Outpatient Care, Outpatient Partial Hospitalization and Outpatient ECT Services, call the MHSA at 1-877-263-9952.
16. Medically Necessary dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

Failure to contact Blue Shield as described above or failure to follow the recommendations of Blue Shield for:

PKU Related Formulas and Special Food Products Benefits,

all bariatric Surgery,

Outpatient speech therapy services,

Hospital and Skilled Nursing Facility admissions,

Outpatient Partial Hospitalization and Outpatient ECT Services for Mental Health Conditions, and

dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures

as described above will result in a reduced payment as described in the Additional and Reduced Payments for Failure to Use The Benefits Management Program section or may result in non-payment if Blue Shield determines that the service is not a covered Service.

Other specific services and procedures may require prior authorization as determined by Blue Shield. A list of services and procedures requiring prior authorization can be obtained by your provider by going to www.blueshieldca.com or by calling the Customer Service telephone number indicated on the back of the Member's identification card.

HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS

Prior authorization must be obtained from Blue Shield for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care and Inpatient Mental Health Services.

Prior Authorization for Other than Mental Health Admissions

Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician must contact Blue Shield at the Customer Service telephone number indicated on the back of the Member's identification card at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Blue Shield will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this health Plan that the Services be performed on an Outpatient basis.

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

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

Failure to contact Blue Shield as described above or failure to follow the recommendations of Blue Shield will result in an additional payment per Hospital or Skilled Nursing Facility admission as described below and may also result in reduction or non-payment if Blue Shield determines that the admission is not a covered Service*.

*Note: For admissions for Special Transplant Benefits and for Bariatric Services for Residents of Designated Counties, failure to receive prior authorization in writing and/or failure to have the procedure performed at a Blue Shield-designated facility will result in non-payment of services by Blue Shield. See Transplant Benefits and Bariatric Surgery Services under the Covered Services section for details.

Prior Authorization for Inpatient Mental Health Services, and Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

All Inpatient Mental Health Services, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, except for Emergency Services, must be prior authorized by the MHSA.

For an admission for Emergency Mental Health Services, the MHSA should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the Subscriber may be responsible for the additional payment as described below.

For prior authorization of Inpatient Mental Health Services, Intensive Outpatient Care, Outpatient Partial Hospitalization and Outpatient ECT Services, call the MHSA at1-877-263-9952.

Failure to contact Blue Shield or the MHSA as described above or failure to follow the recommendations of Blue Shield will result in an additional payment per admission as described in the Additional and Reduced Payments for Failure to Use the Benefits Management Program section and may result in reduction or non-payment if Blue Shield or the MHSA determines that the admission is not a covered Service. For Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, failure to contact Blue Shield or the MHSA as described above or failure to follow the recommendations of Blue Shield will result in non-payment of services by Blue Shield.

Note: Blue Shield or the MHSA will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within 2 business days of the decision. For Urgent Services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

Emergency Admission Notification

If you are admitted for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, whichever is later, or you may be responsible for the additional payment as described under the Additional and Reduced Payments for Failure to Use the Benefits Management Program section.

Hospital Inpatient Review

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

DISCHARGE PLANNING

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

CASE MANAGEMENT

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

ADDITIONAL AND REDUCED PAYMENTS FOR FAILURE TO USE THE BENEFITS MANAGEMENT PROGRAM

For non-Emergency Services, additional payments may be required, or payments may be reduced, as described below, when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization and Hospital and Skilled Nursing Facility Admissions sections of the Benefits Management Program. These additional payments will be required in addition to any applicable Calendar Year Deductible, Copayment and amounts in excess of Benefit dollar maximums specified and will not be included in the calculation of the Member Maximum Calendar Year Copayment Responsibility.

1. Failure to contact Blue Shield as described under the Prior Authorization for Other than Mental Health Admissions section of the Benefits Management Program or failure to follow the recommendations of Blue Shield will result in an additional payment per Hospital or Skilled Nursing Facility admission as described below or may result in reduction or non-payment if Blue Shield determines that the admission is not a covered Service.

    - *$250 per Hospital or Skilled Nursing Facility admission.

*Only one $250 additional payment will apply to each Hospital admission for failure to follow the Benefits Management Program notification requirements or recommendations.

2. Failure to contact the MHSA for Inpatient Services as described under the Prior Authorization for Mental Health Services section or for Substance Abuse Conditions as specified below, or failure to follow the recommendations of the MHSA will result in an additional payment per admission as described below and may also result in reduction or non-payment if the MHSA determines that the admission is not a covered Service.

    - *$250 per Hospital admission for Inpatient Care for diagnosis or treatment of Mental Health conditions;
    - *$250 per Hospital admission for the diagnosis or treatment of Substance Abuse Conditions, if substance abuse coverage is selected as an optional Benefit by your Employer. 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.

    *Only one $250 additional payment will apply per Hospital admission for failure to notify or to follow a recommendation of the MHSA.

3. Failure to obtain prior authorization or to follow the recommendations of Blue Shield for Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services will result in non-payment of services by Blue Shield.

4. Failure to obtain prior authorization or to follow the recommendations of Blue Shield for covered, Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a 50% reduction in the amount payable by Blue Shield after the calculation of the Deductible and any applicable Copayments required by this Plan. You will be responsible for the applicable Deductibles and/or Copayments and the additional 50% of the charges that are payable under this Plan.

5. For other covered Services requiring prior authorization that are not authorized in advance, the amount payable will be reduced by 50% after the calculation of the Deductible and any applicable Copayments required by this Plan. You will be responsible for the remaining 50% and applicable Deductible and/or Copayments.

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

DEDUCTIBLE

CALENDAR YEAR DEDUCTIBLE

There is no Calendar Year Deductible under Level I. The Calendar Year Deductible(s) is shown in the Summary of Benefits and applies to all covered Services, except that the Calendar Year Deductible does not apply to covered travel expenses for bariatric surgery Services. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services. The Deductible must be satisfied once during each Calendar Year by or

on behalf of each Member separately, except that the Deductible shall be deemed satisfied with respect to the Subscriber and all of his covered Dependents collectively after the Family Deductible amount has been satisfied. 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. Charges in excess of the Allowable Amount do not apply toward the Deductible.

Prior Carrier Deductible Credit

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

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

No Member Maximum Lifetime Benefits

Level I ("HMO Plan" Level of Benefits)

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

Level II and Level III ("Preferred Plan" and Non-Preferred Plan Levels of Benefits)

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

No Annual Dollar Limit on Essential Benefits

Level I ("HMO Plan" Level of Benefits), Level II ("Preferred Plan" Level of Benefits) and Level III (Non-Preferred Plan Level of Benefits)

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

Payment

Plan Payment and Member Copayment Responsibilities

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

Complete Benefit descriptions may be found in the Plan Benefits section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Limitation of Liability
(For Level II "Preferred Plan" Level of Benefits)

When covered Services are rendered by a Blue Shield Participating Provider, the Member is responsible only for the applicable Deductibles and Copayments. However, the Member will be responsible for the full charges for any non-covered services rendered.

If a Blue Shield Participating Provider discontinues participation in the Blue Shield POS Plan, you will be notified in writing if you are affected. Blue Shield will make reasonable and medically appropriate provision to have another Blue Shield Participating Provider assume responsibility for Services to you. Once provisions have been made for the transfer of your care, services of a former Blue Shield Participating Provider will no longer be covered under this Plan.

Out-of-Area Program
(Level II and Level III Only)

Benefits will be provided for covered Services received outside of California within the United States. Blue Shield of California calculates the Subscriber's Copayment as a percentage of the Allowable Amount, as defined in this booklet. When Covered Services are received in another state, the Subscriber's Copayment will be based on the local Blue Cross and/or Blue Shield Plan's arrangement with its providers. See the BlueCard Program section in this booklet.

If you do not see a participating provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or to Blue Shield of California for payment. Blue Shield will notify you of its determination within 30 days after receipt of the claim. Blue Shield will pay you at the Non-Preferred provider benefit level. Remember, your Copayment is higher when you see a Non-Preferred provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield of California and the amount allowed by the local Blue Cross and/or Blue Shield plan.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by

the Plan, are the Subscriber's responsibility and are not included in Copayment calculations.

To receive the maximum Benefits of your Plan, please follow the procedure below.

When you require covered Services while traveling outside of California:

1. call BlueCard Access® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield Plan, or go on-line at http://www.bcbs.com and select the "Find a Doctor or Hospital" tab.
2. visit the participating Physician or Hospital and present your membership card.

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

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

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies, and Durable Medical Equipment. To receive prior authorization from Blue Shield of California, the out-of-area provider should call the Customer Service telephone number indicated on the back of the Member's identification card.

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

Benefits will also be provided for covered Services received outside of the United States through the BlueCard Worldwide Network. If you need urgent care while out of the country, call either the toll-free BlueCard Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should call Blue Shield of California at the Customer Service telephone number indicated on the back of the Member's identification card. For inpatient hospital care at participating hospitals, show your I.D. card to the hospital staff upon arrival. You are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for inpatient hospitalization, if you do not use the BlueCard Worldwide Network, you will have to pay the entire bill for your medical care and submit a claim form (with a copy of the bill) to Blue Shield of California.

Before traveling abroad, call your local Customer Service office for the most current listing of participating Hospitals worldwide or you can go on-line at http://www.bcbs.com and select the "Find a Doctor or Hospital" tab.

BLUECARD PROGRAM

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 below.

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 Blue 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 Evidence of Coverage.

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 Allowable Amount as defined in this Evidence of Coverage.

Utilization Review Process

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.

Maximum Calendar Year Copayment Responsibility

Level I ("HMO Plan" Level of Benefits)

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

Note: It is the Member's responsibility to maintain accurate records of their 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 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.

Note: For Level II and Level III Services, Additional and Reduced Payments assessed as a result of not following the procedures of the Benefits Management Program and the Calendar Year Deductible are not included in the Member Maximum Calendar Year Copayment Responsibility.

Level II ("Preferred Plan" Level of Benefits)

Your maximum Copayment required per Calendar Year for services under Level II for any combination of Blue Shield Participating Providers is shown in the Summary of Benefits. Once a Member's maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Member's covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as described below.

Charges for services which are not covered are the Member's responsibility, and may cause Member's payment responsibility to exceed the Copayment maximum.

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

Level III (Non-Preferred Plan Level of Benefits)

Your maximum Copayment required per Calendar Year for covered Services under Level III for any combination of Blue Shield Participating Providers and non-Blue Shield Participating Providers or other providers is shown in the Summary of Benefits. Once a Member's maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Member's covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as described below.

Charges for services which are not covered, and charges by non-Blue Shield Participating Providers in excess of the amount covered by the Plan, such as Physician charges above the Allowable Amount, are the Member's responsibility, and are not included in the calculations for the maximum Calendar Year Copayment responsibility, and may cause a Member's payment responsibility to exceed the maximums stated above.

*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 Responsibility continue to be the Member's responsibility after the Calendar Year Copayment Maximum is reached.

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

Reimbursement Under Levels I, II, and III

Payment of Providers — Level I

Blue Shield generally contracts with groups of Physicians to provide Level I 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 in the back of this booklet or talk to your Plan Provider.

Payment of Providers — Level II

Level II Services are those Services received from Blue Shield Participating Providers. Please see the Payment section, under Level II, for payment parameters.

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

Payment of Providers — Level III, Claims Reimbursement

Under Level III, Members are reimbursed directly by Blue Shield for covered Services rendered by a non-Blue Shield Participating Provider. Requests for payment must be submitted to Blue Shield within 1 year after the month Services were provided. Special claim forms are not necessary, but each claim must contain the Member's name, home address, group contract number, Member number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name and relationship to the Member. Blue Shield will notify you of its determination within 30 days after receipt of the claim.

Members are not responsible to a Blue Shield Participating Provider for payment for covered Services, except for the Deductibles, Copayments, amounts in excess of the specified Benefit dollar maximums, or as provided under the Exception for Other Coverage provision and the section on Reductions – Third Party Liability.

Plan Service Area

The Plan Service Area of this Plan is identified in the Blue Shield 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

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 your Employer. 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.

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 employer'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 of the birth or placement for adoption. Eligibility during the first 31 days includes coverage for treatment of injury or illness only but does not include well-baby care Benefits unless the child is enrolled. Well-baby care Benefits are provided for enrolled children.

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

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

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

Coverage is never automatic; an application is always required.

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

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are 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 Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer 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.

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

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

EFFECTIVE DATE OF COVERAGE

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

If, during the initial enrollment period, you have included your eligible Dependents on your application to 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 employer'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, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another health plan sponsored by your Employer to the Blue Shield POS Plan. 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 Employer'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 a previous group health plan that was offered by your Employer, you and all your Dependents who were validly covered under the previous group health plan on the date of discontinuance, will be eligible under this Plan.

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. Employer 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 your Employer's group contract. The initial Dues are payable on the effective date of the group health service 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 your Employer and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group health service 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. Your Employer will receive notice from the Plan of any changes in Dues at least 60 days prior to the change. Your Employer will then notify you immediately.

The section 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

No change in the Plan Benefits nor waiver of any of its provisions shall be valid without the approval of Blue Shield.

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 Plan Benefits will be provided based on the change. There is no vested right to obtain Benefits. Benefits for Services or supplies furnished on or after the effective date of any benefit modification shall be provided based on that modification.

PLAN BENEFITS

The Benefits available to you under the Blue Shield POS Plan are listed in this section, subject to the applicable Deductible and Copayment responsibilities.

As set forth in the Exclusions and Limitations section, the Services and supplies described here are covered only if they are Medically Necessary as determined by the Medical Group/IPA or by the Plan. 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.

Subject to the terms, conditions, exclusions (including Medical Necessity), limitations, Deductibles, Copayments, and other requirements contained in this Evidence of Coverage or the Group Health Service Contract, and to any conditions or limitations set forth in the benefit descriptions below, and to the Exclusions and Limitations set forth in this booklet, Benefits are provided for the following health care Services under the Blue Shield POS Plan. The Deductibles and Copayments are listed in the Summary of Benefits. All of the Services are provided under Levels I, II and III except as otherwise stated.

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.

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 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 Hospital to a Plan Hospital or between Plan facilities when in connection with authorized confinement/admission and the 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 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:

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.

BARIATRIC SURGERY BENEFITS

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for Services received under Levels I, II, and III for all Members, whether residents of a designated or non-designated county.

Note: The following paragraphs do not apply to Members obtaining bariatric surgery Services under Level I (HMO Plan Level) or to Members obtaining bariatric surgery Services under Level II or Level III if those Members are residents of non-designated counties. (A list of designated counties is provided below.) Bariatric surgery Services under Level I, or under Level II and III for residents of non-designated counties, will be paid as any other surgery as described elsewhere in this Plan Benefits section when:

1. Services are consistent with Blue Shield's medical policy; and,
2. prior authorization is obtained, in writing, from Blue Shield's Medical Director.

For bariatric surgery Services under Level I, or under Level II and III for residents of non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

Level II Bariatric Surgery Services for Residents of Designated Counties in California

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric Services*, Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1. performed at a Preferred Bariatric Surgery Services Hospital or Ambulatory Surgery Center and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shield to provide the procedure; and,
2. they are consistent with Blue Shield's medical policy; and,
3. prior authorization is obtained, in writing, from Blue Shield's Medical Director.

*See the list of designated counties below.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric 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.

For Members who reside in a designated county and obtain bariatric surgery Services under Level II, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred Bariatric Surgery Services Hospital by a Preferred Bariatric Surgery Services Physician will result in denial of claims for this benefit.

Note: Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must be provided by a Preferred Bariatric Surgery Services Physician, whether performed in a Preferred Bariatric Surgery Services Hospital, a qualified Ambulatory Surgery Center, or the Preferred Bariatric Surgery Services Physician's office.

The following are designated counties in which Blue Shield has contracted with facilities and physicians to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement for Level II Bariatric Surgery Services for Residents of Designated Counties in California

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric Services at a Preferred Bariatric Surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Preferred Bariatric Surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. for the Member for a maximum of 3 trips:

      1 trip for a pre-surgical visit,

      1 trip for the surgery, and

      1 trip for a follow-up visit.

   b. for one companion for a maximum of 2 trips:

      1 trip for the surgery, and

      1 trip for a follow-up visit.
2. Hotel accommodations not to exceed $100 per day:
   a. for the Member and one companion for a maximum of 2 days per trip,

      1 trip for a pre-surgical visit, and

      1 trip for a follow-up visit.

   b. for one companion for a maximum of 4 days for the duration of the surgery admission.

      All hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.
3. Related expenses judged reasonable by Blue Shield not to exceed $25 per day per Member up to a maximum of 4 days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Calendar Year Deductible and do not accrue to the Member Maximum Calendar Year Copayment Responsibility.

CLINICAL TRIAL FOR CANCER BENEFITS
(Benefits are provided only under Level I)

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.

DIALYSIS CENTERS BENEFITS

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

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

Note: Prior authorization by Blue Shield is required for all dialysis Services. See the Benefits Management Program section for details.

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, 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 two 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, 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.)

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. When all these requirements are met, the Services will be covered under Level I, subject to the applicable Copayment. The Services will be reviewed retrospectively by Blue Shield 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. If Blue Shield determines they were not Emergency Services as described above, the Member will be notified of that determination. The Services may be covered under Level II or Level III subject to all applicable Deductibles, Copayments and other payment requirements of the Plan.

   Emergency Services Copayment does not apply if a Member is admitted directly to the Hospital as an Inpatient from the emergency room.

2. Continuing or Follow-up Treatment.
   (This Benefit is provided only under Level I.)

   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. The Plan will provide benefits for care in a Hospital only for as long as the Member's medical condition prevents transfer to a Plan Hospital in the Member's service area, as approved by the Medical Group/IPA or by Blue Shield. Unauthorized continuing or follow-up care after the initial emergency has been treated in a Hospital, or by a provider, is not a covered service under this Plan.

FAMILY PLANNING AND INFERTILITY BENEFITS

1. Family Planning Counseling, including Physician office visits for diaphragm fitting and injectable contraceptives. (This Benefit is provided only under Level I.)
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. (This Benefit is provided only under Level I.)
3. Infertility Services. Infertility Services, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose and treat the cause of Infertility, except as excluded in the Principal Limitations, Exceptions, Exclusions and Reductions section. Any services related to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service) are not covered. (This Benefit is provided only under Level I.)
4. Tubal Ligation.
5. Elective Abortion.
6. Vasectomy.
7. Injectable contraceptives when administered by a Physician. (This Benefit is provided only under Level I.)
8. Diaphragm fitting procedure. (This Benefit is provided only under Level I.)

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 as shown in the Summary of Benefits during any Calendar Year.

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

(Note: See Hospice Program Benefits in the Plan 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 visits, parenteral nutrition Services, enteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary, FDA approved injectable medications when prescribed by the Personal Physician and prior authorized, and when provided by a Home Infusion Agency.

This Benefit does not include medications, drugs Insulin, Insulin syringes, Specialty Drugs covered under 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, Chiropractic 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 Service for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members 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 en-

sure 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 purposes of this section, the person providing these services shall be referred to as the "medical director".

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

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

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

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

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

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

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

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

HOSPITAL BENEFITS (FACILITY SERVICES)

(Other than bariatric surgery Services which are described under the Bariatric Surgery Benefits section.)

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 for the purpose of transition from the Hospital to home.
    h. Surgical and anesthetic supplies, dressings, and cast materials, surgically implanted devices and prosthe-

ses, other medical supplies and medical appliances and equipment administered in the Hospital.

i. Administration of blood and 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 seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

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 maximum is a combined Benefit maximum for all skilled nursing Services whether in a Hospital or a Skilled Nursing Facility for Services received under all levels combined.

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 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:

(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 or ambulatory surgery center.

*Note: There is a visit maximum shown in the Summary of Benefits per person Calendar Year maximum for all Physical Therapy Covered Services performed on an Outpatient basis (except for Physical Therapy provided under Home Health Care Benefits) under all levels combined.

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 seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

c. 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 are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphe-

demas. 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:

1. Provided for 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);

   *Note: There is a visit maximum as shown in the Summary of Benefits per person Calendar Year maximum for all Physical Therapy Covered Services performed on an Outpatient basis (except for Physical Therapy provided under Home Health Care Benefits) under Levels II and III combined.
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 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

Level I (HMO) Benefits

All Non-Emergency Mental Health Services must be arranged through the MHSA. Also, all Mental Health Services, except for Emergency or Urgent Services, must be prior authorized by the MHSA. For prior authorization for Mental Health Services, Members should contact the MHSA at1-877-263-9952.

All Non-Emergency Mental Health Services must be obtained from MHSA Participating Providers. (See the Obtaining Medical Care section, the Mental Health Services paragraphs for more information.)

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

Benefits are provided for Hospital and professional Services in connection with Partial Hospitalization, Intensive Outpatient Care and Outpatient 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 and the procedure is prior authorized by the MHSA.

5. Psychosocial Support through LifeReferrals 24/7

See the Mental Health Services paragraphs under the Obtaining Medical Care section for information on psychosocial support services.

Level III (Non-Participating) Benefits*

*Benefits for Services for Mental Health are provided under Levels I and III only.

All Inpatient Mental Health Services, Outpatient Partial Hospitalization Services, Intensive Outpatient Care and Outpatient ECT, except for Emergency and Urgent Services, must be prior authorized by the MHSA including those obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this booklet for an explanation of how payment is made for out of state services. For prior authorization, Subscribers should contact the MHSA at 1-877-263-9952. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following covered Mental Health Conditions, subject to applicable Deductibles, Copayments and charges in excess of any Benefit maximums, Participating Provider provisions, Benefits Management Program provisions. 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 Exclusions and Limitations set forth in this booklet.

Note: For all Inpatient Hospital care except for Emergency and Urgent Services, failure to contact the MHSA prior to obtaining Services will result in the Subscriber being responsible for an additional payment as outlined in the Additional and Reduced Payments for Failure to Use the Benefits Management Program paragraphs of the Benefits Management Program section. For Outpatient Partial Hospitalization Services, Intensive Outpatient Care and Outpatient ECT, failure to contact Blue Shield or the MHSA or failure to follow the recommendations of Blue Shield will result in non-payment of services by Blue Shield.

No benefits are provided for Substance Abuse Conditions, unless substance abuse coverage has been selected as an optional Benefit by your Employer, 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 Care

Benefits are provided for Inpatient Services in connection with hospitalization for the treatment of Mental Health Conditions. Residential care is not covered.

Note: Medically Necessary Inpatient medical detoxification is not included in this Benefit. It is included as an Inpatient Hospital Services Benefit.

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 ECT Services

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

4. Psychological testing

Psychological testing is a covered Benefit when provided to diagnose a Mental Health Condition.

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 two 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 prior authorized and 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 exclusion 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 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized.

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 Bariatric Surgery Benefits and 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. Medically Necessary home visits by the Member's 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 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"). Internet based consultations for Mental Health Conditions and Substance Abuse Conditions are not covered. 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.

   Internet based consultations are not available to Persons accessing care outside of California.

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 Employer 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.

*Note: Under Levels II and III, there is a per person Calendar Year combined visit maximum as shown in the Summary of Benefits for all Outpatient Physical Therapy Covered Services provided by any provider and all covered Services provided by a chiropractor. Physical Therapy provided under Home Health Care Benefits is not subject to the visit maximum.

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 POS health Plan if your Employer 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, Chiropractic and Respiratory Therapy)

Rehabilitation Services include Physical Therapy, Occupational Therapy, Chiropractic 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 additional subsequent Medically Necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is Medically Necessary and is provided with the expectation that the patient has restorative potential.

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 for Services received under all Levels combined. 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 are covered 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. Before initial services are provided under Level II and III, you or your provider should determine if the proposed treatment will be covered by following Blue Shield's prior authorization procedures. (See the section on the Benefits Management Program.)

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

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

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, or in the case of Persons accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield, (2) prior authorization is obtained, in writing, from Blue Shield's Medical Di-

rector, 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 liver transplants;
    e. Human kidney and pancreas transplants in combination;
    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 Obtaining Medical Care. When outside the Personal Physician 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, if possible, the Member should contact the Personal Physician or Blue Shield Member Services at the number listed on the last page of this booklet in accordance with the Obtaining Medical Care 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 or the United States, Members should, if possible, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. If Urgent Services are not available through a BlueCard Program participating provider, and 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 Obtaining Medical Care section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

For Level I services, up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. When a BlueCard Program participating provider is available, you should obtain out of area Urgent or follow-up Services from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. (See preceding paragraph for what to do if a participating provider is not available.) Authorization by Blue Shield is required for more than two follow-up outpatient visits. To receive Level I services, Blue Shield may direct the member to receive the additional follow-up care from the Personal Physician.

Outside the United States, Urgent Services are available through the BlueCard Worldwide Network, but may be received from any provider.

Members before traveling abroad should, if possible, call their local Member Services office for the most current listing of participating providers worldwide and to obtain a copy of the BlueCard Worldwide Network brochure that provides helpful information on receiving covered Services in a foreign country or they can visit Blue Shield's internet site at http://www.blueshieldca.com. However, a Member is not required to receive Urgent Services outside of the United States from the BlueCard Worldwide Network. If the Member does not use the BlueCard Worldwide Network, a claim must be submitted as described in Claims for Emergency and Out-of-Area Urgent Services in the Obtaining Medical Care section. See the BlueCard Program section for additional information.

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 Benefits 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; or rest;
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 your Employer 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 Physician-consultant of Blue Shield. 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 Services for Pregnancy and Maternity Care 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 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 dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits 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, or nutritional counseling except as specifically provided for under Diabetes Care Benefits;
20. for learning disabilities, or behavioral problems or social skills training/therapy;
21. for or incident to acupuncture except as specifically provided;
22. for spinal manipulation and adjustment except as specifically provided under Professional (Physician) 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 testing for intelligence or learning disabilities;
26. for rehabilitation services except as specifically provided under Professional (Physician) Benefits; Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Home Health Care Benefits, Rehabilitation (Physical, Occupational, Chiropractic and Respiratory Therapy) Benefits**,** and Speech Therapy Benefits in the Plan Benefits section;
27. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and, unless the Member's employer provides benefits for pre-

scription drugs through the supplemental Benefit for Outpatient Prescription Drugs;

28. for contraceptives except as specifically included under Family Planning and Infertility Benefits in the Plan Benefits section and under the Outpatient Prescription Drug Supplement; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drug Supplement; no benefits are provided for contraceptive implants;
29. for transportation services other than provided under Ambulance Benefits in the Plan Benefits section;
30. performed by a close relative or by a person who ordinarily resides in the Member's home;
31. for orthopedic shoes, except as provided under Diabetes Care Benefits in the Plan Benefits section, home testing devices, environmental control equipment, exercise equipment, generators 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 under Durable Medical Equipment Benefits in the Plan Benefits section;
35. for 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, bath chairs, and breast pumps, that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, 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 provided 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 bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits in the Plan Benefits section;
42. for services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
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.

The determination of whether services or supplies are excluded or limited by the Plan, are Medically Necessary, or are an emergency or urgent will be made by Blue Shield. The determination of Medical Necessity will be based upon Blue Shield's review consistent with generally accepted medical standards, and will be subject to grievance in accordance with the procedures outlined in the Grievance Process section.

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

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your 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 Allowable Amount).

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

An HMO Plan Provider or a Blue Shield Participating 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 Independent Practice Association 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 Independent Practice Association 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 ten (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 Independent Practice Association.

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

When a person who is covered under this Plan is also covered under another 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 of the services 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 claims of 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 your Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (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 the group contract.

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

If your Employer 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). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

If a health statement, if applicable, and an application are not submitted for a newborn or a child placed for adoption within the 31 days following that Dependent's effective date of coverage, Benefits under the 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.

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;
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;
4. Abusive or disruptive behavior which: (1) threatens the life or well-being of the Plan personnel and providers of Services, or, (2) substantially impairs the ability of Blue Shield of California to arrange for Services to the Member, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Member or to other patients.

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 Personal Physician section;
2. Failure to pay any Copayment or supplemental charge.

Termination of coverage under the Blue Shield POS Plan terminates coverage under Levels I, II and III.

REINSTATEMENT

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

CANCELLATION WITHOUT CAUSE

The group contract also may be cancelled by your Employer 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 your Employer fails to pay the required Dues when due, coverage will end 60 days after the date for which Dues are due. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 60-day grace period.

Blue Shield of California will mail your Employer a Notice Confirming Termination of Coverage. Your Employer must provide you with a copy of the Notice Confirming Termination of Coverage.

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

CANCELLATION/RESCISSION FOR FRAUD OR INTENTIONAL MISREPRESENTATIONS OF MATERIAL FACT

Blue Shield may cancel or rescind the group contract for fraud or intentional misrepresentation of material fact by your Employer, 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 employer) may, at the discretion of Blue Shield, result in the cancellation or rescission of this Plan. 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 your Employer, it is your Employer's responsibility to notify you of the rescission or cancellation.

RIGHT OF CANCELLATION

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

If your Employer 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 your Employer.

Any Dues paid Blue Shield for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer 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 Employer (Contractholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a 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 Employer 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 Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would oth-

erwise terminate under this Plan because of a Qualifying Event.

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

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the 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 Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the 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 Employer, 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 Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

Payment of Dues

Dues for the 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 Employer 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 Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to 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 Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

CONTINUATION OF GROUP COVERAGE AFTER COBRA AND/OR CAL-COBRA

The following section only applies to enrollees who became eligible for Continuation of Group Coverage After COBRA and/or Cal-COBRA prior to January 1, 2005:

Certain former Employees and their Dependent spouses or Dependent Domestic Partners (including a spouse who is divorced from the current Employee/former Employee and/or a spouse who was married to the Employee/former Employee at the time of that Employee/former Employee's death, or a Domestic Partner whose partnership with the current Employee/former Employee has terminated and/or a Domestic Partner who was in a Domestic Partner relationship with the Employee/former Employee at the time of that Employee/former Employee's death) may be eligible to continue group coverage beyond the date their COBRA and/or Cal-COBRA coverage ends. Blue Shield will offer the extended coverage to former Employees of employers that are subject to the existing COBRA or Cal-COBRA, and to the former Employees' Dependent spouses, including divorced or widowed spouses as defined above, or Dependent Domestic Partners, including surviving Domestic Partners or Domestic Partners whose partnership was terminated as defined above. This coverage is subject to the following conditions:

1. The former Employee worked for the Employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended.
2. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)
3. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent Domestic Partner (a former Domestic Partner, i.e., a surviving Domestic Partner or Domestic Partner whose partnership has been terminated as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)

Items 1., 2. and 3. above are not applicable to a former spouse or former Domestic Partner electing continuation coverage. The former spouse or former Domestic Partner must elect such coverage by notifying the Plan in writing within 30 calendar days prior to the date that the former spouse's or former Domestic Partner's initial COBRA and/or Cal-COBRA benefits are scheduled to end.

If elected, this coverage will begin after the COBRA and/or Cal-COBRA coverage ends and will be administered under the same terms and conditions as if COBRA and/or Cal-COBRA had remained in force.

For Members who transfer to this coverage from COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 102 percent of the applicable age adjusted group dues rate. For Members who transfer to this coverage from Cal-COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 110 percent of the applicable age adjusted group dues rate. Payment is due at the time the Employer's payment is due.

Termination of Continuation Coverage After COBRA and/or Cal-COBRA

This coverage will end automatically on the earliest of the following dates:

1. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner reaches 65;
2. the date the Employer discontinues this Group Health Service Contract and ceases to maintain any group health plan for any active Employees;
3. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner transfers to another health plan, whether or not the benefits of the other health plan are less valuable than those of the health plan maintained by the Employer;
4. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner becomes entitled to Medicare;
5. for a spouse or Domestic Partner or former spouse or former Domestic Partner, 5 years from the date the spouse's or Domestic Partner's COBRA or Cal-COBRA coverage would end.

Availability of Blue Shield of California Individual Plans

Blue Shield's Individual Plans described at the beginning of this section may be available to Members whose group coverage, COBRA or Cal-COBRA coverage, or Continuation of Group Coverage After COBRA and/or Cal-COBRA is terminated or expires while covered under this group Plan. (Note, only Individual Conversion Coverage is available to Members who are terminated from Continuation of Group Coverage After COBRA and/or Cal-COBRA.)

Individual Conversion Plan

Continued Protection

Regardless of age, physical condition or employment status, you may continue Blue Shield protection when you retire, leave the job or become ineligible for group coverage. If you have held group coverage for three or more consecutive months, you and your enrolled Dependents may apply to transfer to an individual conversion health plan then being issued by Blue Shield. Your Employer is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of termination of the Plan'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 your Employer with similar coverage under another contract within 15 days, transfer to the individual conversion health plan will not be permitted. You will not be permitted to transfer to the individual conversion plan 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;
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates for an individual conversion health plan are, generally, different from those in a 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 prompt 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, Continuation of Group Coverage After COBRA and/or Cal-COBRA, or other Blue Shield individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Member Services representative at the telephone number noted on your ID Card.

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under the Plan and continues to be Totally Disabled on the date the group contract terminates, Blue Shield will extend the Benefits of the 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 Member is no longer Totally Disabled;
2. 12 months from the date the group health service contract terminated;
3. the date on which the Member'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.

Other 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, sub-contractors, 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: 1-415-229-5065

Please follow the following procedure:

1. Submit your recommendations, suggestions or comments in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.
2. Include your name, address, phone number, Subscriber number, and Plan number with each communication.
3. State the policy issue 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 60 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 the Plan are not assignable by the Member.

INDEPENDENT CONTRACTORS

Blue Shield Participating Providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield conducts a process of credentialing and certification of all Physicians who participate in the Blue Shield POS Plan. 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.

PLAN INTERPRETATION

Blue Shield shall have the power and complete discretionary authority to construe and interpret the provisions of the group health service 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 Members entitled to receive Benefits under the group health service contract.

MEMBER SERVICES

FOR ALL SERVICES OTHER THAN MENTAL HEALTH

For Level I, II, and III Services

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 listed 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 healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Member Services Department at the number listed on the last page of this booklet.

FOR ALL MENTAL HEALTH SERVICES-

For Level I (HMO) and III (MHSA Non-Participating) Services*

***Benefits for Services for Mental Health are provided under Levels I and III only.**

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 network Providers, or Mental Health Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

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

The MHSA can answer many questions over the telephone.

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 healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the number listed above.

GRIEVANCE PROCESS

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

1-877-263-9952

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 your Employer's health Plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. 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 ex-

ternal 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:

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

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

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

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

1. For a Participating Provider, the amount that the Provider and Blue Shield have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a Non-Participating Provider anywhere within or outside of the United States who provides Emergency Services:
    a. For Physicians and Hospitals – the Reasonable and Customary Charge;
    b. All other providers – the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield have agreed upon some other amount; or
3. For a Non-Participating Provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or
5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of

the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local plan has no non-participating provider allowance, Blue Shield will assign the Allowable Amount used for a Non-Participating Provider in California.

Allowed Charges — the amount an HMO Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-HMO Plan Providers (except 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).

Alternate Care Services Providers — home health care agencies, home infusion pharmacies, Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Ambulatory Surgery Center — an Outpatient surgery facility which:

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

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.

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

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

Contract Month — a period beginning on the first day of a calendar month and continuing to the first day of the next calendar month.

Copayment — the amount that a Member is required to pay for specific Covered Services.

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

Covered Services (Benefits) — those services which a Member is entitled to receive pursuant to the terms of the group health service 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 fixed Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive any 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 or retired Subscriber's surviving spouse who is:
   a. not covered for Benefits as a Subscriber; and
   b. not legally separated from the Subscriber;

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

   or,
3. a child of, adopted by, or in legal guardianship of the Subscriber, deceased retired 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 Employer's or Blue Shield's request; and

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

        (1) within 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.

Doctor of Medicine — a licensed medical doctor (M.D.) or doctor of osteopathic medicine (D.O.).

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

1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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

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 Blue Shield 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 your Employer.

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

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 Subscribers 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.

HMO Plan Provider — a provider who has an agreement with Blue Shield to provide Level I Benefits ("HMO Plan" level of Benefits) to Members in the Blue Shield POS Plan.

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

pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

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

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

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

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

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

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 Mental Health Service Administrator (MHSA).

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

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine 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 Mental Health Service Administrator (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's 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 a 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 Services — Services provided to treat a Mental Health Condition.

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

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

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

Non-Participating/Non-Preferred Providers — any provider who has not contracted with Blue Shield to accept Blue

Shield's payment, plus any applicable Deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services.

Note: This definition does not apply to Mental Health Services. For MHSA-Non-Participating Providers for Mental Health Services, see the MHSA Non-Participating Provider definition above.

Non-Preferred Bariatric Surgery Services Providers — any provider that has not contracted with Blue Shield to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery Services provider by Blue Shield. Non-Preferred Bariatric Surgery Services Providers may include Blue Shield Preferred/Participating Providers if the Provider does not also have an agreement with Blue Shield to provide bariatric surgery Services.

Note: Bariatric surgery Services are not covered under Level II and III for Members who reside in designated counties in California if the service is provided by a Non-Preferred Bariatric Surgery Services Provider. (See the Bariatric Surgery Benefits section under Plan Benefits for more information.)

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

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

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

Other Providers —

1. Independent Practitioners: licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; licensed occupational therapists; certificated acupuncturists; certified respiratory therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2. Health Care Organizations: nurses registry; licensed mental health, free-standing public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society and Catholic Charities.

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, 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.

Participating Physician — a Physician who has agreed to accept Blue Shield of California's payment, plus Subscriber payments of any applicable Deductibles and Copayments as payment-in-full for covered Services.

Participating Provider — a Physician, Hospital, Alternate Care Services Provider, Ambulatory Surgery Center, or Certified Registered Nurse Anesthetist that has contracted with Blue Shield to furnish services and to accept Blue Shield's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered services, except as provided under the Payment provision in this booklet. A Participating Provider may not necessarily be an HMO Plan Provider.

Note: This definition does not apply to Mental Health Services. For MHSA Participating Providers for Mental Health Services, see the MHSA Participating Provider definition above.

Personal Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with Blue Shield 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 Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — is defined as a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.). For Benefits, the

term Physician also includes clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, licensed marriage and family therapist, and registered physical therapist.

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

Plan — the Blue Shield Added Advantage POS Health Plan and/or Blue Shield of California.

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

Plan Non-Physician Health Care Practitioner — a health care professional who is not a physician and has an agreement with one of the contracted Independent Practice Associations, 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 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 services to Members on referral by Personal Physician. For all Mental Health Services, this definition includes MHSA Participating Providers.

Preferred Bariatric Surgery Services Provider — a Preferred Hospital or a Physician Member that has contracted with Blue Shield to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield.

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

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

Note: For MHSA Participating Providers for Mental Health Services, see the MHSA Participating Provider definition above.

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

Note: For Preferred Providers for Mental Health Services, see the MHSA Participating Provider definition above.

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

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

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

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

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

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

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 primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, Chiropractic and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. 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 Doctor of Medicine and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
    a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 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 under the terms of the 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 (or Totally Disabled) —

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

be expected to engage, in view of the individual's station in life and physical and mental capacity.

Urgent Services — those covered services rendered outside of the 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 Added Advantage POS Plan.

Should you have any questions, please call the Blue Shield of California Member Services Department at the number provided on the back 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 جانبی 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

សេវាកម្មភាសាដោយឥតគិតថ្លៃ ។ 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 Key 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		
Formulary Generic Drugs	$10 per prescription	Not covered
Formulary Brand Name Drugs	$25 per prescription	Not covered
Non-Formulary Brand Name Drugs	$40 per prescription	Not covered
Mail Service prescriptions		
Formulary Generic Drugs	$20 per prescription	Not covered
Formulary Brand Name Drugs	$50 per prescription	Not covered
Non-Formulary Brand Name Drugs	$80 per prescription	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.

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 Copayments 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 and are obtained from a Participating Pharmacy. 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. Non-Formulary Drugs may be covered subject to higher Copayments. 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.

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.

Benefits may be provided for Non-Formulary Drugs subject to higher Copayments.

Definitions

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

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (5) oral contraceptives and diaphragms, (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.

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. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

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

Participating Pharmacy — a pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members. 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 applicable Copayment for each new and refill prescription Drug. The pharmacist will collect from the Member the applicable Copayment at the time the Drugs are obtained.

For diaphragms, the Formulary Brand Name Copayment applies.

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.

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 prescription specifies a Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if Generic Drug equivalent is not available, the Member is responsible for paying the applicable Brand Name Drug Copayment.

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, including Drugs for emergency contraception.

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 and the Member's medication dosage has been stabilized, 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, except for Insulin, are not available through the Mail Service Prescription Drug Program.

The Member is responsible for the applicable Mail Service Prescription Drug Copayment for each new or refill prescription Drug.

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. 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 prescription specifies a Mail Service Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Mail Service Generic Drug equivalent is not 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

Select Formulary Drugs, as well as most Specialty Drugs may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. 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 five business days or within 72 hours for an expedited review.

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, Drugs for emergency contraception, 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. 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;
5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
6. Drugs that are considered to be experimental or investigational;
7. Medical devices or supplies, except as specifically listed as covered herein (see 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;
8. Blood or blood products (see the Hospital Benefits (Facility Services) section of your Evidence of Coverage and Disclosure Form);
9. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;

10. Dietary or Nutritional Products (see 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);
11. 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;
12. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
13. 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;
14. Contraceptive devices (except diaphragms), injections and implants;
15. 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;
16. Replacement of lost, stolen or destroyed prescription Drugs;
17. 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;
18. 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;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.
20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

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.

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***

Blue Shield POS Member Services Department (See last page) _____

For information contact Blue Shield of California.

Members may call Blue Shield's Member Services Department toll free: 1-800-424-6521

For Mental Health Services and information, call the MHSA: 1-877-263-9952

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