

Access+ HMO

(for Members selecting Guaranteed Issue coverage)

Health Plan for Individuals and Families

Evidence of Coverage and Health Service Agreement

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service Plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Dues, Blue Shield agrees to provide the Benefits of this Agreement.

NOTICE TO NEW SUBSCRIBERS

Please read this Service Agreement carefully. If you have any questions, contact Blue Shield. You may surrender this Agreement by delivering or mailing it with the identification cards, within ten (10) days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 50 BEALE STREET, SAN FRANCISCO, CALIFORNIA 94105. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and Dues paid will be refunded.

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

Blue Shield's Access+ HMO Health Plan

Member Bill of Rights

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

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

Blue Shield's Access+ HMO Health Plan

Member Responsibilities

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

1. Carefully read all Blue Shield Access+ HMO materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield Access+ HMO membership as explained in the Evidence of Coverage and 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. 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.
5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
6. Make and keep medical appointments and inform the Plan Physician ahead of time when you must cancel.
7. Communicate openly with the Personal Physician you choose so you can develop a strong partnership based on trust and cooperation.
8. Offer suggestions to improve the Blue Shield Access+ HMO Plan.
9. 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.
10. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
11. Select a Personal Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection.
12. Treat all Plan personnel respectfully and courteously as partners in good health care.
13. Pay your Dues, Copayments, and charges for non-covered Services on time.
14. For all Mental Health and substance abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Non-Emergency Mental Health and substance abuse Services.

Table of Contents

Access+ HMO Summary of Benefits	1
Introduction	10
Choice Of Physicians and Providers.....	10
Selecting a Personal Physician	10
Role of the Medical Group or IPA	11
Changing Personal Physicians or Designated Medical Group or IPA.....	11
Continuity of Care by a Terminated Provider	12
Relationship with Your Personal Physician	12
Using Your Health Plan.....	12
Use of Personal Physician	12
Obstetrical/Gynecological (OB/GYN) Physician Services	12
Referral to Specialty Services.....	13
Second Medical Opinion	13
Access+ Specialist.....	13
NurseHelp 24/7 and LifeReferrals 24/7.....	14
Mental Health and Substance Abuse Services.....	14
Inpatient, Home Health Care, Hospice Program, and Other Services	15
Emergency Services	16
Urgent Services	16
Deductible and Copayments.....	17
Member Maximum Lifetime Benefits.....	17
Member’s Calendar Year Copayment Maximum Responsibility.....	17
Liability of Subscriber or Member for Payment.....	18
Limitation of Liability	18
Utilization Review.....	19
Plan Service Area	19
Dues.....	19
Conditions Of Coverage	19
Enrollment	19
Limitation of Enrollment.....	20
Duration of the Agreement	20
Renewal of the Agreement	20
Termination Of Benefits And Cancellation Provisions	20
Termination/Cancellation/Reinstatement of the Agreement	20
Cancellation of the Agreement for Nonpayment of Dues	21
Reinstatement of the Agreement after Cancellation	21
Transfer of Coverage.....	21
Commencement or Termination of Coverage	22
Plan Changes	22
Entire Agreement: Changes.....	22
Endorsements and Appendices.....	22
Notices.....	22
Plan Benefits.....	22
Ambulance Services	23
Claims for Emergency And Out-Of-Area Urgent Services	23
Clinical Trial for Cancer.....	23
Diabetes Care	24
Durable Medical Equipment, Prostheses, And Other Services.....	24
Emergency Services	25
Family Planning	25
Home Health Care Benefits.....	25
Home Infusion/Home Injectable Therapy Benefits	26
Hospice Program Services.....	26
Hospital Services.....	28
Medical Treatment of The Teeth, Gums, Jaw Joints, Or Jaw Bones	29
Mental Health and Substance Abuse Services.....	29
Orthoses.....	30

Other Outpatient Services.....	30
Outpatient Prescription Drugs	31
Outpatient Rehabilitation Services	35
PKU Related Formulas and Special Food Products	35
Pregnancy, Maternity Care And Routine Circumcision	35
Preventive Health Services.....	36
Professional Services (Other than for Mental Health and substance abuse Services)	36
Reconstructive Surgery	37
Skilled Nursing Facility Services	37
Speech Therapy	37
Transplant Benefits.....	38
Urgent Services	38
Dental Benefits - Access+ Dentist.....	39
Access+ Dentists	39
Definitions.....	39
Covered Services and Supplies.....	40
Diagnostic and Preventive Services.....	40
Major Services.....	40
Additional Services	41
Emergency Services	41
General Limitations and Exclusions.....	41
Dental Necessity Exclusion.....	43
Dental Claims and Services Review.....	43
Member Services and Grievance Process For Dental Services.....	43
Principal Limitations, Exceptions, Exclusions And Reductions.....	44
General Exclusions and Limitations.....	44
Medical Necessity Exclusion.....	47
Limitations for Duplicate Coverage	47
Exception for Other Coverage.....	48
Claims and Services Review	48
Reductions - Third Party Liability.....	48
Other Provisions	48
Payment of Providers	48
Plan Interpretation	48
Independent Contractors.....	49
Membership Identification Cards	49
Statutory Requirements	49
Legal Process.....	49
Non-Assignability	49
Notice	49
Confidentiality of Personal and Health Information.....	49
Access to Information.....	49
Public Policy Participation Procedure	50
Access+ Satisfaction.....	50
Organ and Tissue Donation	50
Member Services	50
For all Services other than Mental Health and substance abuse.....	50
For all Mental Health and substance abuse Services.....	51
Grievance Process.....	51
For all Services other than Mental Health and substance abuse.....	51
For all Mental Health and substance abuse Services.....	51
For all Services.....	52
External Independent Medical Review.....	52
Department of Managed Health Care Review.....	52
Definitions	52
Notice of the Availability of Language Assistance Services.....	59

Access+ HMO Summary of Benefits

What follows is a summary of your benefits and the copayments applicable to the benefits of your plan. A more complete description of your benefits is contained in the PLAN BENEFITS section. Please be sure to read that section and the exclusions and limitations in the EXCLUSIONS AND LIMITATIONS section for a complete description of the benefits of your plan.

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

For Benefits that have a visit maximum, all visits count toward the visit maximum, regardless of whether the Calendar Year Deductible has been satisfied, or you have reached the Maximum Calendar Year Copayment Responsibility.

Should you have any questions about your plan, please call the Member Services Department at: 1-800-431-2809.

SUMMARY OF BENEFITS¹

Access+ HMO Plan

Member Calendar Year Deductible (Medical Plan Deductible)	Deductible Responsibility
<p>Member's Calendar Year Deductible*</p> <ul style="list-style-type: none"> ▪ The Calendar year Deductible is \$2,000 per Member and \$4,000 per Family for the following facility Services: ▪ Inpatient Hospital Services ▪ Outpatient Hospital Surgery Services ▪ Skilled Nursing Facility Services ▪ Ambulatory surgery center Services and ▪ Continuous home care provided during a period of crisis and general inpatient care for Hospice Program Services 	<p>\$2,000 per Member \$4,000 per Family</p>

*Before the Plan provides Benefit payments for the covered facility Services listed above, the Deductible must be satisfied once during the Calendar Year by or on behalf of each Member separately. Payments applied to your Calendar Year Deductible accrue towards the Member Maximum Calendar Year Copayment.

Member's Maximum Calendar Year Copayment Responsibility	Member's Maximum Calendar Year Copayment
<p>Member's Maximum Calendar Year Copayment</p> <p>Member's maximum Calendar Year Copayment for all Covered Services except for:</p> <p>Access+ Dentist Services;</p> <p>Access+ Specialist visits including visits for Mental Health and substance abuse Services;</p> <p>Durable Medical Equipment, Prostheses and other Services except for Prostheses in connection with laryngectomies, supplies/equipment in connection with Diabetes Care, and nebulizers and peak flow monitors for the treatment of asthma;</p> <p>Internet-based Consultation;</p> <p>Orthoses (except for Orthoses in connection with Diabetes Care);</p> <p>Outpatient Prescription Drugs;</p> <p>Outpatient Psychiatric Care* for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child and substance abuse Services excluding the initial visit.</p> <p>*Note: Outpatient Partial Hospitalization Psychiatric Care and Outpatient electroconvulsive therapy (ECT) Services do apply to the Member's maximum Calendar Year Copayment</p>	<p>\$3,000 per Member \$6,000 per Family</p>

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

Services	Member Copayment
<p>Access+ Specialist Office Visit An office visit, examination or other consultation with a Plan Specialist in the same Medical Group or IPA as the Member's Personal Physician.</p> <p>Conventional x-rays, laboratory Services, diagnostic tests</p> <p>Note: See the How to Use your Health Plan section for more information and for a list of services which are not covered under this Benefit. Your Medical Group or IPA must be an Access+ Provider in order for you to use this Benefit. Refer to the HMO Physician and Hospital Directory or call Member Services at the number provided on the back page of this booklet to determine whether a Medical Group or IPA is an Access+ Provider.</p>	<p>\$35 per visit</p> <p>No Charge</p>
<p>Allergy Testing and Treatment Allergy serum purchased separately for treatment</p> <p>Office visits including injectables and serum</p>	<p>50% of Allowed Charges</p> <p>\$20 per visit</p>
<p>Ambulance Services Emergency and non-emergency Services</p>	<p>\$50 per trip</p>
<p>Ambulatory Surgery Center Services Surgery</p> <p>Services and supplies for treatment (including radiation and chemotherapy)</p> <p>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 the Hospital Services section.</p>	<p>\$150 per visit after the Deductible requirement is met.</p> <p>\$35 per visit</p>
<p>Diabetes Care Diabetic Equipment Diabetes Self-Management Training, education</p>	<p>50% of Allowed Charges</p> <p>\$20 per Day</p>
<p>Durable Medical Equipment and Prostheses Prostheses (except those provided to restore and achieve symmetry incident to a mastectomy, which are covered under the Reconstructive Surgery Benefit and specified devices following a laryngectomy, which are covered under Physician Services, surgical Benefits), Durable Medical Equipment and oxygen⁽²⁾</p> <p>Surgically implanted devices and supplies</p>	<p>50% of Allowed Charges</p> <p>Office: Physician Services Copayments apply Outpatient facility Services Copayment applies (in an Outpatient Facility)</p>
<p>Emergency Room Benefits Emergency room Physician Services Emergency room Services not resulting in admission Emergency room Services resulting in admission (billed as part of Inpatient Hospital Services)</p> <p>Note: For emergency ambulance Services, see the Ambulance Benefits section of this Summary of Benefits. Copayment applies after Deductible requirement is met.</p>	<p>\$20 per visit</p> <p>\$75 per visit</p> <p>\$250 per admission</p>

Services	Member Copayment
<p>Family Planning Services Elective Abortion Physician Office Visit for diaphragm fitting Injectable contraceptives when administered by a Physician Family Planning Counseling Tubal Ligation Vasectomy</p>	<p>\$100 per occurrence \$20 per visit \$25 per Injection plus Physician Services office visit copayment \$20 per visit \$20 per visit \$100 per occurrence unless done in conjunction with delivery or abdominal surgery) \$75 per occurrence</p>
<p>Home Health Care Benefits⁽³⁾ Home health care services 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 home health care visits by home health care agency providers per Member per Calendar Year. Medical supplies and related laboratory Services to the extent the Benefits would have been provided had the Member retained in the hospital or Skilled Nursing Facility.</p>	<p>\$20 per visit No charge</p>
<p>Home Infusion/Home Injectable Therapy Benefits Home visits by an infusion nurse Home infusion/home IV injectable therapy provided by a Home Infusion Agency⁽³⁾ Intravenous solutions/injectable⁽³⁾ medications and related lab services and medical supplies Note: There is a combined Benefit maximum of 100 visits per Member per Calendar Year for all visits by Home Health Care and Home Infusion Agency providers.</p>	<p>\$20 per visit No charge No charge</p>
<p>Hospice Program Services when received and authorized by a Participating Hospice Agency Continuous Home Care provided during a Period of Crisis General Inpatient Care Inpatient Respite Care Pre-hospice consultative visit Routine Home Care</p>	<p>\$50 per day After the medical Deductible is met, \$50 per day No charge No charge No charge</p>
<p>Hospital Services Inpatient Hospital Services for acute medical detoxification due to substance abuse. Inpatient services including semi-private room and board; operating room, intensive cardiac care units, general nursing care, Subacute Care, drugs, medications, oxygen, blood and blood plasma.⁽²⁾ Outpatient Services for renal dialysis, radiation therapy, chemotherapy, treatment and supplies Outpatient Services for surgery and necessary supplies</p>	<p>\$250 per admission after the Deductible requirement is met \$250 per admission after the Deductible requirement is met \$35 per visit \$250 per visit after the Deductible requirement if met</p>

Services	Member's Copayment
<p>Mental Health and Substance Abuse Access+ Specialist Services An office visit, examination or other consultation for Mental Health and substance abuse conditions with an MHSA⁽⁴⁾ Participating Provider without a referral from the MHSA Note: See the Mental Health and Substance Abuse paragraphs in the How to Use Your Health Plan section for more information. Psychological testing and written evaluation are not covered under this Benefit.</p>	\$35 per visit
<p>Mental Health and Substance Abuse Services. All non-emergency Mental Health and substance abuse Services must be arranged through the MHSA⁽⁴⁾ and prior authorized by MHSA The Member Copayment for the initial visit to determine the condition and diagnosis of the Member (except for Mental Health and substance abuse Services Access+ Specialist visits) will be the Physician office visit Copayment amount. Mental Health and substance abuse Services Access+ Specialist visits will accrue toward the 20-visit per Calendar Year maximum. Initial visits which are subsequently diagnosed as being for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for substance abuse care will also accrue toward the 20-visit maximum.</p> <p>Outpatient psychiatric Partial Hospitalization for the treatment of mental illnesses</p> <p>Outpatient Psychiatric Care for other than severe mental illnesses or serious emotional disturbances of a child, and substance abuse counseling up to 20 visits per Calendar Year.</p> <p>Outpatient Psychiatric Care, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT) for Severe Mental Illness of a Member of any age and of Serious Emotional Disturbances of a Child.</p> <p>Psychological testing</p> <p>Psychosocial Support through Life Referrals 24/7</p>	<p>Professional Services: \$20 per visit</p> <p>\$150 per episode of care⁽⁵⁾ after the Deductible requirement is met</p> <p>\$20 per visit</p> <p>\$20 per visit</p> <p>\$20 per visit</p> <p>No charge</p>
<p>Orthoses Medically Necessary Orthoses for Activities of Daily Living</p>	50% of Allowed Charges ⁽⁶⁾

Outpatient Prescription Drug Benefits

Brand Name Drug Deductible	Member Responsibility	
	Participating Pharmacy	Non-Participating Pharmacy⁷
Brand Name Drug Deductible Per Member Applicable to all covered Brand name Drugs, including Home Self-Administered Injectables.	\$200 per Member per Calendar Year	

Benefit	Member Copayment	
	Participating Pharmacy	Non-Participating Pharmacy⁹
Retail prescriptions		
Formulary Generic Drugs	\$10	Not covered
Formulary Brand Name Drugs	\$35	Not covered
Non-Formulary Brand Name Drugs	Not covered	Not covered
Home Self-Administered Injectables, including any combination kit or package containing both oral and Self-Administered Injectable Drugs	20% of Blue Shield's negotiated pharmacy contracted rate, up to a maximum of \$100 for each prescription	Not covered
Mail service prescriptions		
Formulary Generic Drugs	\$20	Not covered
Formulary Brand Name Drugs	\$70	Not covered
Non-Formulary Brand Name Drugs	Not covered	Not covered
Home Self-Administered Injectables, including any combination kit or package containing both oral and Self-Administered Injectable Drugs	Not covered	Not covered

Services	Member Copayment
<p>PKU Related Formulas and Special Food Products PKU related formulas and Special Food Products</p>	No Charge
<p>Pregnancy, Maternity Care, and Routine Circumcision. (Pregnancy and Maternity Care are a waived condition benefit, excluded from coverage for charges and expenses incurred during the six months following the effective date of coverage).</p> <p>All necessary Inpatient Hospital Services for normal delivery, routine newborn circumcision, caesarian section, and involuntary complications of pregnancy, or related medical conditions arising from pregnancy or resulting childbirth.</p> <p>Outpatient Routine Newborn circumcision performed within 31 days of birth unrelated to illness or injury.</p>	<p>\$250 per admission after the Deductible is met</p> <p>Office: \$20 per visit Outpatient facility: \$250 per visit after Deductible is met Ambulatory Surgery Center: \$150 per visit after Deductible is met</p>
<p>Preventive Health Services Routine physical exams, including well-baby, well child, women’s gynecological exams and adult exams according to schedule.</p> <p>Medically Necessary immunizations as defined.</p> <p>Colorectal Cancer Screening</p> <p>Health education/health promotion services</p> <p>Osteoporosis Screening</p> <p>Vision/hearing screening by Personal Physician for Members under 18.</p>	<p>\$20 per visit No Copayment other than the office visit copayment will be charged for a covered Pap test or other Food and Drug Administration (FDA) approved cervical cancer and human papillomavirus virus (HPV) screening tests or mammography</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Professional (Physician) Services Office visits including surgery, chemotherapy, radiation therapy, diabetic counseling, asthma self-management training, audiometry examinations when performed by a Physician or by an audiologist at the request of a Physician, second opinion consultations when authorized or OB/GYN Services from an obstetrician/gynecologist or family practice Physician who is within the same Medical Group/IPA as the Personal Physician.</p> <p>Home visits by Plan Physician.</p> <p>Lab, X-ray, diagnostic tests</p> <p>Inpatient Hospital and Skilled Nursing Facility Services by Physicians, including the Services of a surgeon, assistance surgeon, anesthesiologist, pathologist and radiologist.</p> <p>Injectable medications</p> <p>Internet-based consultations</p>	<p>\$20 per visit</p> <p>\$35 per visit</p> <p>\$20 per visit</p> <p>\$20 per visit</p> <p>\$20 per visit</p> <p>\$10 or office visit copayment, whichever is less</p>

Services	Member Copayment
<p>Reconstructive Surgery Inpatient or outpatient surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance, reconstructive surgery incident to a mastectomy and prosthetic devices provided to restore and achieve symmetry incident to a mastectomy. ⁽⁸⁾</p>	Professional Services: \$20 per visit Hospital Services: \$250 per admission
<p>Rehabilitation Services Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings: In the Rehabilitation unit of a Hospital for Medically Necessary days In an Outpatient department of a Hospital, or In an office location.</p>	Hospital Services Copayments apply Skilled Nursing Facility Services Copayments apply \$20 per visit \$20 per visit
<p>Skilled Nursing Facility Services Inpatient Skilled Nursing Facility Services, including Subacute Care and other necessary Services and supplies for up to 100 days per Calendar Year. ⁽²⁾⁽⁹⁾</p>	\$50 per day after the Deductible requirement is met
<p>Speech Therapy Services Speech Therapy Services by a licensed speech pathologist or certified speech therapist in the following settings: In an Outpatient department of a Hospital, or In the Rehabilitation unit of a Hospital for Medically Necessary days, or In the Skilled Nursing Facility Rehabilitation unit for Medically Necessary days, or</p>	Hospital Services Copayments apply. Skilled Nursing Facility Services Copayment applies \$20 per visit
<p>Transplant Benefits Organ Transplant Benefits – Inpatient Hospital and professional Services for transplant of a cornea, kidney or skin and Services to obtain the human organ transplant with prior written authorization of Blue Shield’s Medical Director Special Transplant Benefits – Inpatient Hospital and professional Services for transplants of human heart, lung, heart and lung 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 as specified in the Description of Benefits, and Services to obtain the human transplant material</p>	Hospital Services: \$250 per admission after the Deductible requirement is met Professional Services: \$20 per visit Hospital Services: \$250 per admission after the Deductible requirement is met Professional Services: \$20 per visit
<p>Urgent Services Urgent Services outside your Personal Physician Service Area Medically Necessary Out-of-Area Follow-up Care is covered. Note: See the “Using your Health Plan” section for more information.</p>	\$50 per visit

Footnotes

- ¹ All Benefits must be provided or authorized by your Personal Physician and/or the Medical Group/IPA except in an emergency or as otherwise specified.
- ² For care received by a Participating Hospice Agency, see the Hospice Program Services section.
- ³ Home infusion injectable medications require prior authorization by Blue Shield and must be obtained from Home Infusion Agencies. See the Outpatient Prescription Drugs section for coverage of home self-administered injectable medication.
- ⁴ The MHSA, Mental Health Services Administrator, is a specialized health care service plan contracted by Blue Shield to administer all Mental Health Services.
- ⁵ 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.
- ⁶ This Covered Service has a Benefit maximum of \$2,000 per Member per Calendar Year.
- ⁷ See the Outpatient Prescription Drugs section under Plan Benefits for a description of Blue Shield's process for authorization of Non-Formulary Drugs.
- ⁸ The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the Reconstructive Surgery section.
- ⁹ Skilled nursing Services are limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency.

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: All Services except those meeting the Emergency and Urgent Services requirements must have prior approval by the Personal Physician, Medical Group/IPA or MHSA, including those the Member obtains after the Maximum Calendar Year Copayment has been met. The Member will be responsible for payment of services that are not authorized, those that are not an Emergency or covered Urgent Service procedures or Mental Health and substance abuse Services not authorized by the MHSA. Members must obtain Services from the Plan Providers that are authorized by their Personal Physician.

The following Summary of Benefits for the Access+ Dentist is separate from the Access+ HMO Health Plan coverage. The Calendar Year Copayment Maximum and the Calendar Year Deductible provisions in the Access+ HMO Health Plan do not apply to these benefits. See the Dental Benefits – Access+ Dentist section for more information.

SUMMARY OF BENEFITS*

Access+ Dentist

Member Calendar Year Deductible (Dental Plan Deductible)	Deductible Responsibility
There is no Dental Plan Deductible for the Calendar Year.	None

Member's Maximum Calendar Year Copayment Responsibility	Member's Maximum Calendar Year Copayment
There is no maximum year Copayment responsibility for this Access+ Dentist Plan.	None

Dental Benefit - Access+ Dentist

Services	Member Copayment
Diagnostic and Preventive Services clinical oral examinations; dental prophylaxis; diagnostic casts; and x-rays	\$20 per visit
Full mouth series x-rays (limited to one series in any period of 36 consecutive months)	\$10, in addition to the \$20 per visit Copayment
Sealants (limited to Members under age 16, one treatment to permanent molars only in any period of 60 consecutive months)	\$10 per tooth up to a maximum of 4 teeth per lifetime, in addition to the \$20 per visit copayment
space maintainers (limited to Members under age 16)	\$40 or Billed Charge whichever is less for lab fees, in addition to the \$20 per visit copayment
Major Services	80% of the Access+ Dentist's Billed Charges
Additional Services	80% of the Access+ Dentist's Billed Charges
Emergency Services a. In State Note: Palliative treatment received for Emergency services from a non-Access+ Dentist is covered. b. Out-of-State	Member copayments for services shown above \$50 or Billed Charge whichever is less.

Blue Shield's Access+ HMO Health Plan

Evidence of Coverage and Health Service Agreement

INTRODUCTION

Your interest in Blue Shield's Access+ HMO Health Plan is truly appreciated. Blue Shield has served California for over 65 years, and we look forward to serving your health care needs.

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

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

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

To determine whether a provider is a Plan Provider, consult the Blue Shield HMO Directory of Physicians and Hospitals. 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 at the back of this booklet.

NOTE: A Plan Provider status may change. It is your obligation to verify whether the Physician, Hospital, or Alternate Care Services provider you choose is a Plan Provider, in case there have been any changes since your directory was published.

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

- Services received during an Access+ Specialist visit,
- OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group or IPA as your Personal Physician,
- Emergency Services, or

- Mental Health and substance abuse Services.*

*See the *Mental Health and Substance Abuse Services* paragraphs in the Using Your Health Plan section for information.

NOTE: A decision will be rendered on all requests for prior authorization of Services as follows:

- for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other Services, within five (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 two (2) business days of the decision.

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

As a partner in health with Blue Shield, you will receive the benefit of Blue Shield's commitment to service, an unparalleled record of more than 65 years.

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

If you have any questions, contact the Member Services Department at 1-800-431-2809. Members may also submit questions to the Member Services Department by accessing Blue Shield of California's Internet site located at <http://www.blueshieldca.com>.

CHOICE OF PHYSICIANS AND PROVIDERS

Selecting a Personal Physician

Each covered Family Member is required to select a Personal Physician at the time of enrollment. This decision is an important one because your Personal Physician will:

1. Help you decide on actions to maintain and improve your total health;
2. Coordinate and direct all of your medical care needs;
3. Work with your Medical Group/IPA to arrange your referrals to Plan Specialists, Hospitals, and all other health Services, including requesting any prior authorization you will need;
4. Authorize Emergency Services when appropriate;
5. Prescribe those lab tests, x-rays, and Services you require; and,

6. If you request it, assist you in obtaining prior approval from the MHSA for Mental Health and substance abuse Services.*

*See the *Mental Health and Substance Abuse Services* paragraphs in the Using Your Health Plan section for information.

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

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

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption, but always within 31 days from the date of birth or placement for adoption. 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 of 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 Conditions of Coverage section of this Evidence of Coverage.

Role of the Medical Group or IPA

Most Blue Shield Access+ HMO Personal Physicians contract with Medical Groups or IPAs to share administrative and authorization responsibilities with them. 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 special arrangements that designate a specific hospital as "in network." Your designated Medical Group/IPA works with your Personal Physician to authorize Services and ensure that service is performed by their in-network provider.

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

Changing Personal Physicians or Designated Medical Group or IPA

You or your Dependent may change Personal Physicians or designated Medical Group/IPA by calling Member Services at 1-800-431-2809 or submitting a Member Change Request Form to the Member Services Department. Some Personal Physicians are affiliated with more than one Medical Group/IPA. If you change to a Medical Group/IPA with no affiliation to your Personal Physician, you must select a new Personal Physician affiliated with the new Medical Group/IPA and transition any specialty care you are receiving to specialists affiliated with the new Medical Group/IPA. The change will be effective the first day of the month following notice of approval by Blue Shield. Once your Personal Physician change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group or IPA as your Personal Physician, and Access+ Specialist visits.

Once your Medical Group/IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new Medical Group/IPA, even if you remain with the same Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician or Medical Group/IPA.

Voluntary Medical Group/IPA changes are not permitted during the third trimester of pregnancy or while confined to a Hospital. The effective date of your new Medical

Group/IPA will be the first of the month following discharge from the Hospital, or when pregnant, following the completion of post-partum care.

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

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

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

Continuity of Care by a Terminated Provider

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

Relationship with Your Personal Physician

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

If your Personal Physician recommends procedures or treatments that 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 or she 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 available 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.

USING YOUR HEALTH PLAN

Use of Personal Physician

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

The Personal Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care Services and requesting any needed prior authorization. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Personal Physician or the Mental Health Service Administrator (MHSA) and self-arranged appointments with an Access+ Specialist or for OB/GYN Services. Because your Physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the Physician. Some offices may advise you that a fee (not to exceed your Copayment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Personal Physician for any reason, you must contact Member Services at 1-800-431-2809, Monday through Friday, between 8 A.M. and 5 P.M. to select a Personal Physician to obtain Benefits.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/or gynecological (OB/GYN) Services by an obstetrician/gynecologist or family practice Physician who is not her designated Personal Physician without obtaining a referral. However, the obstetrician/gynecologist or family

practice Physician must be in the same Medical Group/IPA as her Personal Physician.

Obstetrical and gynecological Services are defined as:

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

It is important to note that Services by an OB/GYN or family practice Physician outside of the Personal Physician's Medical Group or IPA without authorization will not be covered under this Plan. Before making the appointment, the Member should call the Member Services Department at 1-800-431-2809 to confirm that the OB/GYN is in the same Medical Group or IPA as her Personal Physician.

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

Referral to Specialty Services

Although self-referrals to Plan Specialists are allowed through the Access+ Specialist feature described below, Blue Shield encourages you to receive specialty Services through a referral from your Personal Physician. The Personal Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty Services. Your Personal Physician will generally refer you to a Plan Specialist or Plan Non-Physician Health Care Practitioner in the same Medical Group or IPA as your Personal Physician, but you can be referred outside the Medical Group or IPA if the type of specialist or Plan 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 Care and substance abuse Benefits, see the Mental Health and Substance Abuse paragraphs in the Using Your Health Plan section for information regarding how to access care. The Plan Specialist or Plan Non-Physician Health Care Practitioner will provide a complete report to your Personal Physician so that your medical record is complete. You may contact Member Services at 1-800-431-2809 for information on Plan Non-Physician Health Care Practitioners in your Personal Physician Services Area.

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

Personal Physician will designate the Plan Provider from whom you will receive Services.

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

Second Medical Opinion

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Personal Physician to refer you to another Physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from your Personal Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA as your Personal Physician. If you are requesting a second opinion about care received from a specialist, any Plan Specialist of the same or equivalent specialty may provide the second opinion. 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.

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

Access+ Specialist

You may arrange an office visit with a Plan Specialist in the same Medical Group or IPA as your Personal Physician without a referral from your Personal Physician, subject to the limitations described below. Access+ Specialist office visits are available only to Members whose Personal Physicians belong to a Medical Group or IPA that participates as an Access+ Provider. Refer to the Access+ HMO Physician and Hospital Directory or call Blue Shield Member Services at 1-800-431-2809 to determine whether a Medical Group or IPA is an Access+ Provider. This in-

formation is also available on Blue Shield of California's Internet site located at <http://www.blueshieldca.com>. You will be responsible for the Copayment listed in the Summary of Benefits for each Access+ Specialty visit. This Copayment is in addition to any Copayments that you may incur for specific Benefits as described in the Plan Benefits section. Each follow-up office visit with the Plan Specialist which is not referred or authorized by your Personal Physician is a separate Access+ Specialist visit and requires a separate Copayment.

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

NOTE: For Access+ Specialist visits for Mental Health and substance abuse Services, see the following *Mental Health and Substance Abuse* paragraphs.

The Access+ Specialist visit includes:

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

An Access+ Specialist visit does not include:

- Any Services which are not covered or which are not Medically Necessary;
- Services provided by a non-Access+ Provider (such as podiatry and Physical Therapy), except for the x-ray and laboratory Services described above;
- Allergy testing;
- Endoscopic procedures;
- Any diagnostic imaging including CT, MRI, or bone density measurement;
- Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics;
- Infertility Services;
- Emergency Services;
- Urgent Care Services;

- Inpatient Services, or any Services which result in a facility charge, except for the x-ray and laboratory Services described above;
- Services for which the Medical Group or IPA routinely allows you to self-refer without authorization from the Personal Physician;
- OB/GYN Services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician;
- Internet Based Consultations.

NurseHelp 24/7 and LifeReferrals 24/7

NurseHelp 24/7 and LifeReferrals 24/7 programs provide Members with no charge confidential, unlimited 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. Additional information may also be obtained by accessing Blue Shield of California's Internet site located at <http://www.blueshieldca.com>.

These programs include:

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

Psychosocial support through LifeReferrals 24/7 – Members may call 1-800-985-2405 on an unlimited, 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

Note: see the following Mental Health and Substance Abuse Services paragraphs for important information concerning this feature.

Mental Health and Substance Abuse Services

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

All Mental Health and substance abuse Services, except for Emergency or Urgent Services, must be provided by an MHSA network Participating Provider. MHSA Providers are indicated in the Blue Shield of California Behavioral

Health Provider Directory. Members may contact the MHSA directly for information on, and to select, an MHSA Provider by calling 1-877-263-9952. Your Personal Physician may also contact the MHSA to obtain information regarding MHSA Participating Providers for you.

Non-Emergency Mental Health and substance abuse Services received from a Provider who does not participate in the MHSA Participating Provider network will not be covered, and all charges for these services will be the Member's responsibility.

For complete information regarding Benefits for Mental Health and substance abuse Services, see the Plan Benefits section under Mental Health and Substance Abuse Services.

1. Prior Authorization

All Non-Emergency Mental Health and substance abuse Services must be prior authorized by the MHSA. For prior authorization of Mental Health and substance abuse Services, the Member should contact the MHSA at 1-877-263-9952.

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

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

- for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other Services, within five (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 two (2) business days of the decision.

2. Access+ Specialist Visits for Mental Health and substance abuse Services

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

The Member may arrange for an Access+ Specialist office visit for Mental Health and substance abuse Services without a referral from the MHSA, as long as the Provider is an MHSA Participating Provider. Refer to the Blue Shield of California Behavioral Health Provider Directory or call the MHSA Member Services at 1-877-263-9952 to determine the MHSA Participating Providers. Members will be responsible for the Copayment listed in the Summary of Benefits for each Access+ Specialist Visit for Mental Health and substance abuse Services. Each follow-up office visit

for Mental Health and substance abuse Services which is not referred or authorized by the MHSA is a separate Access+ Specialist visit and requires a separate Copayment.

Access+ Specialist Visits for Mental Health and substance abuse Services are subject to, and accrue toward the Calendar Year Benefit visit maximum as specified in the Plan Benefits section under Mental Health and Substance Abuse Services.

3. Psychosocial Support through LifeReferrals 24/7

Notwithstanding the Benefits provided under the Mental Health and Substance Abuse Services section, the Member also may call 1-800-985-2405 on an unlimited, 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 (3) no charge, face-to-face visits within a six (6) month period. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and Substance abuse Services.

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 and Substance abuse Services which are described under the Mental Health and Substance Abuse Services section.

Inpatient, Home Health Care, Hospice Program, and Other Services

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

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 the Plan Benefits section on Pregnancy and Maternity

Care, for information relative to the Newborns' & Mothers' Health Protection Act.

Emergency Services

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.

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

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.

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

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

Urgent Services

Blue Shield Access+ HMO provides coverage for you and your Family for your urgent service needs when you or your Family are temporarily traveling outside of your Personal Physician Service Area. Temporarily traveling is defined as a Member or Dependent who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.

Urgent Services are defined as those Covered Services rendered outside of the Personal Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury, or complications of an existing medical condition, for which treatment 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.

Outside of California

The Blue Shield Access+ HMO provides coverage for you and your family for your Urgent Service needs when you and your family are temporarily traveling outside of Cali-

fornia. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement.

Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Through the BlueCard® Program, you can access urgent care services across the country and around the world. While traveling within the United States, you can locate a BlueCard provider anytime by calling 1-800-810-BLUE (2583) or going online at www.bcbs.com and selecting the "Find a Doctor of Hospital" tab. If you are traveling outside of the United States, you can call (804) 673-1177 collect 24 hours a day to locate a BlueCard Worldwide® Network provider.

Out of Area Follow-up Care is covered and services may be received through the BlueCard® Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two (2) Out of Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up Services from the Personal Physician.

If services are not received from a BlueCard 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 and Out-of-Area Follow-up Care rendered outside of California and not provided by a BlueCard Program participating provider will be reviewed retrospectively for coverage.

Under the BlueCard Program, when you obtain health care Services outside of California, the amount you pay, if not subject to a flat dollar Copayment, is calculated on the lower of:

1. The Allowed Charges for your Covered Services, or
2. The negotiated price that the local Blue Cross and/or Blue Shield plan passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the local Blue Cross and/or Blue Shield plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected saving with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield plan to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, Blue Shield of California would then calculate your liability for any covered health care Services in accordance with the applicable state statute in effect at the time you received your care.

For any other providers, the amount you pay, if not subject to a flat dollar copayment, is calculated on the provider's billed charges for your covered services.

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Member Services at 1-800-431-2809 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://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. Remember that when you are within your Personal Physician Service Area, Urgent Services must be provided or authorized by your Personal Physician just like all other non-Emergency Services of the Plan. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

If services are not received from a Blue Shield of California Plan Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield 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 Service Area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's Allowed Charges.

Deductible and Copayments

You are responsible for paying a minimum charge (Copayment), when applicable, to the physician or provider of Services at the time you receive Services. The specific

Copayments, as applicable, are listed in the Summary of Benefits.

Medical Plan Deductible

The Calendar Year Deductible is listed in the Summary of Benefits. The Calendar Year Deductible, which is based on Allowed Charges, applies to facility charges for Inpatient Hospital Services, Outpatient Hospital surgery Services, Skilled Nursing Facility Services, and Ambulatory Surgery Center Services. Additionally, the Calendar Year Deductible applies to Continuous Home Care provided during a Period of Crisis and General Inpatient Care as described in the section entitled Hospice Program Services.

Before Benefits will be provided for these Services, the Deductible must be satisfied once during the Calendar Year by or on behalf of each Member separately, except that the Deductible shall be met with respect to the Member 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.

Note: The Calendar Year Deductible is separate from the Brand Name Drug Deductible (see Outpatient Prescription Drugs section).

Member Maximum Lifetime Benefits

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

Member's Calendar Year Copayment Maximum Responsibility

Your Copayment Maximum responsibility each Calendar Year for Covered Services, except those listed below, is listed 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. Additionally, when a Member and a 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.

*Certain Services are not included in the calculation of the Maximum Calendar Year Copayment as indicated below.

Copayments for the following Services, if covered, do not apply towards the Member's Calendar Year Copayment Maximum responsibility:

1. Internet-based Consultation;

2. Outpatient visits* for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child and for substance abuse visits or sessions;
3. Durable Medical Equipment, Prostheses, and other Services except for
 - a. prostheses for speech following a laryngectomy as specifically provided under the Durable Medical Equipment, Prostheses, and Other Services section; and,
 - b. supplies/equipment as specifically provided under the Diabetes Care section; and,
 - c. nebulizers and peak flow monitors for the treatment of asthma;
4. Orthoses (except for orthoses as specifically provided under Diabetes Care in the Plan Benefits section);
5. Outpatient Prescription Drugs;
6. Access+ *Dentist* Services;
7. Access+ Specialist Visits including Access+ Specialist Visits for Mental Health and substance abuse Services.

*Note: Outpatient Partial Hospitalization Psychiatric Care Services do apply to the Member's maximum Calendar Year Copayment.

Charges for Services not covered and Services not prior approved by the Personal Physician, except those meeting the emergency and urgent care requirements, are your responsibility, do not apply towards the Member's Calendar Year Copayment Maximum, and may cause your payment responsibility to exceed the Member's Calendar Year Copayment Maximum Responsibility defined above.

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

Payments applied to your Calendar Year Deductible also accrue towards the Calendar Year Copayment Maximum.

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

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

Liability of Subscriber or Member for Payment

It is important to note that all Services except those meeting the emergency and out of service area Urgent Services requirements, Access+ Specialist Visits, Hospice Program Services received from a Participating Hospice Agency after the Member has been accepted into the Hospice Program, OB/GYN Services by an obstetrician/gynecologist or family practice Physician who is in the same Medical Group/IPA as the Personal Physician, and all Mental Health and substance abuse Services, must have prior authorization by the Personal Physician or Medical Group/IPA. The Member will be responsible for payment of Services that are not authorized or those that are not emergency or covered out of service area urgent service procedures. (See the previous Urgent Services paragraphs for information on receiving Urgent Services out of the service area but within California.) Members must obtain Services from the Plan Providers that are authorized by their Personal Physician or Medical Group/IPA and, for all Mental Health and substance abuse Services, from MHSA Participating Providers. Hospice Services must be received from a Participating Hospice Agency.

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

Limitation of Liability

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

If a Plan Provider ceases to be a Plan Provider, you will be notified if you are affected. The Plan will make every reasonable and medically appropriate provision to have another Plan Provider

assume responsibility for services to you. You will not be responsible for payment (other than Copayments) to a former Plan Provider for any authorized Services you receive. Once provisions have been made for the transfer of your care, Services of a former Plan Provider are no longer covered.

Utilization Review

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

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

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

PLAN SERVICE AREA

The Plan Service Area of this Plan is identified in the Blue Shield Access+ HMO Physician and Hospital Directory. You and your eligible Dependents must live or work in the Plan Service Area identified in that document to enroll in this Plan.

DUES

Monthly Dues are as stated in the Appendix. Blue Shield of California offers a variety of options and methods by which you may pay your Dues. Please call Member Service at 1-800-431-2809 to discuss these options or visit the Blue Shield of California internet site at <http://www.blueshieldca.com>.

Payments by mail are to be sent to:

Blue Shield of California
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional Dues may be charged in the event that a State or any other taxing authority imposes upon Blue Shield a tax or license fee that is calculated upon base Dues or Blue Shield's gross receipts or any portion of either. Dues increase according to the Subscriber's age, as stated in the Appendix. Dues may also increase from time to time as determined by Blue Shield of California. You will receive 30 days written notice of any changes in the monthly Dues for this Plan.

CONDITIONS OF COVERAGE

Enrollment

1. Enrollment of Members or Dependents is not effective until Blue Shield of California approves an application and accepts the applicable Dues. Applications can be approved only by Blue Shield of California's Underwriting Department.

2. An applicant, upon completion and approval by Blue Shield of California of the application, is entitled to the Benefits of this Agreement upon the Effective Date.*

* By completing an application, Subscribers and Dependents agree to cooperate with Blue Shield of California by providing or providing access to documents and other information that Blue Shield of California may request to corroborate the information that was provided in the application for coverage. If Subscribers or Dependents fail or refuse to provide documents or information to Blue Shield of California, coverage under this Plan may be cancelled.

3. The Effective Date of the Benefits of a newborn child will be the date of birth if the Member contacts Blue Shield of California at the Customer Service telephone number listed at the back of this booklet, to have the newborn child added to this Agreement as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 32nd day.

If the Member wishes to add a newborn child as a Dependent 32 or more days after birth, Blue Shield of California will require the submission of a completed application and the child will be subject to medical underwriting. This may result in the child being declined coverage by Blue Shield of California.

Unless the child is enrolled, eligibility during the first 31 days includes treatment for injury or illness only, but does not include Well-baby care Benefits. Well-baby care Benefits are provided for enrolled children.

4. The Effective Date of Benefits for an adopted child will be the date the Subscriber or spouse or Domestic Partner has the right to control the child's health care, if the Member requests the child be added to this Agreement as a Dependent. Such request must be made within 31 days of the date the Member, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 32nd day.

To add a child placed for adoption to this Agreement as a Dependent, the Subscriber must contact Blue Shield of California at the Customer Service telephone number listed at the back of this booklet. The Customer Service Department will advise the Member of the exact process for adding a child placed for adoption as a Dependent, including, but not limited to, the necessary documentation and how the documentation shall be submitted to Blue Shield of California. Enrollment requests for an adopted child must be accompanied by evidence of the Subscriber's or spouse's or Domestic Partner's right to control the child's health care, which includes a facility minor release report, a medical authorization form, or a relinquishment form.

If the Member wishes to add a child placed for adoption as a Dependent 32 or more days after the date the Member, spouse, or Domestic Partner has the right to control the child's health care, Blue Shield of California will require the submission of a completed application, and the child will be subject to the medical underwriting. This may result in the child being declined coverage by Blue Shield of California.

Unless the child is enrolled, eligibility during the first 31 days includes treatment for injury or illness only, but does not include Well-baby care Benefits. Well-baby care Benefits are provided for enrolled children.

5. If a court has ordered that you provide coverage for your spouse or 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 Section 3751.5 of the Family Code.

Limitation of Enrollment

1. Members must be residents of California, live or work in the Plan Service Area, and 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. Upon change of residence outside the Plan Service Area, this Agreement will terminate. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any. See the Transfer of Coverage section.
2. Dependent Benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled DEFINITIONS:
 - a. The date the Dependent child attains age 19, if not a full-time student.
 - b. The date the Dependent child attains the age of 23, if a full-time student.
 - c. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment,

dissolution of marriage, or termination of the domestic partnership from the Subscriber.

Duration of the Agreement

This Agreement shall be renewed upon receipt of prepaid Dues. Renewal is subject to Blue Shield's right to amend this Agreement. Any change in Dues or Benefits, including but not limited to Covered Services, deductible, Copayment, and annual copayment maximum amounts, is effective after 30 days notice from date of mailing to the Subscriber's address of record with Blue Shield.

Renewal of the Agreement

Blue Shield shall renew this Agreement, except under the following conditions:

1. Non-payment of Dues;
2. Fraud, misrepresentation, or omission;
3. Termination of plan type by Blue Shield;
4. Subscriber moves out of the Plan Service Area or the Member is no longer a Resident of California;
5. If a bona fide association arranged for the Subscriber's coverage under this Agreement, when that Subscriber's membership in the association ceases.

TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

Termination/Cancellation/Reinstatement of the Agreement

Blue Shield may terminate this Agreement together with all like Agreements by giving 90 days written notice. No Member shall be terminated individually by Blue Shield for any cause other than as provided under the CONDITIONS OF COVERAGE section. A Subscriber desiring to terminate this Agreement shall give Blue Shield 30 days written notice.

This Agreement may be cancelled by Blue Shield for false representations to, or concealment of material facts from, Blue Shield in any health statement, application, or any written instruction furnished to Blue Shield by the Member at any time before or after issuance of this Agreement, or fraud or deception in enrollment. Cancellation in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

The Agreement may also be cancelled if the Subscriber or Dependents fail or refuse to provide access to documents and other information that was provided in the application for coverage.

Blue Shield may terminate this Agreement for cause immediately upon written notice for the following:

- a. Material information that is false or misrepresented information provided on the enrollment application or given to the Plan;
- b. Permitting a non-Member to use a Member's identification card to obtain Services and Benefits;
- c. Obtaining or attempting to obtain Services or Benefits under this Agreement by means of false, materially misleading, or fraudulent information, acts, or omissions;
- d. Abusive or disruptive behavior which: (1) threatens the life or well-being of the Plan personnel, providers of Services, or (2) substantially impairs the ability of Blue Shield of California to arrange for Services to Member, or (3) substantially impairs the ability of providers of Services to furnish Services to the Member or to other patients.

Blue Shield may terminate this Agreement for cause upon 30 days written notice for the following:

- a. Inability to establish a satisfactory Physician-patient relationship after following the procedures in the Relationship with Your Personal Physician section;
- b. Failure to pay any Copayment or supplemental charge;
- c. Moving out of the Plan Service Area. See "Transfer of Coverage".

Blue Shield shall, within 30 days of the notice of termination or cancellation, return to the Subscriber the amount of prepaid Dues, if any, minus any monies paid by Blue Shield for Incurred claims that Blue Shield determines will not have been earned as of such terminating date. However, Blue Shield reserves the right to recoup all payments from the Subscriber for Incurred charges which exceed the Dues paid by the Subscriber, if this Agreement is cancelled for fraud or deception.

Cancellation of the Agreement for Nonpayment of Dues

If the Agreement is being cancelled because you failed to pay the required Dues when due, then coverage will end retroactively back to the last day of the month for which Dues were paid. This retroactive period will not exceed 60 days from the date of mailing of the Notice Confirming Termination of Coverage. The Plan will notify you in a Prospective Notice of Cancellation if your Dues have not been received. This notice will provide you with the following information:

- a. That Dues due have not been paid and that the Agreement will be cancelled if you do not pay the required Dues within 15 days from the date the Prospective Notice of Cancellation is mailed;

- b. The specific date and time when coverage for you and all of your Dependents will end if Dues are not paid;
- c. Information regarding the consequences of any failure to pay the Dues within 15 days.

Within five (5) business days of canceling or not renewing the Agreement, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

- a. That the Agreement has been cancelled, and the reasons for cancellation;
- b. The specific date and time when coverage for you and all your Dependents ended;
- c. Information regarding the availability of reinstatement of coverage under the Agreement.

Reinstatement of the Agreement after Cancellation

If the Agreement is cancelled for nonpayment of Dues, the Plan will permit reinstatement of the Agreement or coverage twice during any twelve-month period, without a change in Dues and without consideration of the medical condition of you or any Dependent, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you. If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Agreement is cancelled for nonpayment of Dues more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to re-apply for coverage. In this case, the Plan may impose different Dues and consider the medical condition of you and your Dependents.

Transfer of Coverage

If a Subscriber moves outside the Plan Service Area, but remains within California, as soon as the Subscriber notifies Blue Shield of the new address, Blue Shield can transfer coverage to a Blue Shield PPO Plan. Subscribers should notify Blue Shield of an address change within 30 days after moving.

If a Subscriber moves out of California, coverage under this Agreement will terminate. If a Subscriber moves out of state to an area served by another Blue Cross and/or Blue Shield (BC/BS) plan, the Subscriber's coverage may be transferred to the plan serving his new address.

1. The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to Subscribers who leave a group and apply for new coverage as individuals.
2. Conversion policies provide coverage without a medical examination or health statement.

3. If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this Plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.
4. The required Dues or premium amount and Benefits available from the new plan may vary significantly from this Plan.
5. In addition, the new plan may offer other types of coverage outside the transfer program which may:
 - require a medical examination or health statement to exclude coverage for pre-existing conditions; and
 - not credit the time enrolled in this Plan.

Commencement or Termination of Coverage

Whether this Agreement may provide for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of that date.

PLAN CHANGES

The benefits of this Plan, including but not limited to Covered Services, deductible, Copayment, and annual copayment maximum amounts, are subject to change at any time, Blue Shield will provide at least 30 days' written notice of any such change.

Benefits for Services or supplies furnished after the Effective Date of any change in Benefits will be provided based on the change. There is no vested right to obtain Benefits.

Entire Agreement: Changes

This Agreement, including the appendices, attachments, or other documents incorporated by reference, constitutes the entire Agreement. Any statement made by the Member shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by a corporate officer of Blue Shield and unless a written endorsement is issued. No representative has

authority to change this Agreement or to waive any of its provisions.

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are the Appendix pertaining to Dues, and any endorsements (amendments to this Agreement) that, from time to time, may be issued. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Member may be mailed to the most current address appearing on the records of Blue Shield of California. Notice to Blue Shield may be mailed to Blue Shield of California, 50 Beale Street, San Francisco, CA 94105.

PLAN BENEFITS

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

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

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

Except as specifically provided herein, Services are covered only when rendered by an individual or entity that is

licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

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

For many covered Services, the Member will only be responsible for a fixed dollar copayment. For other Services, a copayment percentage will apply. Copayment obligations are listed in the Summary of Benefits for each benefit description below. Unless otherwise indicated, Blue Shield of California's payment percentage is based upon the Allowed Charges.

Ambulance Services

The Plan will pay for ambulance Services as follows:

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

Claims for Emergency And Out-Of-Area Urgent Services

1. Emergency

If Emergency Services were received and expenses were incurred by the Member for Services other than medical transportation, the Member must submit a complete claim with the emergency service record for payment to the Plan, within one (1) year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the Services are not preauthorized, the Plan will review

the claim retrospectively for coverage. If the Plan determines that the Services were not in fact Emergency Services, would not otherwise have been authorized, and, therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. In the event covered medical transportation Services are obtained in such an emergency situation, the Blue Shield Access+ HMO shall pay the medical transportation provider directly.

2. Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating BlueCard Program provider you must submit a complete claim with the urgent service record for payment to the Plan, within one (1) year after the first provision of Urgent Services for which payment is requested.

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

Clinical Trial for Cancer

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 Plan Benefits section.

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 Department of Veterans Affairs; or
2. Involves a drug that is exempt under federal regulations from a new drug application.

Diabetes Care

1. Diabetic Equipment

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

- 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 Drugs section.

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.

Durable Medical Equipment, Prostheses, And Other Services

Medically Necessary Prostheses and Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, ostomy, and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function are covered. When authorized as DME, 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 (2) or more professionally recognized items equally appropriate for a condition, Benefits will be based on the most cost effective item.

1. Prostheses

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

- a. Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy;
- b. artificial limbs and eyes;
- c. Supplies necessary for the operation of Prostheses;
- d. Initial fitting and replacement after the expected life of the item;
- e. Repairs, even if due to damage.

Routine maintenance is not covered. Benefits do not include wigs for any reason, environmental control equipment, generators, self-help/educational devices, or any type of speech or language assistance devices except as specifically provided above. See the Exclusions and Limitations section for a listing of excluded speech and language assistance devices. No benefits are provided for backup or alternate items.

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: For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy are covered under Reconstructive Surgery. Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

2. Durable Medical Equipment

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

- a. Rental charges for Durable Medical Equipment in excess of purchase price are not covered;
- b. Routine maintenance or repairs, even if due to damage, are not covered;
- c. 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 Drugs section for Benefits for asthma inhalers and inhaler spacers.

NOTE: 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 additional information, please see the section entitled "Hospice Program Services" in the Plan Benefits section.

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

Emergency Services

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. If you obtain Emergency Services, you should notify the Personal Physician or the MHSA by phone 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 reasonably possible. The Services will be reviewed retrospectively by the Plan to determine whether the Services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition. Emergency Services Copayment does not apply if the Member is admitted directly to Hospital as an Inpatient from the emergency room.
2. **Continuing or Follow-up Treatment.** If you receive Emergency Services from a Hospital which is a non-Plan Hospital, follow-up care must be authorized by Blue Shield or it may not be covered. If, once your Emergency medical condition is stabilized, and your

treating health care provider at the non-Plan Hospital believes that you require additional Medically Necessary Hospital Services, the non-Plan Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital Services by the non-Plan Hospital. If Blue Shield determines that you may be safely transferred to a Hospital that is contracted with the Plan and you refuse to consent to the transfer, the non-Plan Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for Services provided to you once your Emergency condition is stable. Also, if the non-Plan Hospital is unable to determine the contact information at Blue Shield in order to request prior authorization, the non-Plan Hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan Hospital, you should contact Blue Shield at the telephone number on your identification card.

Family Planning

1. Family Planning Counseling.
2. Tubal Ligation.
3. Elective Abortion.
4. Vasectomy.
5. Physician office visits for diaphragm fitting.
6. Injectable contraceptives when administered by a Physician.

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 four (4) visits per day, two (2) hours per visit, not to exceed eight (8) hours per day by any of the following professional providers:

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

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

In conjunction with the professional Services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan, and related laboratory Services are covered to the extent the Benefits would have been provided had the Member remained in the Hospital or Skilled Nursing Facility.

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

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

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

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

Home Infusion/Home Injectable Therapy Benefits

Benefits are provided for home infusion and IV injectable therapy, including home infusion agency Skilled Nursing Services, parenteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services; and for medically necessary FDA approved injectable medications, when prescribed by the Personal Physician and prior-authorized by the Plan.

NOTE: This benefit does not include medications, drugs, Insulin, insulin syringes or Home Self-Administered Injectables, which are covered under the Outpatient Prescription Drug benefit.

NOTE: Skilled Services provided by a Home Health Agency and/or a Home Infusion Agency are limited to a combined visit maximum as shown in the Summary of Benefits per Member per Calendar Year for all providers other than Plan Physicians.

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).

Hospice Program Services

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a Terminal Illness as determined by their Plan Provider's

certification and the admission must receive prior approval from Blue Shield of California. (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 and only when authorized by Blue Shield of California.

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

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services, and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services / Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Member to the extent that these needs are not met by the Member's other providers.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Nursing care Services that are covered on a continuous basis for as much as 24-hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either Homemaker Services or Home Health Aide Services or both, may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five (5) consecutive days at a time.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members can receive care for two (2) 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating 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 one (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 eight (8) hours of continuous care, during the 24-hour day, beginning and ending at midnight is required. This care could be four (4) hours in the morning and another four (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 eight (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 physician, 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 of the Member, as the unit of care.
2. Utilizes and Interdisciplinary Team to assess the physical, medical, psychological, and social and spiritual needs of the Member and their family.
3. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Member's death to assist the family to cope with social and emotional needs associated with the death.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.
8. Is provided through a Participating Hospice.

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

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

Period of Care – the time when the Participating Provider recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one (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 provider to the Member and his family that pertain to the palliative, supportive services required by the Member with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Member and his family and are available on a 24-hour on-call basis.

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

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of one (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 Services

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

1. Inpatient Hospital Services include:

- a. Semi-private room and board, unless a private room is Medically Necessary;
- b. General nursing care, and special duty nursing when Medically Necessary;
- c. Meals and special diets when Medically Necessary;
- d. Intensive care Services and units;
- e. Operating room, special treatment rooms, delivery room, newborn nursery, and related facilities;
- f. Hospital ancillary Services including diagnostic laboratory, x-ray Services, and therapy Services;
- g. Drugs, medications, biologicals, and oxygen administered in the Hospital, and up to three (3) days’ supply of drugs supplied upon discharge by the Plan Physician for the purpose of transition from the Hospital to home;
- h. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and Prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital;
- i. Administration of blood, blood plasma including the cost of blood, blood plasma and in-Hospital blood processing;
- j. Radiation therapy, chemotherapy, and renal dialysis;
- k. Subacute Care;
- l. General anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status when the Member is under the age of seven (7) or developmentally disabled regardless of age, or when the Member’s health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon;
- m. Medically Necessary Inpatient substance abuse detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room, or when Medically Necessary Inpatient substance abuse detoxification is prior authorized.
- n. Rehabilitation when furnished by the Hospital and authorized by the Blue Shield Access+ HMO.

Note: For information on Inpatient Hospital Services provided under the Hospice Program Services, see the section entitled “Hospice Program Services”.

2. Outpatient Hospital Services.
 - a. Services and supplies for treatment (including radiation and chemotherapy) in an outpatient Hospital setting.
 - b. Surgery in an outpatient Hospital setting.
 - c. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures, when performed in the Outpatient Facility of a Hospital or Ambulatory Surgery Center because of an underlying medical condition or clinical status and the Member is under the age of seven (7) or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.
 - 1) Services in an outpatient Hospital setting.
 - 2) Services in an Ambulatory Surgery Center.

Medical Treatment of The Teeth, Gums, Jaw Joints, Or Jaw Bones

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. Provided for the treatment of damage to the 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 medical non-surgical treatment (e.g., splint and Physical Therapy) of Temporomandibular Joint Syndrome (TMJ);
 4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
 5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or
 6. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct skeletal deformity.

This Benefit does not include:

1. Services performed on the teeth, gums (other than tumors), 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, 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 Limitations, Exceptions, Exclusions and Reductions section for additional services that are not covered.

Mental Health and Substance Abuse Services

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

All Mental Health and substance abuse Services must be obtained from MHSA Participating Providers. (See the USING YOUR HEALTH PLAN section, the *Mental Health and Substance Abuse Services* paragraphs for more information.)

Benefits are provided for the following Medically Necessary covered Mental Health and substance abuse Services, 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.

1. Inpatient Services

Inpatient Hospital and professional Services in connection with hospitalization, for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child), are covered. 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 Services for information on Medically Necessary Inpatient substance abuse detoxification.

2. Outpatient Services

a. Medically Necessary outpatient Mental Health Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and substance abuse visits or sessions. This Benefit is limited to a combined maximum of **20 visits** for diagnosis and treatment in any Calendar Year. Intensive Outpatient Care is not covered under this Benefit.

b. Medically Necessary outpatient Mental Health Care for the diagnosis and treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child. Intensive Outpatient Care is covered under this Benefit.

NOTE: Access+ Specialist visits for Mental Health Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child will accrue towards the Calendar Year maximum. All Access+ Specialist visits require a separate Copayment per visit.

3. Outpatient Partial Hospitalization and Outpatient ECT Services

Hospital and professional Services in connection with psychiatric Partial Hospitalization and ECT for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child) are covered.

4. Psychological testing

Psychological testing is a covered Benefit when an MHSA provider refers the Member and the procedure is prior authorized by the MHSA.

5. Psychosocial Support through LifeReferrals 24/7

See the *Mental Health and Substance Abuse Services* paragraphs under the Using Your Health Plan section for information on psychosocial support Services.

Orthoses

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 or 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 (2) or more professionally recognized appliances equally appropriate for a condition, this Plan will provide Benefits based on the most cost-effective appliance. Routine maintenance is not covered. No Benefits are provided for backup or alternate items.

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

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

NOTE: All Covered Services have a Calendar Year Benefit maximum per Member as shown in the Summary of Benefits. This maximum does not apply to Services covered under the Diabetes Care Benefit.

Other Outpatient Services

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. Renal Dialysis. Outpatient renal dialysis unless covered by Medicare.

3. Injectable Medications. 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, excluding allergy serum. Insulin and Home Self-Administered Injectables are covered under the Outpatient Prescription Drugs section.

4. Allergy serum purchased separately for treatment.

NOTE: See the Professional Services section for information on separate coverage of allergy injectable medications, subject to the applicable Copayment.

5. 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.
6. Ambulatory Surgery Center Services. Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.
 - a. Surgery in an Ambulatory Surgery Center
 - b. Services and supplies for treatment (including radiation and chemotherapy) in 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 the Hospital Services section.

(NOTE: See the Pregnancy, Maternity Care, and Routine Circumcision section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.)

Outpatient Prescription Drugs

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 Medicare Part D 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 before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

The following prescription drug Benefit is separate from the Access+ HMO Health Plan coverage. The general provisions and exclusions described in this booklet apply. The Calendar Year Copayment Maximum and the Calendar Year Deductible provisions do not apply to this Outpatient Prescription Drug Benefit. Benefits for covered Brand Name Drugs are subject to a Brand Name Drug Deductible per Member, per Calendar Year as shown in the Summary of Benefits.

Benefits are provided for outpatient prescription Drugs, which are prescribed by the Member's Personal Physician and are obtained from a Participating Pharmacy. Benefits are provided for Formulary Drugs, which are Drugs listed in the Blue Shield's Outpatient Drug Formulary. This

Formulary is updated on a periodic basis by Blue Shield Pharmacy and Therapeutics Committee. Unless prior authorization has been received from Blue Shield, as described herein, Non-Formulary Drugs are not covered. Except for Emergency coverage, Drugs obtained from a Non-Participating Pharmacy are not covered. Select Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. 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 Prescription 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 (4) times a year.

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

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 access the Formulary through the Blue Shield of California web site at <http://www.blueshieldca.com>.

Definitions

Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name. NOTE: covered Brand Name Drugs are subject to a Brand Name Drug Deductible per Member, per Calendar Year as shown in the Summary of Benefits.

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 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) inhalers and inhaler spacers for the management and treatment of asthma and (7) smoking cessation Drugs which require a prescription – coverage limited to one 12-week course of treatment per lifetime.

NOTE: No prescription is necessary to purchase the items shown in (2), (3), and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program, which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs. Benefits are provided for Formulary Drugs. Unless prior authorization has been received from Blue Shield, Non-Formulary Drugs are not covered.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Brand Name Drug equivalent.

Home Self-Administered Injectables — Home Self-Administered Injectable medications are defined as those Drugs which are Medically Necessary, administered more often than once a month by the patient or Family Member, administered subcutaneously or intramuscularly, deemed safe for self-administration as determined by Blue Shield Pharmacy and Therapeutics Committee, prior authorized by Blue Shield, and obtained from a Blue Shield Specialty Pharmacy. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable Drugs. Home Self-Administered Injectables are listed in the Blue Shield Drug Formulary.

NOTE: Home Self-Administered Injectables purchased at a Non-Participating Pharmacy are not covered.

Non-Formulary Drugs — Drugs determined by the Blue Shield Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Unless prior authorization has been received from Blue Shield, Non-Formulary Drugs are not covered.

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

Participating Pharmacy — A pharmacy which participates in the Blue Shield Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Subscribers and Dependents.

To select a Participating Pharmacy, Blue Shield Members may access this information at <http://www.blueshieldca.com> or call the toll-free Member Services number on the Blue Shield Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield of California to provide covered Home Self-Administered Injectables. These phar-

macies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, the Subscriber may access this information at <http://www.blueshieldca.com> or call the toll-free Member Services telephone number on their Blue Shield of California 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.

The Member is responsible for paying the applicable Copayment for each new and refill prescription. The pharmacist will collect from the Member the applicable Copayment at the time the Drugs are obtained.

In addition to the Copayments listed in the Summary of Benefits, Brand Name Drugs are first subject to a Brand Name Drug Deductible per Member, per Calendar Year. Until the Brand Name Drug Deductible is satisfied, the Member is responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield of California Participating Pharmacy at the time the Drug is obtained.

NOTE: For diaphragms both the Brand Name Drug Deductible and the Brand Name Copayment apply.

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's contracted rate.

If the Member requests a Formulary Brand Name Drug when a Formulary Generic equivalent is available, even if the physician has written "Dispense As Written," and the Brand Name Drug Deductible has been satisfied, the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Formulary Brand Name Drug and its Formulary Generic Drug equivalent, as well as the applicable Formulary Generic Name Drug Copayment.

If a Formulary Generic Drug equivalent is not available, the Member is responsible for paying the applicable Formulary Brand Name Drug Copayment.

The Member is responsible for paying 100% of the cost of Drugs not listed on the Blue Shield Prescription Drug Formulary, unless prior authorization has been obtained.

The Member is also responsible for the copayment listed in the Summary of Benefits for each new or refill prescription, for Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs. Benefits are

provided for Home Self-Administered Injectables only when obtained from a Blue Shield Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Home Self-Administered Injectables may be obtained from any Participating Pharmacy, or, if necessary, from a Non-Participating Pharmacy.

Except for covered emergencies, Drugs obtained at a Non-Participating Pharmacy are not covered. If the Member must obtain Drugs from a Non-Participating Pharmacy due to an Emergency, including Drugs for emergency contraception, the submission of a Prescription Drug Claim noting "Emergency Request" on the form is required. Claim forms are provided upon request from the Blue Shield Service Center. Claims must be submitted to Blue Shield of California Pharmacy Services, P.O. Box 7168, San Francisco, CA 94120. Claims must be received within one (1) year from the date of service to be considered for payment. Reimbursement for covered emergency claims will be based upon the purchase price of covered prescription Drug(s) less any Brand Name Drug Deductible and applicable Copayment(s).

Blue Shield of California requires that prescriptions be filled with Formulary Generic Drugs when available.

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.

Mail Service Brand Name Drugs are first subject to a Brand Name Drug Deductible per Member, per Calendar Year as shown in the Summary of Benefits. Until the Brand Name Drug Deductible is satisfied, the Member is responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Mail Service Pharmacy prior to the prescription being sent to the Member. 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 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's contracted rate.

NOTE: Home Self-Administered Injectables, except for Insulin, are not available through the Mail Service Pre-

scription Drug Program.

If the Member requests a Formulary Brand Name Drug when a Formulary Generic Drug is available, even if the physician has written "Dispense As Written," and the Brand Name Drug Deductible has been satisfied, the Member is responsible for the difference between the contracted rate for the Formulary Brand Name Drug and its Formulary Generic Drug equivalent, as well as the applicable Mail Service Formulary Generic Name Drug Copayment.

If a Formulary Generic Drug equivalent is not available, the Member is responsible for paying the applicable Mail Service Formulary Brand Name Drug Copayment.

Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables

A Non-Formulary Drug may be covered only if prior authorized by Blue Shield. Select Formulary Drugs and most Home Self-Administered Injectable may also require prior authorization for Medical Necessity. Your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within 5 business days or within 72 hours for an expedited review.

Prior authorization decisions are based upon the following:

1. The requested Drug, dose, and/or quantity are safe and Medically Necessary for the specified use.
2. Formulary alternative(s) have failed or are inappropriate.
3. Treatment is stable and a change to an alternative may cause immediate harm.
4. Drugs recommended as initial treatment have been tried and failed or are inappropriate.
5. Relevant clinical information supports the use of the requested medication over Formulary Drug alternatives.

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

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. 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 60-day supply. If the Member's Physician indicates a prescription quantity of less than a 60-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 60-day supply.
3. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions for Outpatient Drug Benefit

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. 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 Services and Hospital Services sections of your Evidence of Coverage);
3. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Services and Skilled Nursing Facility Services sections of your Evidence of Coverage);
4. Non-Formulary Drugs, except as prior authorized by Blue Shield as described herein;
5. Except as specifically listed as covered herein, Drugs which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
6. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
7. Drugs that are considered to be experimental or investigational;
8. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment, Prostheses, and Other Services section and the Orthoses section of your Evidence of Coverage);
9. Blood or blood products (see the Hospital Services section of your Evidence of Coverage);
10. Drugs when prescribed for cosmetic purposes, including but not limited to Drugs used to retard or reverse the effects of skin aging or to treat hair loss;
11. Dietary or Nutritional Products (see the Home Health Care Benefits, PKU Related Formulas and Special Food Products, and Home Infusion/Home Injectable Therapy Benefits sections of your Evidence of Coverage);
12. Injectable Drugs which are not self-administered and all injectable drugs for the treatment of infertility. Other Injectable Medications may be covered under the Other Outpatient Services, Hospice Program Services, and the Family Planning benefits of the Health Plan;
13. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
14. Drugs when prescribed for smoking cessation purposes (over the counter or by prescription), except to the extent that smoking cessation prescription drugs are specifically listed as covered under the "Drugs" definition in this benefit description;
15. Contraceptive devices (except diaphragms), injections, and implants;
16. Compounded medications if (1) there is a

medically appropriate Formulary alternative or (2) there are no FDA-approved indications. Compounded medications that do not include at least one Drug, as defined, are not covered;

17. Replacement of lost, stolen, or destroyed Prescription Drugs;
18. Drugs for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection or to medications prescribed to treat pain;
19. 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;
20. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

See the Grievance Process portion of your Evidence of Coverage 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.

Outpatient Rehabilitation Services

Rehabilitation Services include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy pursuant to a written treatment plan for as long as continued treatment is Medically Necessary, and when rendered in the provider's office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in the Speech Therapy 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 is determined that continued treatment is Medically Necessary and provided with the expectation that the patient has restorative potential.

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

PKU Related Formulas and Special Food Products

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

Pregnancy, Maternity Care And Routine Circumcision

Pregnancy is a Waivered Condition, and pregnancy and maternity care Service is not available for a Waivered Condition with the exception of Services required to treat Involuntary Complications of Pregnancy. The following pregnancy and maternity care is covered subject to the exclusions listed in the Exclusions and Limitations section. Please see the "note" at the end of this section for important information on prior Creditable Coverage.

1. 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: See the Other Outpatient Services 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, Involuntary Complications of Pregnancy, or related 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 individual and family 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.

NOTE: If you had prior Creditable Coverage and you applied for this Plan within 63 days after termination of the prior Creditable Coverage, then Blue Shield of California will credit the time you were covered under the prior Creditable Coverage toward this limitation.

To receive credit for your prior Creditable Coverage, submit to Blue Shield of California a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact Blue Shield of California's Member Service Department at the telephone number provided in this booklet for assistance.

Preventive Health Services

Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

(NOTE: See the Other Outpatient Services section for information on coverage of genetic testing, and diagnostic procedures.)

1. Schedule for Covered Routine Preventive Health Services and Copayment Information:
 - a. Well-baby care through age 2 years;
 - b. Exams every year, age 3-19 years;
 - c. Exams every 5 years, age 20-40 years;
 - d. Exams every 2 years, age 41-50 years;
 - e. Exams every year over age 50 years;
 - f. Routine breast and pelvic exams and pap tests or other FDA (Food and Drug Administration) approved cervical cancer and human papillomavirus virus (HPV) screening tests every year. A woman may self-refer to an OB/GYN or family practice Physician who is in the same Medical Group/IPA as her Personal Physician for a routine annual gynecological exam;
 - g. Mammography for screening purposes recommended by Member's Personal Physician.
2. Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Ser-

vices through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), except for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.

3. Hearing screening by the Personal Physician for Members under the age of 18 to determine the need for an audiogram or for hearing correction, as well as newborn hearing screening Services.
4. Vision screening by the Personal Physician for Members under the age of 18 to determine the need for a refraction for vision correction.
5. Colorectal cancer screening for Members age 50 and older. Benefits are provided based on Blue Shield's Preventive Health Guidelines. These guidelines regarding examinations and tests are derived from the most recent version with all updates of the Guide to Preventive Services Task Force as convened by the U.S. Public Health Service and those of the American Cancer Society, including frequency and patient age recommendations.
6. Osteoporosis screening benefits are provided for Members age 65 and older or 60 and older if at increased risk.)
7. Health education and health promotion Services provided by Blue Shield include the Blue Shield Member Newsletter.
8. Blue Shield's Internet site is located at <http://www.blueshieldca.com>. Members using a personal computer and modem with World Wide Web access may view healthcare information.

Professional Services (Other than for Mental Health and substance abuse Services)

1. Physician Office Visits. Office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury, including specialist office visits, second opinion consultations when authorized by the Plan, office surgery, outpatient chemotherapy, radiation therapy, and diabetic counseling; audiometry examinations when performed by a Physician or by an audiologist at the request of a Physician; and OB/GYN Services by 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 Plan Physician.
3. Allergy Testing and Treatment. Office visits for the purpose of allergy testing and treatment, including injectables and serum. For allergy serum purchased

separately for treatment, see the Other Outpatient Services section, item 4.

4. 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.
5. Treatment of physical complications of a mastectomy, including lymphedemas.
6. Internet Based Consultation. Medically Necessary consultations with Internet Ready Physicians via Blue Shield approved Internet portal are covered. Internet based consultations are available only to Members whose Personal Physicians or other Physician 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 Psychiatric Care or substance abuse care are not covered. Refer to the Online 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>.

Reconstructive Surgery

Medically Necessary Services in connection with Reconstructive Surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance only to the extent that such Services are received while the Plan is in force with respect to the Member.

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

No Benefits will be provided for the following surgeries or procedures unless determined by Blue Shield to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

- 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 when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

Skilled Nursing Facility Services

Subject to all of the inpatient Hospital Services provisions, Medically Necessary skilled nursing Services for the treatment of an illness or injury, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. This Benefit is limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. Custodial Care is not covered.

Note: For information concerning Hospice Program Services, see the section entitled "Hospice Program Services".

Speech Therapy

Initial Outpatient Benefits for Speech Therapy 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) to evaluate the effectiveness of treatment, and when rendered in the provider's office or Outpatient department of a Hospital.

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

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

Transplant Benefits

Organ Transplant Benefits

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

1. Provided in connection with the transplant of a cornea, a kidney, or skin, and 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 will be covered.

Special Transplant Benefits

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

1. Blue Shield reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding Benefits based on (a) the medical circumstances of each patient and (b) consistency between the treatment proposed and Blue Shield of California medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.
2. The following procedures are eligible for coverage under this provision:
 - a. Human heart transplants;
 - b. Human lung transplants;
 - c. Human heart and lung transplants in combination;
 - d. Human kidney and pancreas transplants in combination;
 - e. Human liver transplants;
 - f. Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
 - g. Pediatric human small bowel transplants;

- h. Pediatric and adult human small bowel and liver transplants in combination.
3. Services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Urgent Services

Urgent Services required when the Member is within his or her Personal Physician Service Area must be obtained in accordance with USING YOUR HEALTH PLAN section. 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, the Member should, if possible, contact Blue Shield Member Services at 1-800-431-2809 in accordance with the Using Your Health Plan section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Plan Provider. Members may also locate a Plan Provider by visiting Blue Shield's internet site at <http://www.blueshieldca.com>. You are not required to use a Blue Shield of California Plan Provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

For urgent Mental Health Services within California, the Member should contact the MHSA at 1-877-263-9952.

Outside California or the United States

When temporarily traveling outside California or the United States, if possible, Members must call the 24-hour toll-free number 1-800-810-BLUE (2583), to obtain information about the nearest BlueCard Program participating provider. (Temporarily traveling is defined as a Subscriber or Dependent who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.) When a BlueCard Program participating provider is available, you should obtain out of area urgent or follow-up care from a participating provider whenever possible, but you may also received care from a non BlueCard participating provider. If you received Services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The Services will be reviewed retrospectively by the Plan to determine whether the Services were urgent care Services. See the Claims For Emergency and Out-of-Area Urgent Services sections for additional information.

Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

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 call their local Member Services office for the most current information on participating providers worldwide or they can go online at www.bcbs.com and select the "Find a Doctor or Hospital" tab. 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 the Claims For Emergency and Out-of-Area Urgent Services in the How to use Your Health Plan section.

DENTAL BENEFITS - ACCESS+ DENTIST

The Dental Benefit is separate from your Access+ HMO Health Plan. The provisions of Access+ Satisfaction do not apply to this Dental Benefit. The dental Copayments are not subject to the Calendar Year Deductible, nor do they accumulate towards your Maximum Calendar Year Copayment Responsibility. Otherwise, the general provisions and exclusions described in the Health Service Agreement apply. The Dental Benefit is offered at no additional charge to the Member.

NOTE: Access+ HMO Members have the option of separately subscribing to either of Blue Shield's two IFP Dental plans, the Dental HMO Plan and the Dental PPO Plan.

These other Dental plans offer more generous dental Benefits than those provided under this Section of the Access+ HMO Plan. If you choose to purchase one of the other Dental plans, you will not receive any of the dental Benefits listed herein. Benefits are provided for Dental Services received from Access+ *Dentists*. No Benefits are provided for Dental Services received from non-Access+ *Dentists*.

The Benefits listed hereunder are administered by a Dental Plan Administrator (DPA) which is a dental care service plan licensed by the California Department of Managed Health Care, and which contracts with Blue Shield to underwrite and administer the delivery of dental services through a network of Participating Dentists.

Access+ *Dentists*

To obtain Covered Services, you must go to Access+ *Dentists*. Access+ *Dentists* agree to accept a Dental Plan Administrator's payment, plus your Copayment, as payment in full for Covered Services.

No Benefits are provided for Dental Services received from non-Access+ *Dentists*.

Directories of Access+ *Dentists* located in your area will be made available to you. If you do not have a directory, please contact your Dental Member Services immediately at 1-888-679-8928.

Definitions

Whenever the following definitions are capitalized in this section, they will have the meaning stated below.

Access+ *Dentist* - A Doctor of Dental Surgery who has signed a service contract with a Dental Plan Administrator to provide Dental Services to Members of the Access+ HMO Plan.

Billed Charges - The prevailing rates of the Dental office.

Dental Care Services - Necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Necessity - Services which are of Dental Necessity include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat dental disease or injury, and which, as determined by a Dental Plan Administrator, are:

1. consistent with the symptoms or diagnosis; and
2. not furnished primarily for the convenience of the patient, the attending *Dentist*, or other provider; and
3. furnished at the most appropriate level which can be provided safely and effectively to the patient.

Dental Plan Administrator - Blue Shield has contracted with the Plan's Dental Plan Administrators (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to underwrite and administer delivery of dental Services through a network of Access+ *Dentists*. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating *Dentists*.

Dentist - a duly licensed Doctor of Dental Surgery or other practitioner who is legally entitled to practice dentistry in the state of California.

Elective Dental Procedure - any dental procedures which are unnecessary to the dental health of the patient, as determined by a Dental Plan Administrator.

Emergency Services - Covered Services to alleviate severe pain or other symptoms or for the diagnosis and treatment of an unforeseen illness or injury which a reasonable person under the circumstances would believe if not treated immediately could lead to serious jeopardy of health or impairment.

Endodontics - Dental Care Services specifically related to necessary procedures for treatment of disease of the pulp chamber and pulp canals, not requiring hospitalization.

Oral Surgery - Dental Care Services specifically related to the diagnosis and the surgical and adjunctive treatment of diseases, injuries, and defects of the mouth, jaws, and associated structures.

Palliative Treatment - Therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

Periodontics - Dental Care Services specifically related to necessary procedures for providing treatment of disease of gums and bones supporting the teeth, not requiring hospitalization.

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

Prosthodontics - Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Specialist - a Dentist who is licensed or authorized by the State of California to provide specialized Dental Care Services as recognized by the appropriate specialty board of the American Dental Association.

Treatment in Progress - Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken.

Covered Services and Supplies

Benefits of the Plan are provided for Services customarily performed by licensed general Dentists for treatment of teeth, jaws, and their dependent tissues.

The following Services are Benefits when provided by an Access+ *Dentist* and when necessary and customary as determined by the standards of generally accepted dental practice. These Benefits are subject to the general limitations and exclusions of the Plan.

Diagnostic and Preventive Services

Clinical oral examinations. Excluding emergency examinations, not more than once in any period of six (6) consecutive months.

Dental prophylaxis. Not more than once in any period of six (6) consecutive months. (Prophylaxis performed in conjunction with fluoridation or any other procedure and periodontal prophylaxis shall be considered as being a prophylaxis for the purpose of applying this limitation.)

Diagnostic casts. Not more than once in any period of 60 consecutive months. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.

X-rays. Bitewing films not more than once in any period of six (6) consecutive months.

Full mouth series. (includes 10 to 14 periapical X-rays and supplementary bitewing films) not more than once in any period of 36 consecutive months. In applying this 36 month limitation, a panoramic X-ray shall be considered a full mouth series. X-rays required to diagnose a specific condition that needs treatment are not subject to this limitation. The Member will be responsible for an additional copayment for the full mouth series as shown in the Summary of Benefits.

Sealants. One (1) treatment in any period of 60 consecutive months limited to permanent molars up to age 16. The Member has a Copayment per tooth up to a maximum of four (4) teeth per lifetime as shown in the Summary of Benefits.

Space Maintainers. Includes all adjustments within six (6) months after installation. Benefits for space maintainers are limited to Members under age 16. The Member has additional Copayments in lab fees for space maintainers.

Major Services

Anesthesia — General, only when Medically Necessary.

Cast Restorations — Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (inlays, onlays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain, and gold); post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). Replacement of an existing crown, inlay or onlay, or other cast restoration which is more than five (5) years old and cannot be repaired. Repair or recementing of inlays, onlays, and crowns, if after six (6) months of installation.

Endodontics — Pulp capping; therapeutic pulpotomy (excluding final restoration); root canal therapy (excluding final restoration).

Oral Surgery — Routine extractions; root removal; surgical removal of erupted teeth.

Periodontics — Periodontal scaling and root planing per quadrant, limited to once every six (6) months; periodontal maintenance procedures after active therapy, allowed twice within 12 months after osseous surgery.

Prosthetics — Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one (1) course of treatment per six (6) month period), and denture duplication (jump case). Replacement of complete or partial dentures, fixed bridgework, or crowns previously covered by the Plan due to loss or theft within 60 months after initial or supplemental placement. This also applies to the

damage of any Prostheses that is not directly related to faulty lab work. "Prostheses" include fixed and removable bridgework.

Replacement of dentures (complete or partial), crowns or fixed bridgework due to provider error. The Access+ *Dentist* is financially responsible for comparable replacement. If replacement is warranted because of an action by, or the non-compliance of the patient, that patient is financially liable for replacement of the Prosthesis (this includes decay or periodontal disease directly related to patient non-compliance). The Plan will pay for a replacement in this instance after the 60 month waiting period from initial placement has elapsed

Denture relines (either complete or partial conventional dentures) within six (6) months after insertion of the Prosthesis. This service is covered once every 12 months following initial insertion or reline. In the case of immediate full or partial dentures, the final reline is performed no sooner than eight weeks after tooth extractions and denture insertion. Chairside tissue conditioners can be used for temporary relief of discomfort and/or to increase retention and be considered palliative treatment. Relines for immediate full and partial dentures will not be covered within two (2) weeks of tooth extraction and Prosthesis insertion. One reline for each Prosthesis is included in the immediate denture fee between two (2) and six (6) months following insertion.

Restorative Dentistry — Amalgam restorations; synthetic restorations (i.e. silicate cement filling, porcelain filling, plastic filling, and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material. Inlays, onlays, crowns (other than stainless steel), veneers, and other laboratory produced restorations and bridges are excluded.

Additional Services

Additional Services — Palliative Treatment, analgesia, application of desensitizing medication, occlusal guards by report, limited occlusal adjustment, complete occlusal adjustment, sterilization surcharge (per visit), after hours surcharge, and broken appointment fee for each missed half-hour appointment without 24 hours notice.

NOTE: If the Member accrues a sterilization surcharge in the course of his Office Visit for Diagnostic and Preventive Care, the surcharge will be included in the Office Co-payment.

Emergency Services

Emergency Services include Covered Services to alleviate severe pain or other symptoms or for the diagnosis and treatment of an unforeseen illness or injury which a reasonable person under the circumstances would believe if not treated immediately could lead to serious jeopardy of health or impairment. The determination of whether the

situation required Emergency Services will be made retrospectively by the Plan Administrator based upon an objective review that is consistent with professionally recognized standards of care.

NOTE: A Dental Plan Administrator will respond to 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 five (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 two (2) business days of the decision.

1. Out-of-State

If a Member receives Emergency care outside of California, the Member shall be entitled to a reimbursement per occurrence as shown in the Summary of Benefits for such Covered Dental Services. Whenever possible, the Member should ask the Dentist to bill the Plan directly.

Payment or reimbursement of Emergency care provided to a Member will be made after a Dental Plan Administrator receives documentation of the charges incurred and upon approval by a Dental Plan Administrator of those charges set forth. Except for Emergency care, as noted above, a Member will be responsible for full payment of dental Services rendered outside of California.

2. In-State

Palliative treatment received in an emergency from a non-Access+ *Dentist* will be covered. A Dental Plan Administrator will retrospectively review the Services provided. If a Dental Plan Administrator determines that the situation did not require Emergency care, the Member will be responsible for the entire cost of the Services. A Dental Plan Administrator will notify the Member of its determination within 30 days from receipt of the claim.

General Limitations and Exclusions

General Limitations

No Benefits are provided for:

1. dental services not listed under Covered Services and Supplies;
2. services of non-Access+ *Dentists* or other practitioners of healing arts not associated with the Dental Plan, except when authorized by a Dental Plan Administrator or when required in a covered emergency;

3. dental treatment that has been previously started by another dentist prior to the participant's eligibility to receive Benefits under this Plan;
4. any cosmetic, beautifying, or elective procedure;
5. dental services performed in a Hospital or any related Hospital fee, except as covered under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones section;
6. any procedure not performed in a dental office setting, except as covered under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones section;
7. experimental procedures or pharmacological regimens;
8. drugs obtainable with or without a prescription or charges for local anesthetics, except as provided under the Outpatient Prescription Drugs section;
9. treatment to correct malignancies, cysts, neoplasm, or congenital and developmental malformations including but not limited to cleft palate, anodontia, mandibular prognathism, or enamel hypoplasia;
10. any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a Dental Plan Administrator and its dental consultants;
11. the placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
12. reimbursement to the Member or another dental office for the cost of services secured from non-Access+ *Dentists*, except:
 - a. when such reimbursement is expressly authorized by the Plan; or
 - b. as cited under Emergency Services section;
13. treatment for which payment is made by any governmental agency, including any foreign government;
14. services pertaining or related to the Temporal Mandibular Joint (TMJ), except as provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones section;
15. dental implants, transplants, or ridge augmentations;
16. general anesthesia; including intravenous and inhalation sedation, except when of Medical Necessity. General anesthesia is considered Medically Necessary when its use is (a) in accordance with generally accepted professional standards, (b) due to the existence of a specific medical condition, and (c) not furnished primarily for the convenience of the patient, the attending Dentist, or other provider.
 - a. Written documentation of the medical condition necessitating use of general anesthesia must be provided by a Dentist and approved by a Dental Plan Administrator;
 - b. Patient apprehension or patient anxiety will not constitute Medical Necessity;
 - c. Mental retardation is an acceptable medical condition to justify use of general anesthesia;
 - d. The Plan reserves the right to review the use of general anesthesia to determine Medical Necessity;
17. prophylaxis more than once every six (6) months;
18. precious metals (if used, will be charged to the patient at the Dentist's cost);
19. removal of 3rd molar (wisdom teeth) other than for Dental Necessity;
20. services of Prosthodontists, Pedodontists, Endodontists, Periodontists, Oral Surgeons, Orthodontists, and all other Specialists;
21. treatment as a result of Accidental Injury, including setting of fractures or dislocation, except as provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones section;
22. charges for second opinions, unless previously authorized by the Plan;
23. charges for services performed by a Close Relative or by a person who ordinarily re-

sides in the Subscriber's or Dependent's home;

24. procedures requiring fixed prosthodontic restoration which are necessary for complete oral Rehabilitation or reconstruction;
25. procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion;
26. temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.

See the Member Services and Grievance Process for Dental Services section below for information on filing a grievance. Also, see the Department of Managed Health Care Review paragraphs under the Grievance Process section for your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Dental Necessity Exclusion

All Services must be of Dental Necessity. The fact that a Dentist may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental Necessity. Even though it is not specifically listed as an exclusion or limitation, a Dental Plan Administrator may limit or exclude Benefits for Services which are not of Dental Necessity.

Dental Claims and Services Review

Blue Shield and a Dental Plan Administrator reserve the right to review all claims and Services to determine if any exclusions or other limitations apply. Blue Shield or a Dental Plan Administrator may use the Services of Dentist consultants, peer review committees of professional societies, and other consultants to evaluate claims.

Member Services and Grievance Process For Dental Services

Questions, inquiries, or complaints regarding Benefits, denied claims, or concerns regarding the quality of care or access to care that you have experienced should be directed to your Dental Member Services at the phone number which appears below:

1-888-679-8928

Member Services can answer many questions over the telephone.

You may write to the Dental Member Services Department at 425 Market St., 12th Floor, San Francisco, CA 94105.

NOTE: a DPA 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. A DPA 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. 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 Dental Member Services Department at the number listed above.

The Member, a designated representative, or a provider on behalf of the Member may contact the Dental 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 Dental Member Services Department at the telephone number as noted below. If the telephone inquiry to the Dental 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 Dental 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 Dental Member Services Department.

If the Member wishes, the Dental Member Services staff will assist in completing the grievance form. Completed grievance forms must be mailed to the address provided below. The Member may also submit the grievance to the Dental Member Services Department online by visiting <http://www.blueshieldca.com>.

1-888-679-8928

Blue Shield of California

Dental Plan Administrator

425 Market Street, 12th Floor
San Francisco, CA 94105

A Dental Plan Administrator will acknowledge receipt of a written grievance within five (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 enrollee's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS

General Exclusions and Limitations

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

1. Experimental or Investigational in Nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under the Clinical Trial For Cancer section;
2. for or incident to Services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided for in the section entitled "Hospice Program Services";
3. for substance abuse treatment or Rehabilitation on an inpatient, partial hospitalization, or outpatient basis, except as specifically provided under the Mental Health and Substance Abuse Services section;
4. performed in a Hospital by Hospital officers, residents, interns, and others in training;
5. 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;
6. for Cosmetic Surgery or any resulting complications, except that Medically Necessary Services to treat complications of Cosmetic Surgery (e.g., infections or hemorrhages) will be a Benefit, but only upon review and approval by a Blue Shield Physician consultant. Without limiting the foregoing, no Benefits will be provided for the following surgeries or procedures:
 - Lower eyelid blepharoplasty;
 - Spider veins;
 - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
 - Hair removal by electrolysis or other means; and
 - Reimplantation of breast implants originally provided for cosmetic augmentation;
7. incident to an organ transplant, except as provided under the Transplant Benefits section;
8. for convenience items such as telephones, TVs, guest trays, and personal hygiene items;
9. for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), any related Services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
10. for or incident to the treatment of infertility, including the cause of infertility, or any form of assisted reproductive technology including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for medically necessary treatment of medical complications;
11. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care under a Blue Shield of California health Plan;
12. for contraceptives and contraceptive devices, except as specifically included in the Family Planning Services benefit and Outpatient Prescription Drugs benefit sections; no Benefits are provided for contraceptive implants;
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 in the Home Health Care Benefits and Speech Therapy sections;

14. for routine foot care including callus, corn paring or excision and toenail trimming (except as may be provided through a Participating Hospice Agency); treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion, or any type of massage procedure on the foot; for special footwear (e.g., non-custom made or over-the-counter shoe inserts or arch supports) except as specifically in the Orthoses and Diabetes Care benefit sections;
15. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, contact lenses except as provided in the Durable Medical Equipment, Prostheses, and Other Services 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 in the Hospital Services and Medical Treatment of the Teeth, Gums, Jaw Joints, or Jaw Bones sections;
18. for or incident to services and supplies for treatment of the teeth and gums (except for tumors), 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 mentioned under the Access+ DENTIST section;
19. for or incident to reading, vocational, educational, recreational, art, dance, or music therapy; weight control or exercise programs, nutritional counseling except as specifically provided for under Diabetes Care Benefits;
20. for learning disabilities or behavioral problems or social skills training/therapy;
21. for or incident to acupuncture;
22. for spinal manipulation or adjustment;
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 in the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits and the Hospice Program Benefits in the Plan Benefits section;
25. for testing for intelligence or learning disabilities;
26. for prescribed Drugs and medicines for outpatient care, except as provided under the Outpatient Prescription Drugs section, and/or Home Infusion/Home Injectable Therapy Benefits section, and/or the Hospice Program Services section;
27. for transportation services other than provided under the Ambulance Services section;
28. for unauthorized non-Emergency Services;
29. not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group or IPA as your Personal Physician, Emergency Services or Urgent Services under the Emergency Services section, or for Hospice Services received by a Participating Hospice Agency, or when specific authorization has been obtained in writing for such Services as described herein;

30. performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
31. for orthopedic shoes, except as provided under the Diabetes Care section, home testing devices, environmental control equipment, generators, exercise equipment, self help/educational devices; or for any type of communicator, voice enhancer, voice Prosthesis, electronic voice producing machine, or any other language assistance devices, except as provided under the Durable Medical Equipment section; for 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 in the Preventive Health Services 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 related Services, except for any resulting complications and Medically Necessary Services as provided in the Reconstructive Surgery section;
34. for home testing devices and monitoring equipment, except as specifically provided in Durable Medical Equipment, Prostheses and Other Services in the Plan Benefits section;
35. for Rehabilitation services except as specified in the Outpatient Rehabilitation Services and Speech Therapy sections;
36. for pre-marital blood tests;
37. for or incident to sexual dysfunction or sexual inadequacies, except as provided for treatment of organically based conditions;
38. for non-prescription (over-the-counter) medical equipment or supplies 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 the Diabetes Care section, the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Services section, and the Outpatient Prescription Drugs section; for disposable hypodermic needles and syringes except as provided under the Home Health Care Benefits, and Home Infusion/Home Injectable Therapy Services section;
39. for Reconstructive Surgery and procedures: 1) where there is another more appropriate surgical procedure that is approved by a Blue Shield Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited in the Reconstructive Surgery benefit section;
40. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); however, drugs and medicines which have received FDA approval for marketing for one (1) or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met;
41. for prescription or non-prescription food and nutritional supplements, except as provided under the 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;
42. for genetic testing except as described in the Other Outpatient Services section;
43. for pregnancy and maternity care for a Waivered Condition except for Services required to treat Involuntary Complications of Pregnancy. However, if you were covered under Creditable Coverage within 63 days of becoming covered, the time spent under Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period; and
44. 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;

45. not specifically listed as a Benefit.

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

Medical Necessity Exclusion

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

Limitations for Duplicate Coverage

When you are eligible for Medicare

1. Your Blue Shield plan will provide benefits before Medicare when you become eligible for Medicare benefits prior to age 65, until the first to occur of the following:
 - a. The date of your actual enrollment under Medicare, or
 - b. The date that you receive notice from Blue Shield of your eligibility for such enrollment.
2. Your Blue Shield plan will provide benefits after Medicare even if you are eligible but do not enroll once you are age 65 or older. Blue Shield will:
 - a. Estimate what Medicare would have paid for services received (based on the reasonable value or Blue Shield's Allowed Charges), and
 - b. Provide your Blue Shield plan benefits as if you were enrolled to receive benefits from Medicare.

When your Blue Shield plan provides benefits after Medicare, the combined benefits from

Medicare and your Blue Shield plan will equal, but not exceed, what Blue Shield would have paid if you were not eligible to receive Medicare benefits (payment will be based on an amount that may be lower than but will not exceed the Medicare allowed amount). Your Blue Shield plan deductible and/or copayments will be applied before plan benefits are provided.

When you are eligible for Medi-Cal

Your Blue Shield plan always provides benefits first.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield plan will pay the reasonable value or Blue Shield's Allowed Charges for covered services provided to you at a Veteran's 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 plan will pay the reasonable value or Blue Shield's Allowed Charges for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision:

1. The combined benefits from that coverage and your Blue Shield plan will equal, but not exceed, what Blue Shield would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowed Charges).
2. Your Blue Shield plan deductible and/or copayments will be applied before payment of plan benefits.

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 plan benefits in the above situations.

Exception for Other Coverage

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

Claims and Services Review

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

Reductions - Third Party Liability

If a Member is injured through the act or omission of another person (a “third party”), Blue Shield and the Member’s designated Medical Group, and the 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 or other available remedy to recover the reasonable costs of Services provided to the Member.

The Member is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Member anticipates bringing 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 with Blue Shield and the Member’s designated Medical Group, and Independent Practice Association to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide Blue Shield and the Member’s designated Medical Group, and Independent Practice Association with a lien, in the amount of the reasonable costs of Benefits provided, calculated in accordance with the 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.

A Member’s failure to comply with 1. through 3., 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 received services from a Plan Hospital for such injuries, 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 Plan Hospital’s right to collect shall be in accordance with California Civil Code Section 3045.1.

OTHER PROVISIONS

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

Payment of Providers

Blue Shield generally contracts with groups of Physicians to provide services to Members. A fixed, monthly fee is paid to 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.

Plan Interpretation

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of the contract, 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 contract.

Independent Contractors

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

Membership Identification Cards

Blue Shield will issue membership identification cards to all Subscribers.

Statutory Requirements

This Agreement is subject to the Knox-Keene Act, Health Care Service Plan Chapter 2.2 of Division 2 of the California Health and Safety Code, and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

Legal Process

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

Non-Assignability

Neither the coverage nor any Benefits of this Agreement may be assigned.

Notice

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans permitting the Plan to use the Blue Shield Service Mark in the State of California and that the Plan is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity, or organization affiliated

with the Association shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Agreement.

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 Member Services at the number listed in the back of this booklet, or by accessing Blue Shield of California's Internet site located at <http://www.blueshieldca.com> and printing a copy.

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

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

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

Email Address:
BlueShieldca_Privacy@blueshieldca.com

Access to Information

Blue Shield of California may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue Shield of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by provid-

ing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California 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 of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Public Policy Participation Procedure

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

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

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

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

Please follow the following procedure:

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

Access+ Satisfaction

You may provide Blue Shield with comments and feedback regarding the service you receive from Plan Physi-

cians. Return the prepaid postcard available from Member Services to Blue Shield. If you are dissatisfied with the service you receive during an office visit with a Plan Physician, you may request a refund of your office visit Co-payment.

Organ and Tissue Donation

Many residents in the state of California are eligible to become organ and tissue donors. By deciding to be an organ and tissue donor, you can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at <http://www.ctdn.org> or Donate Life California's internet site at <http://www.donatelifecalifornia.org>. You may also call the regional organ procurement agency in the city nearest you for additional information on organ and tissue donation.

MEMBER SERVICES

For all Services other than Mental Health and substance abuse

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:

1-800-431-2809

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 serving your county as noted on the last page of this booklet. Member Services can answer many questions over the telephone. Members may also submit questions to the Member Service Department by accessing Blue Shield of California's Internet site located at <http://www.blueshieldca.com>.

NOTE: Blue Shield of California has established a procedure for our Members to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health-care Services. If you would like additional information

regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Member Services Department at 1-800-431-2809.

For all Mental Health and substance abuse Services

For all Mental Health and substance abuse Services Blue Shield of California has contracted with the Plan's Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and substance abuse Services or MHSA Participating Providers. 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
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

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 and substance abuse

The Member, 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 noted on the last page of this Evidence of Coverage 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 our web site at <http://www.blueshieldca.com>.

Blue Shield will acknowledge receipt of a grievance within five (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 and substance abuse Services

The Member, 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 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
Attn: Customer Service
P. O. Box 880609
San Diego, CA 92168

The MHSA will acknowledge receipt of a grievance within five (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 Services

External Independent Medical Review

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

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health Plan at **1-800-431-2809** 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 reasons of 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, the terms will have the meaning as indicated below:

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

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

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

Agreement — this contract, the appendices, all endorsements, and all applications for coverage and health statements.

Allowed Charges — the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan Providers (except that physicians rendering Emergency Services and hospitals rendering any Services who are not Plan Providers will be paid based on the Reasonable & Customary Charge, as defined).

Ambulatory Surgery Center — an Outpatient surgery facility which:

1. is either licensed by the State of California as an ambulatory surgery center or is a licensed facility 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 the Hospital and is not otherwise affiliated with a Hospital.

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

Calendar Year — a period beginning at 12:01 A.M. on January 1 and ending at 12:01 A.M. January 1 of the following year.

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

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

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

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

Creditable Coverage —

1. Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which Benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. Title XVIII of the Social Security Act, e.g., Medicare.
3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored or funded program of medical care.

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

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

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

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

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

Dependent —

1. A Subscriber's legally married spouse who is:
 - (a) A Resident of California; and
 - (b) Not covered for Benefits as a Subscriber; and
 - (c) Not legally separated from the Subscriber; or:
2. A Subscriber's Domestic Partner who is:
 - (a) Not covered for Benefits as a Subscriber; and
 - (b) A Resident of California.
3. A Subscriber's spouse's or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including any stepchild or legally adopted child 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:
 - (a) A Resident of California (unless a full-time student);
 - (b) Primarily Dependent upon the Subscriber, spouse or Domestic Partner for support and maintenance; or
 - (c) Dependent upon the Subscriber, spouse or Domestic Partner for medical support pursuant to a court order; and
 - (d) less than 19 years of age; or
 - (e) less than 23 years of age if enrolled as a full-time student and if proof of student status is submitted to and received by Blue Shield * (This item e. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19). Full-time student means a Dependent must be enrolled in a college, university, or vocational or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student;

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

*Note: For approved full-time students as described in 3.e. above:

- (1) any break in the school calendar shall not disqualify the Dependent from coverage;
 - (2) the coverage for a Dependent on an approved medical leave of absence will not be terminated for a period of 12 months or the date on which the coverage should terminate per the provisions of the Plan whichever comes first;
 - (3) for a medical leave of absence from school to be approved by Blue Shield, the Member must submit documentation or certification of the medical necessity of the leave. This submission should be sent to Blue Shield at least 30 days prior to the first day of the leave or, if not possible, must be sent no later than 30 days after the leave commences.
4. If coverage for a Dependent or Domestic Partner's child would be terminated because of the attainment of age 19 (or age 23, if Dependent has been a full-time student), 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 and must be incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition;
 - b. The Subscriber submits to Blue Shield a Physician's written certification of disability within 60 days from the date of Blue Shield's request; and
 - c. Thereafter, Certification from a Physician is submitted to Blue Shield on the following schedule:
 - (1) Within 24 months after the month when the Dependent would otherwise have been terminated; and
 - (2) Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

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

1. Both partners are:
 - a. 18 years of age or older; and
 - b. of the same or different sex; and
 - c. Residents of California.
2. The partners share:
 - a. An intimate and committed relationship of mutual caring; and

- b. The same principal residence.
3. The partners are:
 - a. Not currently married; and
 - b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited.
 4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

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 prepayment that is made to the Plan by each Subscriber.

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

Effective Date - the date an applicant meets all enrollment and pre-payment requirements and is accepted by Blue Shield of California.

Emergency Services — Services for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that 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.

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 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.

Hospice or Hospice Agency – an entity which 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.

Hospital —

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.

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 and substance abuse Services, this definition includes the Mental Health Service Administrator (MHSA).

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 (or substance abuse) treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Involuntary Complications of Pregnancy -

Conditions which require medical treatment prior to, or subsequent to, termination of pregnancy, and which are distinct from but adversely affected by, or related to, pregnancy. These may include, but are not limited to, puerperal infection, eclampsia, cesarean section, ectopic pregnancy, and toxemia.

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

Medically Necessary —

1. Benefits are provided only for Services which are Medically Necessary.

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

- a. Consistent with Blue Shield Medical Policy; and
- b. Consistent with the symptoms or diagnosis; and
- c. Not furnished primarily for the convenience of the patient, the attending Physician, or other provider; and
- d. Furnished at the most appropriate level which can be provided safely and effectively to the patient.

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

4. Hospital inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician’s office, the outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered.

Inpatient Services which are not Medically Necessary include hospitalization:

- a. For diagnostic studies that could have been provided on an outpatient basis;
- b. For medical observation or evaluation;
- c. For personal comfort;
- d. In a pain management center to treat or cure chronic pain; or
- e. For inpatient Rehabilitation that can be provided on an outpatient basis.

5. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

Member — either a Subscriber or Dependent.

Mental Health Services — see definition for Psychiatric Care.

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

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

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

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

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

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

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

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 as 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.

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

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

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

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

improve a patient's musculoskeletal, neuromuscular, and respiratory systems.

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

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

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

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

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

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

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

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

Psychiatric Care (Mental Health Services) — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist, for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury, or any other condition.

Reasonable & 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 functions or 2) to create a normal appearance to the extent possible.

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, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy benefits. Rehabilitation Services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

Resident of California — an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

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.

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

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

1. Have one (1) 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 six (6) months or are likely to continue for more than one (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 State Department of Health as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

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

1. Prescribed by a Physician or Nurse Practitioner for the treatment of phenylketonuria (PKU) and 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 (1) 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 a 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 is a Resident of California and who satisfies the eligibility requirements of this Agreement, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Agreement.

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

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.

Waivered Condition - a condition that is excluded from coverage for charges and expenses incurred during the six (6) month period beginning as of the Effective Date of coverage. A Waivered Condition applies only to a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the Effective Date of coverage.

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 Օգնություններ: Դուք կարող եք թարգման և լսողներին և փաստաթղթերը ընթերցել սալ և ել համար հայերեն լեզվով: Օգնության համար մեզ գաղտնագրեք ձեր ինքնության (ID) ստմնի վրա նշված կամ 1-866-346-7198 համարով: Armenian

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

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

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

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

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាស័យដ្ឋានជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន ចង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

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

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

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Officer, to take effect on the Subscriber's Effective Date.



Mark Gastineau, Senior Vice President
Individual, Small Group, and Government Business Unit
Blue Shield of California

For Information, Members may call Member Services toll-free at:
1-800-431-2809

The hearing impaired may call Blue Shield's toll-free TTY telephone number at 1-800-241-1823

Please direct correspondence to:
Blue Shield of California
P O Box 272540
Chico, CA 95927-2540