Evidence of Coverage and Disclosure Form

Effective January 1, 2027

CCPOA Medical Plan
EPO Basic Plan

Exclusive Provider Organization (EPO)

Sponsored by California Correctional Peace Officers Association Benefit Trust Fund

Approved by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

Notice About Health Information Exchange Participation

Blue Shield participates in the Manifest MedEx Health Information Exchange ("HIE") making its Members' health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

Manifest MedEx respects Members' right to privacy and follows applicable state and federal privacy laws. Manifest MedEx uses advanced security systems and modern data encryption techniques to protect Members' privacy and the security of their personal information. The Manifest MedEx notice of privacy practices is posted on its website at www.manifestmedex.org.

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx, should fill out the online form at www.manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142.

Notice about fertility preservation services

You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network costsharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can

arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Notice about telehealth

You have the right to access your medical records. The records of any services provided to you through a Third-Party Corporate Telehealth Provider will be shared with your Physician, unless you object.

You can receive Covered Benefits on an in-person basis or via telehealth, if available, from your Physician, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with existing timeliness and geographic access standards. See the Timely Access to Care section for more information.

If your plan includes Covered Benefits from Non-Participating Providers, you can receive the Covered Benefit either on an in-person basis or via telehealth.
Please see the How to Use this Plan section for additional information.

Notice about confidential communication requests

A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to [blueshieldca.com/privacy] and clicking on "privacy

forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

Mail: Blue Shield of California Privacy Office, P.O. Box 272530, Chico CA, 95927

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

Your Introduction to the CCPOA Medical Plan

Welcome to the CCPOA Medical Plan.

Your interest in the CCPOA Medical Plan is appreciated. Blue Shield has served Californians for more than 60 years, and we look forward to serving your health care needs.

The Blue Shield of California EPO Plan is specifically designed for you to use Blue Shield of California Participating/Preferred Providers. You can control your out-of-pocket costs by carefully choosing the providers from whom you receive Covered Benefits. Blue Shield of California has a statewide network of physician members and contracted hospitals known as Participating/Preferred Providers. Many other health care professionals, including optometrists, podiatrists and home health care agencies, are also Participating/Preferred Providers.

The term "Member" is used throughout this booklet to mean employees or retirees and their family members and/or domestic partners who are enrolled in this Blue Shield of California EPO Plan through CCPOA.

IMPORTANT

All Covered Benefits, except for emergency and urgent services, must be provided by Participating/Preferred Providers. No benefits are provided when you receive services from a Non-Participating or Non-Preferred Provider, except for medically necessary Covered Benefits received for emergency or urgent care. If a Participating/Preferred Provider refers you to a Non-Participating or Non-Preferred Provider, you are responsible for the total amount billed by the Non-Participating or Non-Preferred Provider (billed charges).

Directories of Blue Shield of California Participating/Preferred Providers located in your area are available upon request. You can only choose providers from this list. It is your obligation to be sure that the physician, hospital, or alternate care services provider you choose is a Participating/Preferred Provider, in case there have been any changes since your directory was published.

Extra copies of directories are available from Blue Shield of California. If you do not have the directories, please contact Blue Shield of California immediately and request them at the telephone number listed on the back cover of this booklet.

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

If you have questions about your benefits, contact Blue Shield of California before hospital or medical services are received.

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

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

1. You or your physician must obtain Blue Shield of California approval at least 5 working days before hospital or skilled nursing facility admissions for all non-emergency inpatient hospital or skilled nursing facility services, or for all non-emergency inpatient Mental Health or Substance Use Disorder services. (See the "Blue Shield Participating/Preferred Providers" section for information.)

2. You or your physician must notify Blue Shield of California within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.

3. You or your physician must obtain prior authorization in order to determine if contemplated services are covered. See Prior Authorization in the Benefits Management Program section for a listing of services requiring prior authorization.

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

Note: Blue Shield will render a decision on all requests for prior authorization within 5 business days, but not to exceed 7 calendar days, from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

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

Please review this booklet which summarizes the coverage and general provisions of the CCPOA Medical Plan.

If you have any questions regarding the information, you may contact us through our Member Services Department at 1-800-257-6213. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free text telephone (TTY) number, 711.

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BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Summary of Covered Benefits

Category Description	Member Copayment & Limitations
Hospital	
Inpatient (includes blood and blood products - collection and storage of autologous blood)	$100 per admission
Outpatient (other than surgery)	No Charge
Outpatient surgery (surgery performed in a Hospital or Outpatient Surgical Center)	$50
Physician Services	
Office Visits	$15/visit
Home Visits	$15/visit
Allergy Testing/Treatment	No Charge
Inpatient Hospital Visits	No Charge
Surgery/Anesthesia	No Charge
Preventive Health	No Charge
Diagnostic X-ray/Lab	No Charge
Durable Medical Equipment (including breast pump, orthoses and prostheses)	No Charge
Pregnancy & Maternity	
Prenatal and Postnatal Physician Office Visits	No Charge
Family Planning Counseling	No Charge
Infertility Testing & Treatment	50% of Allowable Amount
Ambulance Services	No Charge
Emergency Care/Services	$75/visit – does not apply if hospitalized or kept for observation - if admitted, $100 per admission fee will apply
Urgent Services	
Outside your primary care physician Service Area within California	$15/visit
Outside of California	$25/visit Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.
Home Health Services	$15/visit - up to 100 visits per calendar year.
Physical/Occupational/Speech Therapy	No Charge
Skilled Nursing Care	No Charge - up to 100 days per calendar year.
Hospice	No Charge
Biofeedback	$15/visit

BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Summary of Covered Benefits

Category Description	Member Copayment & Limitations
Prescription Drugs	$50 calendar year Pharmacy deductible per Member, not to exceed $150 per family. The Pharmacy deductible is applicable to all covered drugs not in Tier 1. Does not apply to contraceptive drugs and devices, or oral anticancer drugs. Prescription Drugs Obtained at a Retail Pharmacy You pay nothing for contraceptive drugs and devices**, $10 Tier 1, $25 Tier 2, $50 Tier 3, $50 Tier 4/prescription - not to exceed a 30-day supply for short-term or acute illness. You pay nothing for contraceptive drugs and devices**, $30 Tier 1, $75 Tier 2, $150 Tier 3, $150 Tier 4/prescription - not to exceed a 90-day supply for short-term or acute illness. Home delivery Prescription Drugs You pay nothing for contraceptive drugs and devices**, $20 Tier 1, $50 Tier 2, $100 Tier 3/prescription - not to exceed a 90-day supply for mail order drugs which are taken over long periods of time (maintenance drugs). Tier 4 Drugs $100 per prescription
Mental Health or Substance Use Disorder	
Inpatient Hospital Services	$100 per admission
Inpatient Physician Services	No Charge
Residential Care	$100 per admission
Office Visits for Outpatient Mental Health or Substance Use Disorder Services	$15/visit
Other Outpatient Mental Health or Substance Use Disorder Services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization programs, and transcranial magnetic stimulation.)	No Charge
Vision Care	
Eye Refraction to determine need for corrective lenses	$15/visit. *(However, this service is limited to one visit per calendar year for Members aged 18 and over. No limit on number of visits for Members under age 18.)*
Eyeglasses	Not Covered, except for eyeglasses that are necessary after cataract surgery.
Hearing Aid Services	
Audiological Evaluation	$15/visit
Hearing Aid up to a maximum of $800 per Member every calendar year for both ears for the hearing aid instrument and ancillary equipment	Charges in excess of $800

BASIC PLAN

THIS IS ONLY A BRIEF SUMMARY. REFER TO THE BENEFIT DESCRIPTIONS AND LIMITATIONS IN THIS BOOK FOR FURTHER INFORMATION.

Summary of Covered Benefits

Category Description	Member Copayment & Limitations
Chiropractic Services	
Chiropractic Examination	$15/visit - up to 20 visits per calendar year.
Diagnostic Services for Chiropractic Care	No Charge
Chiropractic Appliances (up to a maximum of $50 is covered during a calendar year)	No Charge
Member's Calendar Year Out-of-Pocket Maximum	
Member's calendar year out-of-pocket maximum for all Covered Benefits.	$ 1,500 per Member $ 4,500 per Family (3 or more Members enrolled)

* The statement of benefits, exclusions and limitations in this Evidence of Coverage is complete and is incorporated by reference into the contract.

See the "Obtaining outpatient prescription Drugs at a Participating Pharmacy" section of this Evidence of Coverage for more information about how a brand contraceptive may be covered without a Co-payment or Coinsurance.

BASIC PLAN

Benefit Changes for Current Year

BENEFITS OF THIS PLAN ARE AVAILABLE ONLY FOR SERVICES AND SUPPLIES FURNISHED DURING THE TERM THE PLAN IS IN EFFECT AND WHILE THE INDIVIDUAL CLAIMING BENEFITS IS ACTUALLY COVERED BY THE GROUP AGREEMENT.

IF BENEFITS ARE MODIFIED, THE REVISED BENEFITS (INCLUDING ANY REDUCTION IN BENEFITS OR ELIMINATION OF BENEFITS) APPLY TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF MODIFICATION. THERE IS NO VESTED RIGHT TO RECEIVE THE BENEFITS OF THIS PLAN.

Evidence of Coverage and Disclosure Form Template Language Updates

In accordance with state mandate AB 118, the following sections have been updated to reflect template language changes: Exclusions and Limitations; Claims and Services Review; Member Rights and Responsibilities; Third Party Recovery Process and the Member's Responsibility; and Definitions. Benefit Descriptions have also been updated to preserve previous Benefit-specific exclusions.

Fertility Preservation

In accordance with state mandate SB 600, the Notices section and Section H. Fertility Preservation have been updated to reflect coverage and notice requirements for Standard Fertility Preservation Services.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
Or call:
888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's Service Area. When you use your work ZIP Code, all enrolled dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's Service Area, even if they do not reside in that area.

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician.

Vested Rights

There is no vested right to receive any particular benefit set forth in the plan. plan benefits may be modified. any modified benefit (such as the elimination of a particular benefit or an increase in the member's copayment) applies to services or supplies furnished on or after the effective date of the modification.

How to Use the Plan

Blue Shield Participating/Preferred Providers

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

The Blue Shield of California EPO Plan is specifically designed for you to use Blue Shield of California Participating/Preferred Providers. They are listed in the Blue Shield CCPOA EPO Physician and Hospital Directory. It is your obligation to be sure that the provider you choose is a Participating/Preferred Provider in case there have been any changes since your directory was published. If you do not have a copy of Blue Shield's provider directory, you may call 1-800-257-6213 and request one.

Please note services performed by yourself, your spouse, Domestic Partner, child, brother, sister, or parent are not covered. In addition, services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program are not covered.

IMPORTANT

All Covered Benefits, except for emergency and urgent services, must be provided by Participating/Preferred Providers. No benefits are provided when you receive Covered Benefits from a Non-Participating or Non-Preferred Provider except for medically necessary Covered Benefits received for emergency or urgent care, or services provided by a 988 center, Mobile Crisis Team, or other provider of Behavioral Health Crisis Services. If a Participating/Preferred Provider refers you to a Non-Participating or Non-Preferred Provider, you are responsible for the total amount billed by the Non-Participating or Non-Preferred Provider (billed charges). If a Participating Provider is not available, the Member can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be obtained from a Participating Provider, Blue Shield will approve the request and the Member will only be responsible for the Participating Provider Cost Share.

You are not responsible to a Participating/Preferred Provider for payment for Covered Benefits, except for copayments or amounts in excess of specified benefit maximums.

Your Primary Care Physician

You are required to have a Primary Care Physician (PCP). However, you do not need to visit your PCP or get a referral from your PCP before you receive care.

We do suggest your PCP be your first point of contact when you need Covered Benefits. Your PCP can provide primary care and help direct you to specialized care.

Each Member is required to select a PCP at the time of enrollment. Blue Shield will choose a PCP for you if one is not selected at the time of enrollment, but you can change this selection. You can change your PCP at any time. To change your PCP, visit blueshieldca.com.
PCPs may be:

- General practitioners;
- Family practitioners;
- Internists;
- Obstetrician/gynecologists; or
- Pediatricians.

You do not need to choose the same PCP for each Member in your family.

Your PCP must be a Participating Provider within the EPO network. If your PCP leaves this plan's network, Blue Shield will choose a new PCP for you and notify you.

Continuity of Care

Continuity of care with a non-Participating Provider may be available if:

- Blue Shield no longer contracts with your Former Participating Provider for the services you are receiving,
- You are a newly-covered Member whose coverage choices do not include out-of-network Benefits, or

- You are a newly-covered Member whose previous health plan was withdrawn from the market.

Continuity of care may also be available to you when your Employer terminates its contract with Blue Shield and contracts with a new health plan (insurer) that does not include your Blue Shield Participating Provider in its network.

If your Former Participating Provider is no longer available to you for one of the reasons noted above, Blue Shield will notify you of the option to continue treatment with your former Participating Provider.

You can request to continue treatment with your Former Participating Provider in the situations described above if you are currently receiving the following care:

Continuity of care with a Former Participating Provider	
Qualifying Conditions	**Timeframe**
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.

To request continuity of care with a Former Participating Provider, visit www.blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and may review your request for Medical Necessity.

Under Federal law, the Former Participating Provider must accept Blue Shield's Allowable Amount as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Participating Provider at the Participating Provider Copayment or Coinsurance.

Financial Responsibility for Continuity of Care Services

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

How to Receive Care

How to Use the Blue Shield EPO Plan

When you need health care, present your Blue Shield identification card to your physician, hospital or other licensed health care provider. Your identification card has your subscriber and group number on it.

Benefits Management Program

Blue Shield has established the Benefits Management Program to assist you, your dependents or provider in identifying the most appropriate and cost-effective course of treatment for which certain benefits will be provided under this health plan and for determining whether the services are medically necessary. However, you, your dependents and provider make the final decision concerning treatment. The Benefits Management Program includes prior authorization review for certain services, emergency admission notification, hospital inpatient review, discharge planning, and case management if determined to be applicable and appropriate by Blue Shield. Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in reduced payment or non-payment if Blue Shield determines the service was not a Covered Benefit. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefit Management Program also apply to your dependents.

Blue Shield requires prior authorization for selected inpatient and outpatient services, supplies and durable medical equipment; admission into an approved hospice program; and certain radiology procedures. Prior authorization is required for all inpatient hospital and skilled nursing facility services (except for emergency services*).

*See the paragraph entitled Emergency Admission Notification later in this section for notification requirements. By obtaining prior authorization for certain services prior to receiving services, you and your provider can verify: (1) if Blue Shield considers the proposed treatment medically necessary, (2) if plan benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by Blue Shield. You and your provider may be informed about services that could be performed on an outpatient basis in a hospital or outpatient facility.

Prior Authorization

For services and supplies listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a Covered Benefit and may also receive a recommendation for an alternative service. Failure to contact Blue Shield as described below or failure to follow the recommendations of Blue Shield for Covered Benefits may result in non-payment by Blue Shield if it is determined that the service is not a Covered Benefit.

For services other than those listed in the sections below, you, your dependents or provider should consult the Benefit Descriptions section of this booklet to determine whether a service is covered.

You or your physician must call 1-888-732-0000 for prior authorization for the services listed in this section except for the outpatient radiological procedures described in item 13. below. For prior authorization for outpatient radiological procedures, you or your physician must call 1-888-642-2583. For prior authorization of oncology services, you or your physician must call 1-888-999-7713.

Blue Shield requires prior authorization for the following services:

1. Admission into an approved hospice program as specified under Hospice Program Services in the Benefit Descriptions section.

2. Clinical Trials for Cancer.

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

3. Hip and knee joint replacement surgery services and associated travel expense reimbursement.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for the services described in items 1. through 3. above will result in non-payment of services by Blue Shield.

4. Durable medical equipment benefits, including but not limited to motorized wheelchairs, insulin infusion pumps, and continuous blood glucose monitors.

5. Home health care benefits from Non-Preferred Providers.

6. Home infusion/home injectable therapy benefits from Non-Preferred Providers.

7. Hemophilia home infusion products and services.

8. Arthroscopic surgery of the temporomandibular joint (TMJ) services.

9. Reconstructive surgery.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for the services described in items 4. through 9. above may result in non-payment of services by Blue Shield.

10. Hospital and skilled nursing facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).

11. Medically necessary dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

12. Special transplant benefits (see the benefit description in the Benefit Descriptions section).

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for the services described in items 10. through 12. above will result in a 50% reduction in the amount payable by Blue Shield after the calculation of any applicable copayments required by this plan or may result in non-payment if Blue Shield determines that the service is not a Covered Benefit. You will be responsible for the applicable copayments and the additional 50% of the charges that are payable under this plan.

13. The following advanced imaging procedures when performed in an outpatient setting on a non-emergency basis:

    CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnostic procedure utilizing Nuclear Medicine.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield for the services described in item 13. above will result in a reduced payment amount per procedure or may result in non-payment if Blue Shield determines that the service is not a Covered Benefit.

- For Covered Benefits that are not authorized in advance, the amount payable will be reduced by 50% after the calculation of any applicable copayments required by this plan. You will be responsible for the remaining 50% and applicable copayments.
- For services provided by a Non-Preferred Provider, the subscriber will also be responsible for all charges in excess of the allowable amount.

Other specific services and procedures may require prior authorization as determined by Blue Shield. A list of services and procedures requiring prior authorization can be obtained by your provider by going to http://www.blueshieldca.com or by calling 1-888-732-0000.

Hospital and Skilled Nursing Facility Admissions

Prior authorization must be obtained from Blue Shield for all hospital and skilled nursing facility admissions (except for admissions required for emergency services). Included are hospitalizations for continuing inpatient rehabilitative and skilled nursing care.

Prior Authorization for Other than Mental Health or Substance Use Disorder Services

Whenever a hospital or skilled nursing facility admission is recommended by your physician, you or your physician must contact Blue Shield at 1-888-732-0000 at least 5 business days prior to the admission. However, in case of an admission for emergency services, Blue Shield should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Blue Shield will discuss the benefits available, review the medical information provided and may recommend that to obtain the full benefits of this health plan that the services be performed on an outpatient basis.

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

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

Failure to contact Blue Shield as described above or failure to follow the recommendations of Blue Shield will result in non-payment by Blue Shield if it is determined that the admission is not a Covered Benefit.

Prior Authorization for Inpatient Mental Health or Substance Use Disorder Services

Prior authorization is required for all nonemergency Mental Health Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield at 1-800-334-5847 at least five business days prior to the admission. Other Outpatient Mental Health Services include Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Neuropsychological and Psychological Testing, and Transcranial Magnetic Stimulation (TMS) and must also be prior authorized.

For an admission for emergency mental health or substance use disorder services, Blue Shield should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

Failure to contact Blue Shield as described above or failure to follow the recommendations of Blue Shield may result in non-payment by Blue Shield if it is determined that the admission is not a Covered Benefit.

Blue Shield will render a decision on all requests for prior authorization within 5 business days, but not to exceed 7 calendar days, from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and subscriber within five calendar days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request. A written notice will be sent to the Member and the provider within 72 hours of the decision.

If prior authorization is not obtained for a mental health inpatient admission or for any Other Outpatient Mental Health Services and the services provided to the member are determined not to be a Benefit of the plan, coverage will be denied.

Prior authorization is not required for an emergency admission.

Emergency Admission Notification
If you are admitted for emergency services, Blue Shield should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so.

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

Discharge Planning
If further care at home or in another facility is appropriate following discharge from the hospital, Blue Shield may work with you, your physician and the hospital discharge planners to determine whether benefits are available under this plan to cover such care.

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

Second Medical Opinions
If you have a question about your diagnosis or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another physician for a second medical opinion. Your attending physician may also offer to refer you to another physician for a second opinion.

Remember that the second opinion visit is subject to all Plan contract benefit limitations and exclusions.

NurseHelp 24/7 and LifeReferrals 24/7
If you are unsure about what care you need, you should contact your physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by telephone 24 hours a day, seven days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

1. Symptoms you are experiencing, including whether you need emergency care;
2. Minor illnesses and injuries;
3. Chronic conditions;
4. Medical tests and medications;
5. Preventive care.

If your physician's office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is listed on your Member identification card.

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

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

These programs include:

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

Psychosocial Support
Notwithstanding the benefits provided under R. Outpatient Mental Health or Substance Use Disorder Services in the Benefit Descriptions section, the Member also may call 1-800-985-2405 on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-to-face visits within a 6-month period.

In the event that the services required of a Member are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Member will be referred to Blue Shield to access his Mental Health or Substance Use Disorder services which are described under R. Outpatient Mental Health or Substance Use Disorder Services.

Evaluations and Services under the CARE Act

Blue Shield covers the cost of developing an evaluation and the provision of all health care services for an enrollee when required or recommended pursuant to a CARE (Community Assistance, Recovery, and Empowerment) agreement or CARE plan approved by a court in accordance with the CARE Act. The evaluation and services, other than prescription Drugs, are covered at no charge whether they are provided by a Participating Provider or Non-Participating Provider. You do not need prior authorization for services, other than prescription Drugs, provided under a court-approved CARE agreement or CARE plan.

Emergency Services

What is an Emergency?
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 patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those 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.

What to do in case of Emergency:

Life Threatening

Obtain care immediately.

Contact your Primary Care Physician no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening

Consult your Primary Care Physician, anytime day or night, regardless of where you are prior to receiving medical care.

Follow-Up Care

Follow-up care, which is any care provided after the initial emergency room visit, must be provided or authorized by your Primary Care Physician.

For a complete description of the Emergency Services benefit and applicable copayments, see J. Emergency Services.

Urgent Services

The Blue Shield EPO plan provides coverage for you and your family for your urgent service needs when you or your family are temporarily traveling outside of your Primary Care Physician Service Area.

Urgent services are defined under Definitions.

Out-of-area follow-up care is defined under Definitions.

(Urgent care) While in your Primary Care Physician Service Area

Urgent, same-day care for a condition that could reasonably be treated in your Primary Care Physician's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part). You may see your Primary Care Physician or visit an urgent care center.

Outside of California

The Blue Shield EPO plan provides coverage for you and your family when you or your family are temporarily traveling outside of California. Covered Benefits may be obtained from any provider; however, using the BlueCard® or Blue Shield Global® Core programs 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. See the Inter-Plan Programs section of this Evidence of Coverage for more information on the BlueCard® or Blue Shield Global® Core programs.

Out-of-Area Follow-up Care is also covered and services may be received through the BlueCard® or Blue Shield Global® Core programs. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

Within California

If you are temporarily traveling within California, but are outside of your Primary Care Physician Service Area, if possible, you should call Shield Concierge at 1-800-257-6213 for assistance in receiving urgent services through a Blue Shield of California Participating Provider. You may also locate a Blue Shield Participating Provider by visiting our web site at http://www.blueshieldca.com. However, you are not required to use a Blue Shield of California Participating Provider to receive urgent services; you may use any California provider.

Out-of-Area Follow-up Care is also covered through a Blue Shield of California provider and may be received from any provider. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

If services are not received from a Blue Shield of California Participating Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for urgent services obtained outside of your Primary Care Physician Service Area within California will be reviewed retrospectively for coverage. Blue Shield will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information. Once the missing information is received, Blue Shield will have 30 calendar days to process your claim.

When you receive Covered Benefits outside your Primary Care Physician Service Area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated based on Blue Shield's Allowable Amount.

See J. Urgent Services for benefit description, applicable copayment information, and information on payment responsibility and claims submission.

Out-of-Area Services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Programs. These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Benefits outside of California, the claims for those services may be processed through one of these Inter-Plan Programs.

When you access Covered Benefits outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will generally receive care from participating providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, you may receive care from non-participating providers that do not have a contractual agreement with the Host Blue. Blue Shield's payment practices in both instances are described below.

This Blue Shield plan provides limited coverage for health care services from non-participating providers outside of California. Except where prohibited by state law, Out-of-Area Covered Health Care Services from non-participating providers are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care.

Inter-Plan Programs

Emergency Services

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

BlueCard Program

Under the BlueCard® Program, when you access Covered Benefits within the geographic area served by a Host Blue, Blue Shield will remain responsible for doing what we agreed to in the provisions of this Evidence of Coverage. However the Host Blue is responsible for handling all interactions with its providers, including contracting with participating providers and direct payment to the provider.

The BlueCard Program enables you to obtain Covered Benefits outside of California from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Covered Benefits provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment, coinsurance and deductible amounts, if any, as stated in this booklet.

When you receive Covered Benefits outside of California and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Benefits; or

2. The negotiated price that the Host Blue makes available to Blue Shield.

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

Estimated pricing and average pricing, going forward, also consider adjustments to correct

for over or underestimation of modifications of past pricing as noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because these adjustments will not be applied retroactively to claims already paid.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully-insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee as part of the claim charges passed on to you.

Claims for covered emergency services are paid based on the Allowable Amount as defined in this booklet.

Non-participating Providers Outside of California

Coverage for health care services provided outside of California and within the BlueCard Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Out-of-Area Covered Health Care Services as described in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

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

Your cost share will govern payments for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Benefits, as listed in the Summary of Covered Benefits.

Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (BlueCard Service Area), you may be able to take advantage of Blue Shield Global® Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global® Core is not served by a Host Blue. As such, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

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

Submitting a Blue Shield Global® Core Claim

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

Member Calendar Year Out-of-Pocket Maximum

Your out-of-pocket maximum amount each calendar year for Covered Benefits, except those listed below, is $ 1,500 per Member and $ 4,500 per family (three or more Members enrolled).

Once a Member's out-of-pocket maximum amount has been met, the Plan will pay 100% of the Allowable Amount for that Member's Covered Benefits for the remainder of that calendar year, except as described below. Additionally, for Plans with a Member and a family out-of-pocket maximum amount, once the family out-of-pocket maximum amount has been met, the Plan will pay 100% of the Allowable Amount for the subscriber's and all covered dependents' Covered Benefits for the remainder of that calendar year, except as described below.

Covered Benefits received at a facility that is a Participating Provider will accrue to the Calendar Year Out-of-Pocket Maximum whether Services are provided by a health professional who is a Participating Provider or Non-Participating Provider.

Charges for services not covered and services not prior approved by the Physician, except those meeting the emergency and urgent care requirements, are your responsibility, do not apply towards the Member Calendar Year Out-of-Pocket Maximum amount, and may cause your payment responsibility to exceed the Member Calendar Year Maximum Out-of-Pocket amount defined above

Note that copayments and charges for Services not accruing to the Member Calendar Year Out-of-Pocket maximum amount continue to be the Member's responsibility after the Calendar Year Out-of-Pocket maximum amount is reached.

Note: It is your responsibility to maintain accurate records of your copayments and to determine and notify Blue Shield when the Member Calendar Year Out-of-Pocket maximum amount has been reached.

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

Accrual balance

Blue Shield provides a summary of your accrual balances toward your Calendar Year Deductible, if any, and Out-of-Pocket Maximum for every month in which your Benefits were used until the full amount has been met. This summary will be mailed to you unless you opt to receive it electronically or have already opted out of paper mailings. You can opt back in to receive paper mailings at any time or elect to receive your balance summary electronically by logging into your member portal online and updating your communication preferences, or by calling Customer Service at the number on the back of your ID card. You can also check your accrual balances at any time by logging into your member portal online, which is updated daily, or calling Customer Service. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

Limitation of Liability

Members shall not be responsible to Participating Providers or health professionals who are Non-Participating Providers rendering Services at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) for payment for services if they are a benefit of the Plan, unless the Non-Participating Provider provides the Member with written notice of what they may charge and the Member consents to those terms. When Covered Benefits are rendered by a Participating Provider or rendered by a health professional who is a Non-Participating Provider at a Participating Provider facility, the Member is responsible only for the applicable copayments, except as set forth in the Third Party Recovery Process and the Member's Responsibility section. Members will not be

responsible for additional charges above the Allowable Amount without written notice and consent. Members are responsible for the full charges for any non-covered services they obtain.

Member Identification Card

You will receive your EPO identification card after enrollment. If you do not receive your identification card or if you need to obtain medical or prescription services before your card arrives, contact the Blue Shield Member Services Department so that they can coordinate your care and direct your Physician or pharmacy.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Member's eligibility, or payments on fraudulent claims.

Member Services Department

If you have a question about services, providers, benefits, how to use this plan, or concerns regarding the quality of care or access to care that you have experienced, you should call the Blue Shield Member Services Department at 1-800-257-6213. The hearing impaired may contact Blue Shield's Member Services Department through Blue Shield's toll-free TTY number, 711. Member Services can answer many questions over the telephone.

Expedited Decision

Blue Shield of California has established a procedure for our Members to request an expedited decision (including those regarding grievances). 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 1-800-257-6213.

For chiropractic services

For all chiropractic services, Blue Shield of California has contracted with American Specialty Health Plans (ASHP) to act as the Plan's chiropractic Services administrator. ASHP should be contacted for questions about chiropractic services, ASHP Participating Providers, or chiropractic benefits. You may contact ASHP at the telephone number or address which appear below:

1-800-678-9133

American Specialty Health Plans of
California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

For information on additional rights, see the Grievance Process section.

Rates for Basic Plan

The CCPOA Medical Plan is regionally rated. The rates reflect the health care costs for each area. There will be two rating regions. The total CCPOA Medical Plan cost per month (including Prescription Drug, Mental Disorders and Substance Use Disorder, and Chiropractic Benefits) are shown below:

Northern California Only

	Rates
Subscriber only	$1,343.68

Subscriber and one
Family Member $2,693.42
Subscriber and two
or more Family Members $3,636.45

Southern California Only

Rates

Subscriber only $1,107.93
Subscriber and one
Family Member $2,221.84
Subscriber and two
or more Family Members $3,002.37

State Employees and Annuitants

The rates shown above are effective January 1, 2027, and will be reduced by the amount the State of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your employing agency or retirement system health benefits officer.

Rate Change

The plan rates may be changed as of January 1, 2028, following at least 60 days' written notice to the CalPERS Board of Administration prior to such change.

Benefit Descriptions

The Plan benefits available to you are listed in this section. The copayments for these services, if applicable, follow each benefit description.

The following are the basic health care services covered by the CCPOA Medical Plan without charge to the Member, except for copayments where noted, and as set forth in the Third Party Recovery Process and the Member's Responsibility section. These services are covered when medically necessary. Coverage for these services is subject to the Benefits Management Program and all terms, conditions, limitations and exclusions of the Agreement, to any conditions or limitations set forth in the benefit descriptions below, and to the Exclusions and Limitations set forth in this booklet.

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.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Participating Providers:

Urgent Care	**Access to Care**
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	**Access to Care**
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health or substance use disorder provider (who is not a physician)	Within 10 business days
Follow-up appointments with a mental health or substance use disorder provider (who is not a physician)	Within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	**Access to Care**

Access to a health professional for telephone triage or screening services by calling Customer Service	24 hours/day, 7 days/week

Call Customer Service if you need help finding a Participating Provider or if a Participating Provider is not available. Please see the *Blue Shield Preferred Providers* section for more information.

Note: For availability of interpreter services at the time of the Member's appointment, consult the list of Blue Shield Participating Providers available at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this EOC.

A. 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 3 days' supply of drugs supplied upon discharge by the physician for the purpose of transition from the hospital to home. Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Participating Provider.

    For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for that disease will be covered without a Cost Share;

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

    i. Processing, storage and administration of blood, and blood products (plasma), in inpatient and outpatient settings. Includes the storage and collection of autologous blood;

    j. Radiation therapy, chemotherapy and renal dialysis;

    k. Respiratory therapy and other diagnostic, therapeutic and rehabilitative services as appropriate;

    l. Coordinated discharge planning, including the planning of such continuing care as may be necessary;

    m. Inpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon;

n. Subacute care;

o. Medically necessary inpatient substance use disorder withdrawal management (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 use disorder withdrawal management (detoxification) is prior authorized;

p. Rehabilitative services when furnished by the hospital and authorized.

See Section P. for inpatient hospital services provided under the "Hospice Program Services" benefit.

Copayment: $100 per admission.

2. Outpatient hospital services include:

a. Services and supplies for treatment (other than surgery) in an outpatient hospital setting or ambulatory surgery center;

Copayment: No charge.

b. Services and supplies for surgery in an outpatient hospital setting or ambulatory surgery center;

Copayment: $50.

c. Outpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes enrollees under the age of 7 and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon.

Copayment: No charge.

Benefits do not include:

- Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
- Hospital care programs or services provided in a home setting (Hospital-at-home programs).
- Domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
- Custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Inpatient Hospital care.

B. Physician Services (Other Than for Mental Health or Substance Use Disorder 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 or other consultations, administration of injectable medications that must be administered by a Health Care Provider, medical nutrition therapy, and diabetic counseling. Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person. 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 meter.

Copayment: $15 per visit. No additional charge for surgery or anesthesia; radiation or renal dialysis treatments; medications administered in the physician's office, including chemotherapy.

2. Allergy Testing and Treatment

   Office visits for the purpose of allergy testing on and under the skin such as prick/puncture, patch and scratch tests, and treatment, including injectables and serum. This Benefit does not include blood testing for allergies.

   Copayment: No charge.

3. Inpatient Medical and Surgical 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 physician services are covered only when hospital and skilled nursing facility services are also covered.

   Copayment: No charge.

4. Medically necessary home visits by Plan physician

   Copayment: $15 per visit.

5. Treatment of physical complications of a mastectomy, including lymphedemas

   Copayment: No charge.

C. Preventive Health Services

1. Preventive health services, as defined, when rendered by a physician are covered.

   Copayment: No charge.

2. Eye refraction to determine the need for corrective lenses.

   Copayment: $15 per visit. (Limited to one visit per calendar year, for Members aged 18 and over. No limit on number of visits for Members under age 18.)

D. Diagnostic X-ray/Lab Services

1. X-ray, Laboratory, Major Diagnostic Services. All outpatient diagnostic x-ray and clinical laboratory tests and services, including basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography, electrocardiograms, diagnostic clinical isotope services, bone mass measurements, and periodic blood lipid screening. COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing. Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month. Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of your disease or condition to guide treatment decisions (Benefits must be prior authorized).

2. Genetic Testing and Diagnostic Procedures. Genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be medically necessary and appropriate in accordance with Blue Shield of California medical policy.

See Section F. for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services.

Blue Shield encourages Members to seek services from Participating Providers to avoid paying extra fees. Some Non-Participating Providers may charge extra fees that are not covered by Blue Shield. Any fees not covered by Blue Shield will be the Member's responsibility. See the How to Use this Plan section for information about Participating and Non-Participating Providers.

Copayment: No charge.

E. Durable Medical Equipment, Prostheses and Orthoses and Other Services

Medically necessary durable medical equipment, prostheses and orthoses for activities of daily living, and supplies needed to operate durable medical equipment; oxygen and oxygen equipment and its administration; blood glucose monitors (including continuous blood glucose monitor), and all related necessary supplies for the self-management of diabetes, as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; required dialysis equipment and medical supplies; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. When authorized as durable medical equipment, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standard of practice.

1. Durable Medical Equipment

   a. 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. (See Section Q. for benefits for asthma inhalers and inhaler spacers.)

   b. Medically necessary repairs and maintenance of durable medical equipment, as authorized by Blue Shield. Repair is covered unless necessitated by misuse or loss.

   c. Rental charges for durable medical equipment in excess of the purchase price are not covered.

   d. Benefits do not include environmental control equipment or generators. No benefits are provided for backup or alternate items. Benefits do not include home testing devices and monitoring equipment except for over-the-counter at-home COVID-19 tests and sexually transmitted disease home testing kits. Benefits do not include any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other speech or language assistance devices, except as specifically listed.

   e. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with Blue Shield Medical Policy. For further information call Member Services or go to www.blueshieldca.com.

   f. Pasteurized donor human milk.

See Section W. for devices, equipment and supplies for the management and treatment of diabetes.

If you are enrolled in a hospice program through a participating hospice agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions are provided by the hospice agency. For information see Section P.

2. Prostheses

   a. Medically necessary prostheses for activities of daily living, including the following:

      1) Supplies necessary for the operation of prostheses;

      2) Initial fitting and replacement after the expected life of the item;

      3) Repairs, even if due to damage;

      4) Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;

      5) Prosthetic devices used to restore a method of speaking following laryngectomy, including initial and subsequent prosthetic devices and installation accessories. This does not include electronic voice producing machines;

      6) Cochlear implants;

      7) Contact lenses if medically necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia. Cataract spectacles or intraocular lenses that replace the natural lens of the eye after cataract surgery. If medically necessary with the insertion of the intraocular lens, one pair of conventional eyeglasses or contact lenses;

      8) Artificial limbs and eyes.

   b. Routine maintenance is not covered.

   c. Benefits do not include wigs for any reason, self-help/educational devices or any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other 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.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Section X. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

3. Orthoses

   a. Medically necessary orthoses for activities of daily living, 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, diabetes 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 postoperative rehabilitative services following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis.

   b. Benefits for medically necessary orthoses are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. Routine maintenance is not covered. No benefits are provided for backup or alternate items.

   c. 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.

Copayment: No charge.

See Section W. for devices, equipment and supplies for the management and treatment of diabetes.

F. Pregnancy and Maternity Care

The following pregnancy and maternity care is covered subject to the General Exclusions and Limitations.

1. Prenatal and Postnatal Physician Office Visits

   See Section D. for information on coverage of other genetic testing and diagnostic procedures.

   Copayment: No charge.

2. Inpatient Hospital and Professional Services. Hospital and Professional services for the purposes of a normal delivery, C-section, complications or medical conditions arising from pregnancy or resulting childbirth.

   Copayment: $100 per admission.

3. Abortion Services. Abortion is covered for all pregnant persons including, but not limited to, transgender individuals.

   Copayment: No charge.

4. Includes providing coverage for all testing recommended by the California Newborn Screening Program and for participating in the statewide prenatal testing program, administered by the State Department of Health Services, and known as the Expanded Alpha Feto Protein Program.

   Copayment: No charge.

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

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

G. Family Planning and Infertility Services

1. Family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; and follow-up services related to contraceptive Drugs, devices, products, and procedures, including but not limited to management of side effects, counseling for continued adherence, and device removal.

   Copayment: No charge.

2. Infertility Services. Artificial insemination and the diagnosis and treatment of Infertility, including professional, hospital, ambulatory surgery center, related services to diagnose and treat the cause of infertility with the exception of what is excluded in the General Exclusions and Limitations.

   Copayment: 50% of Allowable Amount for all services.

3. Vasectomy services and procedures

   Copayment: No charge.

4. Voluntary tubal ligation and other similar sterilization procedures

   Copayment: No charge.

5. Contraceptive Devices and Fitting

   Copayment: No charge.

6. Oral, Transdermal Patch, and Vaginal Ring Contraceptives

   Copayment: No charge.

7. Injectable Contraceptives

   Copayment: No charge.

8. Implantable Contraceptives

   Copayment: No charge.

H. Fertility Preservation Services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Benefits that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, Standard Fertility Preservation Services provided for fertility preservation, including retrieval and cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos, are a Covered Benefit and do not fall under the scope of Infertility Services described in Section G.

Blue Shield will provide written notice explaining the covered storage period within 30 business days after receipt of a claim for cryopreservation services.

Blue Shield will provide written notice 90 calendar days prior to the expiration of the storage periods.

I. Ambulance Services and Emergency Medical Services Programs

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 you reasonably believed that the medical condition was an Emergency Medical Condition or a Psychiatric Medical Condition which required ambulance services, as described in Section J.

2. Non-Emergency Ambulance Services

   Medically necessary ambulance services to transfer the Member from a Non-Participating hospital to a Participating hospital, between Participating Provider facilities, or from facility to home when in connection with authorized confinement/ admission and the use of the ambulance is authorized.

3. Emergency Medical Services Programs

   Covered Benefits provided by community paramedicine programs, triage to alternate destination programs, and mobile integrated health programs developed by local Emergency Medical Services (EMS) agencies. Covered Benefits provided by these EMS programs are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

   Copayment: No charge.

Benefits do not include:

Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).

J. Emergency Services

An Emergency Medical Condition 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 patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious

dysfunction of any bodily organ or part. If you receive services in a situation that Blue Shield determines did not require emergency services, or you did not reasonably believe that an emergency condition existed, you will be responsible for the costs of those services.

1. Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member must notify Blue Shield by phone within 24 hours of an emergency admission, or as soon as it is medically possible following the admission. Failure to provide notice as stated will result in the services not being covered.

2. Whenever possible, go to the emergency room of your nearest Blue Shield Participating hospital for medical emergencies. A listing of Blue Shield Participating hospitals is available in your EPO Physician and Hospital Directory.

   Copayment: $75 per visit in the hospital emergency room. (Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit.)

3. 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 or Psychiatric 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.

4. Claims for Emergency Services. Contact Member Services to obtain a claim form.

   Emergency. If emergency services were received and expenses were incurred by the Member, for services other than medical transportation, the Member must submit a complete claim with the emergency service record for payment to the Plan, within 1 year after the first provision of emergency services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those emergency services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not pre-authorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that these services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered, it will notify the subscriber of that determination. The Plan will notify the subscriber 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, Blue Shield EPO shall pay the medical transportation provider directly.

5. Emergency Services and follow-up health care treatment are provided without a Cost Share for Members treated following a rape

or sexual assault for the first nine months after the Member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

The Cost Share waiver is applicable to follow up health care treatment provided by a Participating Provider, any provider of Emergency Services, or a Non-Participating Provider when Blue Shield has approved your request to receive services from the Non-Participating Provider at the Participating Provider Cost Share. For more information, please see the If you cannot find a Participating Provider section. The Cost Share waiver will only apply to services the treating provider has identified in their claim submission using accurate diagnosis codes specific to rape or sexual assault.

K. Urgent Services

Urgent services are provided in response to the patient's need for a prompt diagnostic workup and/or treatment.

These services are applicable for a medical or mental disorder that: (1) could become an emergency if not diagnosed and/or treated in a timely manner, (2) is likely to result in prolonged temporary impairment, (3) could increase the risk of necessitating more complex or hazardous treatment, and (4) could develop in a chronic illness or inordinate physical or psychological suffering of the patient.

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

1. Inside California. For Urgent Services within California but outside of your Primary Care Physician Service Area, if possible, contact Blue Shield Member Services at 1-800-257-6213 for assistance in receiving urgent services. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Participating Provider. Members may also locate a Participating Provider by visiting Blue Shield's internet site at http://www.blueshieldca.com. You are not required to use a Blue Shield of California Participating Provider to receive urgent services; you may use any provider. However, the services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

   Copayment: $15 per visit.

2. Outside California or the United States. When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810 BLUE (2583) to obtain information about the nearest BlueCard or Blue Shield Global® Core participating provider. When a BlueCard or Blue Shield Global® Core participating provider is available, you should obtain Urgent Services and Out-of-Area Follow-up Care from a participating provider whenever possible, but you may also receive care from a non-participating provider. The services will be reviewed retrospectively by Blue Shield to determine whether the services were Urgent Services.

   For information on Urgent Services received outside of California see the Inter-Plan Programs section of the Evidence of Coverage.

   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 Primary Care Physician.

   Copayment: $25 per visit.

3. To receive urgent care within your Primary Care Physician Service Area, call your Primary Care Physician's office or visit an urgent care center.

L. Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy

1. Home Health Care Services

Benefits are provided for home health care services when the services are medically necessary, ordered by the Physician and authorized. Home health benefits are limited to a combined total of 100 visits during any calendar year for all providers other than Participating Physicians, except when provided in a Hospice Program through a Participating Hospice.

a. Home visits to provide Skilled Nursing Services and other skilled services by any of the following professional providers are covered:

1) Registered nurse;

2) Licensed vocational nurse;

3) Certified home health aide in conjunction with the services of 1) or 2), above.

Copayment: $15 per visit.

4) Medical Social Worker.

Copayment: No charge.

5) Physical therapist, occupational therapist, or speech therapist.

Copayment: No charge.

b. 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, to the extent the benefit would have been provided had the Member remained in the hospital or skilled nursing facility, except as excluded in the General Exclusions and Limitations.

Copayment: No charge.

This benefit does not include medications, drugs, or injectables covered under Section Q.

See Section P. for information about when a Member is admitted into a hospice program and a specialized description of Skilled Nursing Services for hospice care.

For information concerning diabetes self-management training, see Section W.

2. Administration of PKU-Related Formulas and Special Food Products

Benefits are provided for administration of enteral formulas, parenteral nutrition formulations, related medical supplies and special food products that are medically necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. These benefits must be prescribed or ordered by the appropriate health care professional.

Copayment: No charge.

3. Home Infusion/Home Injectable Therapy Provided by a Home Infusion Agency

Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency. Note: For services related to hemophilia, see item 4. below.

Services include home infusion agency skilled nursing services, administration of parenteral nutrition formulations, administration of enteral nutrition formulas, 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 Physician and prior authorized, and when provided by a home infusion agency.

This benefit does not include medications, drugs, insulin, insulin syringes, specialty drugs covered under Section Q., and

services related to hemophilia which are covered as described below.

Copayment: No charge.

*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).

4. Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by the Plan and must be provided by a participating Hemophilia Infusion Provider. (Note: Most participating home health care and home infusion agencies are not participating Hemophilia Infusion Providers.) A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. You may also verify this information by calling Member Services at the telephone number shown on the back cover of this booklet.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following evaluation by your physician, a prescription for a blood factor product must be submitted to and approved by the Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in Section J.)

Included in this benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a participating Hemophilia Infusion Provider, and medically necessary services to treat complications of hemophilia replacement therapy are not covered under this benefit but may be covered under other medical benefits described elsewhere in this Benefit Descriptions section.

This benefit does not include:

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

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

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

*Services and certain drugs may be covered under Section M., Section Q., or as described elsewhere in this Benefit Descriptions section.

Copayment: No charge.

M. Physical and Occupational Therapy

Rehabilitative services include physical therapy, occupational therapy, and/or respiratory therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient Department of a Hospital. Benefits for speech therapy are described in Section N. Medically necessary services will be authorized for an initial treatment period and any additional subsequent medically necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is medically necessary.

1. Physical therapy

Physical therapy uses physical agents, and therapeutic treatments, and modalities to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents, and therapeutic treatments, and modalities include but are not limited to:

- Ultrasound;
- Heat;

- Range of motion testing;
- Targeted exercise; and
- Massage performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider. Massage is not covered when performed as the solitary treatment or prescribed to an individual who presents with no complications.

2. Occupational therapy

Occupational therapy uses physical agents, therapeutic is treatment, and modalities to develop, improve, and maintain the skills you need for activities of daily living, such as dressing, eating, and drinking. Testing for intelligence or learning disabilities is not covered. Physical agents, therapeutic treatments, and modalities include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage performed as part of a rehabilitative or habilitative occupational therapy treatment plan by a licensed or certified Health Care Provider. Massage is not covered when performed as the solitary treatment or prescribed to an individual who presents with no complications.

Copayment: No charge.

See Section L. for information on coverage for rehabilitative services rendered in the home.

N. Speech Therapy

Outpatient benefits for Medically necessary speech therapy services when diagnosed and ordered by a physician and provided by an appropriately licensed speech therapist/pathologist, pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

Continued outpatient benefits will be provided 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 may 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 Section L., no outpatient benefits are provided for speech therapy, speech correction, or speech pathology services.

Copayment: No charge.

See Section L. for information on coverage for speech therapy services rendered in the home. See Section A. for information on inpatient benefits and Section P. for hospice program services.

O. Skilled Nursing Facility Services

Subject to all of the inpatient hospital services provisions under Section A. Hospital Services, medically necessary skilled nursing services, including subacute care, will be covered when provided in a skilled nursing facility and authorized. This benefit is limited to 100 days during any calendar year except when received through a hospice program provided by a participating hospice agency. Custodial care is not covered.

This Plan does not cover domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Skilled Nursing services.

For information concerning "Hospice Program Services" see Section P.

Copayment: No charge.

P. 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 his physician's certification and the admission must receive prior approval from Blue Shield. (Note: Members with a terminal illness who have not elected to enroll in a hospice program can receive a pre-hospice consultative visit from a participating hospice agency.) Covered Benefits 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 Benefits that are not related to the palliation and management of the terminal illness from the appropriate provider.

Note: Hospice services provided by a non-participating hospice agency are not covered except in certain circumstances in counties in California in which there are no participating hospice agencies and only when prior authorized by Blue Shield.

All of the services listed below must be received through the participating hospice agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Members do not have to be enrolled in the hospice program to receive this benefit).

2. Interdisciplinary Team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.

3. Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse.

4. Bereavement services.

5. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

6. Medical direction with the medical director being also responsible for meeting the general medical needs for the terminal illness of the Members to the extent that these needs are not met by the Member's other providers.

7. Volunteer services.

8. Short-term inpatient care arrangements.

9. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions.

10. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

11. Nursing care services are covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that 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 5 consecutive days at a time.

Members are allowed to change their participating hospice agency only once during each period of care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another period of care if the Participating Provider recertifies that the Member is terminally ill.

Benefits do not include:

- Domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
- Custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as part of a Hospice program.

Definitions

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

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

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

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

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

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.

2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and the Member's family.

3. Requires the Interdisciplinary Team to develop an overall plan of care and to provide coordinated care which emphasizes

supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

5. Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.

6. Actively utilizes volunteers in the delivery of hospice services.

7. Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

8. Is provided through a participating hospice agency.

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

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

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

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

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

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

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

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

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

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

Copayment: No charge.

Q. Prescription Drugs

Except for the Coordination of Benefits provision, the general provisions and exclusions of the EPO Health Plan Agreement shall apply.

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

Benefits are provided for outpatient prescription drugs which meet all of the requirements specified in this section, are prescribed by a physician or other licensed health care provider within the scope of his or her license as long as the prescriber is a Participating Provider, are obtained from a participating pharmacy, and are listed in the Drug Formulary. Blue Shield's Drug Formulary is a list of preferred generic and brand medications that: (1) have been reviewed for safety, efficacy, and bioequivalency; (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Blue Shield Outpatient Prescription Drug Benefit. Non-Formulary drugs may be covered subject to higher copayments. Select drugs and drug dosages and most specialty drugs require prior authorization by Blue Shield for medical necessity, including appropriateness of therapy and efficacy of lower cost alternatives. Outpatient Prescription Drugs do not include Drugs used for hemophilia, blood or blood products and any Drugs which are not considered to be safe for self-administration. These products and Drugs may be covered under the *Home Health Care Services, PKU-Related Formulas and Special Food Products, and Home Infusion Therapy*, *Hospice program services*, or *Family Planning and Infertility Services* sections.

Prescription Drug information is available by logging into your member portal at blueshieldca.com and selecting "Price Check My Rx". This tool can show you:

- Your eligibility for a prescription Drug;
- The current cost of the prescription Drug;
- Any available lower cost alternative(s) to the prescription Drug based on your plan Formulary and the pharmacy that fills your prescription;
- Any limits, restrictions, or requirements for each Drug, if applicable; and
- Your current plan Formulary.

"Price Check My Rx" prices are based on your Deductible and Out-of-Pocket Maximum accruals (if applicable) at the time you view the prescription Drug price. Costs may be different at the time you fill your prescription due to claims processing. You or your Physician or Health Care Provider can also request this Prescription Drug information by calling Customer Service.

Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Participating Provider.

For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food

and Drug Administration for that disease will be covered without a Cost Share.

Pharmacy Deductible

Benefits for covered prescription drugs in Tier 2, Tier 3, and Tier 4 are subject to a $50 deductible per Member each calendar year. The Pharmacy Deductible does not apply to drugs in Tier 1, contraceptive drugs and devices, or oral anticancer drugs. After the first 2 Members in a family have satisfied their deductible, the remaining family members prescription drug purchases may be combined to satisfy the remaining deductible. When a family has satisfied the $150 family deductible, all covered prescription drugs in Tier 2, Tier 3, and Tier 4 are covered at the applicable copayment amounts.

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year. The Formulary includes most generic drugs. The fact that a drug is listed on the Blue Shield Formulary does not guarantee that a Member's physician will prescribe it for a particular medical condition.

The Formulary is categorized into drug tiers as described in the chart below. Your Copayment will vary based on the drug tier.

Drug Tier	Description
Tier 1	Most Generic Drugs or low cost Preferred Brands
Tier 2	1. Non-preferred Generic Drugs or; 2. Preferred Brand Name Drugs or; 3. Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
Tier 3	1. Non-preferred Brand Name Drugs or; 2. Recommended by P&T committee based on drug safety, efficacy and cost or; 3. Generally have a preferred and often less costly therapeutic alternative at a lower tier.
Tier 4	1. Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2. Self administration requires training, clinical monitoring or; 3. Drug was manufactured using biotechnology or; 4. Plan cost (net of rebates) is >$600

Members may access the Drug Formulary at http://www.blueshieldca.com/bsca/pharmacy/home.sp. Members may also call Customer Service at the number provided on the back of the Evidence of Coverage to inquire if a specific drug is included in the Formulary or to obtain a printed copy.

Definitions

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

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.

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

Network Specialty Pharmacy - select participating pharmacies contracted by Blue Shield to provide covered specialty drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of specialty drugs. Drug manufacturers or other third parties may offer Drug discounts or copayment assistance for certain Drugs. These types of programs can lower your out-of-pocket costs. If you receive any discounts at a Network Specialty Pharmacy, only the amount you pay will be applied to any applicable Deductible and Out-of-Pocket Maximum.

To select a specialty pharmacy, the Member may go to http://www.blueshieldca.com or call Member Services at 1-800-257-6213.

Non-Formulary Drugs - drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary drug alternatives. Benefits may be provided for non-Formulary drugs and are always subject to the non-Formulary copayment.

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

Outpatient Prescription Drug - means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Participating Pharmacy - a pharmacy which participates in the Blue Shield Pharmacy Network. These participating pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Members.

To select a participating pharmacy, the Member may go to http://www.blueshieldca.com or call Member Services at 1-800-257-6213.

Prescription Drug (Drug) - Means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes:

- disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs;
- syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes;
- drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and
- at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Schedule II Controlled Substance — prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.

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

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 identification card will be denied.

Benefits are provided for specialty drugs only when obtained from a Network Specialty Pharmacy, except in the case of an emergency. If you obtain a Specialty Drug anywhere other than at a Network Specialty Pharmacy, you may be responsible for the entire cost of the Drug. In the event of an emergency, covered specialty drugs that are needed immediately may be obtained

from any participating pharmacy, or, if necessary from a non-participating pharmacy.

Copayment: $50 per prescription.

The Member is responsible for paying the applicable copayment for each covered prescription Drug at the time the Drug is obtained.

Copayment: You pay nothing for contraceptive drugs and devices*, $10 Tier 1, $25 Tier 2*, $50 Tier 3 per prescription for the amount prescribed not to exceed a 30-day supply except as otherwise stated below.

See below for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Designated Specialty Drugs may be dispensed for a 15-day trial at a pro-rated Copayment or Coinsurance for an initial prescription, and with the Member's agreement. This Short Cycle Specialty Drug Program allows the Member to obtain a 15-day supply of their prescription to determine if they will tolerate the Specialty Drug before obtaining the complete 30-day supply, and therefore helps save the Member out-of-pocket expenses. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the Short Cycle Specialty Drug Program, which the Member can elect at that time. At any time, either the Member, or Provider on behalf of the Member, may choose a full 30-day supply for the first fill.

If the Member has agreed to a 15-day trial, the Network Specialty Pharmacy will also contact the Member before dispensing the remaining 15-day supply to confirm if the Member is tolerating the Specialty Drug. To find a list of Specialty Drugs in the Short Cycle Specialty Drug Program, the Member may visit

https://www.blueshieldca.com/bsca/pharmacy/home.sp or call the Customer Service number on the Blue Shield Member ID card.

Drug manufacturers or other third parties may offer Drug discounts or copayment assistance for certain Drugs. These types of programs can lower the Member's out-of-pocket costs. If the Member receives any discounts at a Network Specialty Pharmacy, only the amount the Member pays will be applied to any applicable Deductible and Out-of-Pocket Maximum.

Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.

The Member may receive up to a 12-month supply of hormonal contraceptive Drugs. Contraceptive Drugs and devices obtained from a Participating Pharmacy are covered without a Copayment or Coinsurance, except for brands that have a generic equivalent. If your Physician or Health Care Provider determines that the covered Generic Drug is not appropriate for you, the brand name equivalent contraceptive will be covered without a Copayment or Coinsurance upon submission of an exception request.

Drugs not listed on the Formulary may be covered if Blue Shield approves an exception request. If an exception request is approved, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment. For all other Drugs that are approved as an exception, the Tier 3 Copayment applies. If an exception is denied, the Non-Formulary Drug is not covered and you are responsible for the entire cost of the Drug.

If the participating pharmacy contracted rate charged by the participating pharmacy is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate.

Prescription drugs administered in a physician's office, except immunizations, are covered by the $15 copayment for the office visit and do not require another copayment. Drugs dispensed by a

Physician or Physician's office for outpatient use are not covered.

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.

If the Member or Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, the Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.

If the Member requests a brand name drug when a generic drug equivalent is available, the Member is responsible for paying the difference between the participating pharmacy contracted rate for the brand name drug and its generic drug equivalent, as well as the applicable Tier 1 copayment.

If the prescribing Physician requests a Brand Name Drug when a Generic Drug equivalent is available, the Member is responsible for paying the applicable tier Copayment. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception. When drugs are obtained at a non-participating pharmacy for a covered emergency, including drugs for emergency contraception, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services -Emergency Claims, 1606 Ave. Ponce de Leon, San Juan, PR 00909-4830. The Member will be reimbursed the purchase price of covered prescription drug(s) minus any applicable copayment(s). Claim forms are available by contacting Member Services. Claims must be received within 1 year from the date of service to be considered for payment.

Special Programs

Blue Shield may offer programs to support the use of more cost-effective and clinically appropriate prescription Drugs. Such programs may lower your out-of-pocket cost for a limited time if you participate.

Obtaining Outpatient Prescription Drugs Through the Home Delivery Prescription Drug Program

When Drugs have been prescribed on a regular basis to treat an ongoing chronic condition the Member may obtain the drug through Blue Shield's Home Delivery Prescription Drug Program by enrolling via phone, mail or online. The Member's provider must indicate a prescription quantity which is equal to the amount to be dispensed. Specialty Drugs are not available through the Home Delivery Prescription Drug Program.

The Member is responsible for paying the applicable copayment for each prescription Drug. Copayments will be tracked for the Member.

> **Copayment: You pay nothing for contraceptive drugs and devices*, $20 Tier 1, $50 Tier 2, $100 Tier 3 per prescription not to exceed a 90-day supply. If the Member's provider indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed and refill authorizations cannot be combined to reach a 90-day supply.**

See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

If the participating pharmacy contracted rate is less than or equal to the Member copayment, the Member will only be required to pay the participating pharmacy contracted rate.

If the Member requests a home delivery brand name drug when a home delivery generic drug equivalent is available, the Member is responsible for the difference between the contracted rate for the home delivery brand name drug and its home delivery generic drug equivalent, as well

as the applicable home delivery Tier 1 copayment.

If the prescribing Physician requests a home delivery Brand Name Drug when a home delivery Generic Drug equivalent is available, the Member is responsible for paying the applicable tier home delivery Copayment.

For information about the Home Delivery Prescription Drug Program, the Member may visit www.blueshieldca.com/bsca/pharmacy/home.sp. or call Blue Shield Member Services at 1-800-257-6213. The TTY telephone number is 1-866-346-7197.

Prior Authorization Process for Select Formulary, Non-Formulary and Specialty Drugs

Select Formulary drugs, as well as most specialty drugs may require prior authorization for medical necessity. Select Non-Formulary drugs may require prior authorization for medical necessity, and to determine if lower cost alternatives are available and just as effective. Compounded drugs include at least two or more ingredients with at least one being a Drug, as defined under this Section Q. They are not covered unless the following requirements are met: (1) there are no FDA-approved, commercially available, medically appropriate alternative(s), (2) the compounded medication is self-administered, (3) it does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound), and (4) a compounded medication includes at least one Drug. If a compounded medication is approved for coverage, the Non-Formulary Brand Name Drug Copayment applies. You or your physician may request prior authorization by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once all required supporting information is received, prior authorization approval or denial, determined by Blue Shield and based upon Medical Necessity, is provided within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug

To request coverage for a Non-Formulary Drug, the Member, representative, or the Provider may submit an exception request to Blue Shield. You can submit an exception request by calling Customer Service. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. See the Obtaining Outpatient Prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If the Physician or Health Care Provider believes that step therapy coverage requirements for a prescription need not be met and that the medication is Medically Necessary, the step therapy exception process must be utilized and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply. Approvals for prior authorizations can be granted for up to one year, however, the timeframe may be greater or less, depending on the medication.

If Blue Shield denies a request for prior authorization or an exception request, the Member, representative, or the Provider can file a grievance with Blue Shield, as described in the Grievance Process section.

Exclusions

The Plan does not cover the following Prescription Drugs, except as described in this EOC in the Prescription Drug Benefits section or as required by law:

1. When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

2. When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.

3. When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

4. When prescribed solely for the purpose of shortening the duration of the common cold.

5. Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
   - Insulin,
   - Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs),
   - Over-the-counter drugs for reversal of an opioid overdose, or
   - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.

6. Replacement of lost or stolen drugs.

7. Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

8. Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

Call Member Services at 1-800-257-6213 for further information;

See the Grievance Process section of this 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.

R. Inpatient Mental Health or Substance Use Disorder Services

Blue Shield of California administers Mental Health or Substance Use Disorder services for Blue Shield Members within California. All non-emergency Mental Health or Substance Use Disorder services, including Residential Care, must be prior authorized. For prior authorization for Mental Health or Substance Use Disorder services, Members should contact Blue Shield at 1-800-257-6213.

All non-emergency Mental Health or Substance Use Disorder services must be obtained from Participating Providers. (See the How to Use the Plan section, the Mental Health or Substance Use Disorder Services paragraphs for more information.)

Mental Health or Substance Use Disorder Benefits include Medically Necessary basic health care services and intermediate services, at the full range of levels of care, including but not limited to residential treatment, Partial Hospitalization Program, and Intensive Outpatient Program, and prescription Drugs.

If you are unable to schedule an appointment with a Participating Provider for Mental Health or Substance Use Disorder services, contact Blue Shield. Blue Shield will help you schedule an appointment with a Participating Provider and, within five calendar days of your initial request, provide written notice that if we are unable to find a Plan Provider, we will help you schedule an appointment with a Non-Plan Provider. If there is no available Plan Provider for any Covered Benefits, you will only be responsible for paying the Plan Provider Cost Share for these services. Blue Shield may work with you to transition to a Participating Provider when one becomes available.

Benefits are provided for the following medically necessary covered Mental Health or Substance Use Disorders 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 Agreement, to any conditions or limitations set forth in the benefit description below, and to the Exclusions and Limitations set forth in this booklet.

Benefits are provided for inpatient and professional services in connection with Residential care admission for the treatment of Mental Health or Substance Use Disorders. All non-emergency Mental Health or Substance Use Disorder services must be prior authorized and obtained from Participating Providers.

See Section A. for information on medically necessary inpatient substance use disorder withdrawal management (detoxification).

Copayment: $100 per admission.

Benefits are provided for inpatient professional services in connection with hospitalization for the treatment of mental health conditions and substance use disorder conditions. All non-emergency Mental Health or Substance Use Disorder services must be prior authorized and obtained from Participating Providers.

Copayment: No charge.

Benefits are provided for inpatient services in connection with a Residential Care admission for the treatment of Mental Health or Substance Use disorder Conditions.

Copayment: $100 per admission.

This Plan does not cover domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Mental Health or Substance Use Disorder services.

S. Outpatient Mental Health or Substance Use Disorder Services

Office Visits for Outpatient Mental Health or Substance Use Disorder Services

Benefits are available for professional services for the diagnosis and treatment of Mental Health or Substance Use Disorders. You can receive these services at an office visit, including Physician office visit, or in an individual, Family, or group professional outpatient setting, or as a telebehavioral health service.

Benefits include therapy, counseling, and medication management.

Copayment: $15 per visit.

Other Outpatient Mental Health and Substance Use Disorder Services

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

1. Benefits are provided for hospital and professional services in connection with partial hospitalization for the treatment of Mental Health or Substance Use Disorders.

2. Psychosocial Support through LifeReferrals 24/7.

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

3. Behavioral Health Treatment (BHT)

   Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism

   Behavioral health treatment is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by Blue Shield. Behavioral health treatment must be obtained from Participating Providers. Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

4. Telebehavioral health services

   Online telebehavioral health services for Mental Health or Substance Use Disorder conditions are available through Participating Providers and are a Covered Benefit regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health or substance use disorder provider. If you are currently receiving telebehavorial health services for Mental Health and Substance Use Disorders, you can continue to receive those services with the Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider.

5. Electroconvulsive Therapy

   Benefits are provided for electroconvulsive therapy, the passing of a small electric current through the brain to induce a small seizure, used in the treatment of severe mental health conditions.

6. Intensive Outpatient Program

   Benefits are provided for intensive outpatient Mental Health or Substance use disorder treatment programs, utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

7. Office-Based Opioid Treatment

   Benefits are provided for Outpatient opioid withdrawal management (detoxification) and/or maintenance therapy including Methadone maintenance treatment.

8. Neuropsychological and Psychological Testing

   Benefits are provided for testing to diagnose a Mental Health Condition when referred by a Participating Provider.

9. Transcranial Magnetic Stimulation

Benefits are provided for Transcranial Magnetic Stimulation, a non-invasive method of delivering magnetic stimulation to the brain for the treatment of severe depression.

10. Behavioral Health Crisis Services

Benefits are provided for Behavioral Health Crisis Services and other services provided by a 988 center, a Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, regardless of whether the service is rendered by a Participating Provider or Non-Participating Provider.

For Behavioral Health Crisis Services rendered by a Non-Participating Provider, you will pay the same Copayment or Coinsurance for Covered Benefits received from a Participating Provider. Prior authorization is not required for the Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by a 988 center, Mobile Crisis Team, or other Behavioral Health Crisis Services.

Copayment: No charge.

Benefits do not include treatment not supported by current Generally Accepted Standards of Mental Health and Substance Use Disorder Care, including:

1. Outdoor, youth, or wilderness programs and accommodations;
2. Equine assisted therapy;
3. Treatment for the purpose of providing respite or day care;
4. Educational services; or
5. Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.

In addition, Benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs.

T. Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones

Hospital, outpatient surgery center 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 they are provided for:

1. The treatment of odontogenic and non-odontogenic oral tumors (benign or malignant);
2. The treatment of damage to natural teeth caused solely by an accidental injury is limited to medically necessary services until the services result in initial, palliative stabilization of the Member as determined by the Plan;

   Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental (e.g., resulting from chewing or biting).
3. Medically necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically necessary treatment of maxilla and mandible (jaw joints and jaw bones);
6. Orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is medically necessary to correct skeletal deformity; or
7. Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate repair.

Copayment: See applicable copayments for Physician Services and Hospital Services.

This benefit does not include:

1. Services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ, preventive or periodontic services, dental orthosis and prosthesis, including hospitalization incident thereto;

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of reconstructive surgery for cleft palate repair), including treatment to alleviate TMJ;

3. Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

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

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

6. Fluoride treatments except when used with radiation therapy to the oral cavity or for Benefits covered under Preventive Health Services

See the Exclusions and Limitations section for additional services that are not covered.

U. Special Transplant Benefits

Benefits are provided for certain procedures listed below only if: (1) performed at a Transplant Network Facility approved by Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from the Blue Shield Corporate Medical Director, and (3) the recipient of the transplant is a Member.

The Blue Shield Corporate Medical Director shall review all requests for prior authorization and shall approve or deny benefits, based on the medical circumstances of the patient, and in accordance with established Blue Shield medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Blue Shield approved Transplant Network Facility will result in denial of claims for this benefit.

Pre-transplant evaluation and diagnostic tests, transplantation and follow-ups will be allowed only at a Blue Shield approved Transplant Network Facility. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than a Blue Shield Transplant Network Facility will not be approved. Evaluation of potential candidates at a Blue Shield Transplant Network Facility is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or more than one Transplant Network Facility will not be authorized unless the medical necessity of repeating the service is documented and approved. For information on Blue Shield of California's approved Transplant Network, call 1-800-257-6213.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;

2. Human lung transplants;

3. Human heart and lung transplants in combination;

4. Human liver transplants;

5. Human kidney and pancreas transplants in combination (kidney only transplants are covered under Section V.);

6. Human bone marrow transplants, including autologous bone marrow transplantation or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is medically necessary and is not experimental or investigational;

7. Pediatric human small bowel transplants;

8. Pediatric and adult human small bowel and liver transplants in combination.

Reasonable charges for services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Copayment: Physician Services and Hospital Services copayments apply.

V. Organ Transplant Benefits

Hospital and professional services provided in connection with human organ transplants are a benefit to the extent that they are provided in connection with the transplant of a cornea, kidney, or skin, and the recipient of such transplant is a Member.

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

Copayment: Physician Services and Hospital Services copayments apply.

W. 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:

   a. blood glucose monitors, including continuous blood glucose monitors and those designed to assist the visually impaired, and all related necessary supplies;

   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;

   e. 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, see Section Q.

   Copayment: No charge.

2. Diabetes Self-Management Training and Medical Nutrition Therapy

   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 Physician and authorized. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

   Copayment: $15 per visit.

   Benefits do not include:

   1. Routine foot care items and services that are not Medically Necessary, including:
      a. Callus treatment;
      b. Corn paring or excision;
      c. Toenail trimming;
      d. Over-the-counter shoe inserts or arch supports; or
      e. Any type of massage procedure on the foot.

X. Reconstructive Surgery

Medically necessary services in connection with reconstructive surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when reconstructive surgery offers more than a minimal improvement appearance (including congenital anomalies) are covered. In accordance with the Women's Health & Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and reconstructive surgery

on either breast 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 surgeons.

No benefits will be provided for the following surgeries or procedures unless for reconstructive surgery:

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

2. Surgery to reform or reshape skin or bone;

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

4. Hair transplantation; and

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

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

Copayment: Physician Services and Hospital Services copayments apply.

Y. Clinical Trials for Treatment of Cancer or Life Diseases or Threatening Conditions

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a Life-Threatening disease or condition when prior authorized through the Member's Physician, and

1. The clinical trial has a therapeutic intent and the Physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and

2. The hospital and/or physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other Covered Benefits.

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

1. The investigational item, device, or service, itself;

2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;

4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;

5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Copayment: Physician Services and Hospital Services copayments apply.

Z. Additional Services

1. Personal Health Management Program

   Health education and health promotion services provided by Blue Shield's Center for Health and Wellness offer a variety of

wellness resources including, but not limited to: a member newsletter and a prenatal health education program.

Copayment: No charge.

2. Injectable Medications

Injectable medications approved by the FDA are covered for the medically necessary treatment of medical conditions when prescribed or authorized. See Section Q. for information on insulin and specialty drugs coverage and copayment. Drugs dispensed by a Physician or Physician's office for outpatient use are not covered.

Copayment: No charge.

3. Away From Home Care® Program

The CCPOA Medical Plan offers to CCPOA members who are students and families living apart as defined below, the Away From Home Care (AFHC) Program. Subscribers are not eligible for this program.

Families living apart - Available to qualified spouses or other dependents residing outside of California for 90 or more consecutive days. A subscriber is not eligible for this type of guest membership. To qualify for Families Apart guest membership, the subscriber must reside in California while the Guest Member resides in another state. This type of membership is typically used when a subscriber's divorced or separated family permanently resides outside of California. Families living apart memberships may be in effect for a maximum of one full year; however, the membership may be extended through a renewal process and is subject to annual reviews.

Student - This type of guest membership is available to qualified dependents that will be residing outside of California for more than 90 consecutive days while attending school. The subscriber must maintain their permanent address and reside in California. Student memberships may be in effect for a maximum of one full year; however, the membership may be extended through a renewal process.

AFHC is coordinated by calling 1-800-622-9402.

4. Hearing Aid Services

a. Audiological Evaluation. To measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Copayment: $15 per visit. Evaluation is in addition to the $800 maximum allowed each calendar year for both ears for the hearing aid and ancillary equipment.

b. Hearing Aid. Monaural or binaural including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a 1-year period following the provision of a covered hearing aid.

Excludes the purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months. Also excludes surgically implanted hearing devices. Cochlear implants are not considered surgically implanted hearing devices and are covered as a prosthetic under Section E.

Limitations: Up to maximum of $800 per Member each calendar year for both ears for the hearing aid instrument, and ancillary equipment.

5. Biofeedback

   Biofeedback therapy is covered only when it is reasonable and necessary for the individual patient for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities or spasticity, incapacitating muscle spasm, or weakness, and more conventional treatments (heat, cold, massage, exercise, and support) have not been successful. This therapy is not covered for treatment of ordinary muscle tension states or for psychosomatic conditions.

   Copayment: $15 per visit.

6. Teladoc Health

   Your Plan includes a service, Teladoc Health, a Third-Party Corporate Telehealth Provider, that provides you confidential general medical consultations by phone or over secure online video. Teladoc Health general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc Health is not meant to replace your Primary Care Physician but is meant to serve as a supplemental service. You do not need to contact your Primary Care Physician before using the Teladoc Health service.

   Before this service can be accessed, you must complete a Medical History Disclosure (MHD) form. The MHD form can be completed online on Teladoc Health's website at no charge or can be printed, completed and mailed or faxed to Teladoc Health. If you choose to have a Teladoc Health agent assist you in completing the MHD form via telephone, you will be charged $12.

   If your Physician's office is closed or you need quick access to a physician, you can call Teladoc Health toll free at 1-800-Teladoc (800-835-2362) or visit blueshieldca.com/teladochealth. The Teladoc Health physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

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

How to Access Teladoc Health	
Teladoc Health Service	Availability
General medical	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment

   Teladoc Health service is not available for Mental Health or Substance Use Disorder services consultations.

   Copayment: $0 per consultation. If medications are prescribed, the applicable prescription drug copayments apply.

7. Travel expense reimbursement for transplant services

   You may be eligible for reimbursement of your travel expenses for transplant services, including preoperative and postoperative visits, if you live at least 100 miles away from the nearest transplant services Participating Provider.

   For travel expense reimbursement, you must submit receipts, claim forms, and any other documentation required by Blue Shield. You must also have a claim for the transplant service for which you traveled on file with Blue Shield prior to reimbursement. When you see a Participating Provider for transplant

services, your provider submits the claim for those services to Blue Shield.

Blue Shield's maximum travel expense reimbursement will not exceed $5,000 per Member, per lifetime. Expenses must be reasonably necessary. Reimbursable expenses include, if appropriate:

- Transportation to and from the facility to receive transplant services;
- Hotel accommodations if one or more overnight stays are required to obtain transplant services. Limited to 1 double-occupancy room up to $200/day. Only the room is covered. All other hotel expenses are excluded;
- Meals. Limited to $100/day. Expenses for tobacco, alcohol, drugs, phone, television, delivery, and recreation are excluded; and
- Companion expenses for reimbursable expenses as listed above.

Certain travel expense reimbursements may be tax reportable. When required, Blue Shield will issue a Form 1099-MISC to you, reporting travel expense reimbursements. Blue Shield does not provide tax advice. If you have tax questions about travel expense reimbursements, you should consult with your tax advisor.

You will be assigned a case manager who can help coordinate your health care services and submit your travel expense reimbursement forms. For additional questions, contact Blue Shield Customer Service.

AA. Chiropractic Services

Benefits are provided for medically necessary chiropractic services up to a maximum of 20 visits per calendar year for routine chiropractic care when received from an American Specialty Health Plans of California, Inc. (ASHP) Participating Provider. This benefit includes an initial examination and subsequent office visits, adjustments, and conjunctive therapy as authorized by ASHP up to the benefit maximum specified above. Benefits are also provided for X-rays.

Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASHP.

You will be referred to your Primary Care Physician for evaluation of conditions not related to a neuromusculo-skeletal disorder, and for evaluation for non-covered services such as diagnostic scanning (CAT scans or MRIs).

A referral from your Primary Care Physician is not required. All Covered Benefits must be prior authorized by ASHP, except for (1) the medically necessary initial examination and treatment by a Participating Provider, and (2) emergency services.

Note: ASHP will respond to all requests for prior authorization within 5 business days from receipt of the request.

Services received from a provider who does not participate in the ASHP network will not be covered except for emergency services and in certain circumstances, in counties in California in which there are no ASHP Participating Providers.

Copayment: $15 per visit.

Member Calendar Year Out-of-Pocket Maximum

The Member Calendar Year Out-of-Pocket Maximum amount for Covered Benefits excluding those specified, is listed in the Summary of Benefits. (Also, see the Member Calendar Year Out-of-Pocket Maximum paragraphs under How to Use the Plan.)

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

Exclusions and Limitations

General Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

1. Acupuncture Services. This Plan does not cover acupuncture services, except as described in the Acupuncture Benefits section, or as required by law.

2. Chiropractic Services. This Plan does not cover chiropractic services, except as described in the Chiropractic Care section, or as required by law.

3. Clinical Trials.

   This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in the *Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits* section or as required by law.

   Coverage of Approved Clinical Trials does not include the following:

   a. The investigational drug, item, or service itself.
   b. Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
   c. Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
   d. Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.
   e. This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in the *Independent Medical Review* section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in the *California Department of Managed Health Care review* section.

4. Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law.

   This exclusion does not apply to the following:

   a. Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
   b. Reconstructive surgery as described in this EOC in the *Reconstructive Surgery Benefits* section.
   c. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians

specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the *Reconstructive Surgery Benefits* section.

5. Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.

   This exclusion does not apply to the following:

   a. Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.

   b. Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

   c. Custodial care provided in a healthcare facility.

6. Dental Services. This Plan does not cover dental services or supplies, except as described in this EOC in the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections or as required by law.

7. Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in this EOC in the *PKU formulas and special food products section* or as required by law.

8. Disposable Supplies for Home Use. This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in the *Durable Medical Equipment, Prostheses and Orthoses and Other Services, Home health services, Hospice Program Benefits,* and *Prescription Drug Benefits* sections, or as required by law.

9. Experimental or Investigational services.

   This Plan does not cover Experimental Services or Investigational Services, except as required by law.

   Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

   Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

   - Testing is not complete; and
   - The efficacy and safety of such services in human subjects are not yet established; and
   - The service is not in wide usage.

   The determination that a service is an Experimental Service or Investigational Service is based on:

   - Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
   - Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
   - Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an opportunity for you to request an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.

2. Your Health Care Provider must certify to the Plan that you have a Life Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.

3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4. You have been denied coverage by the Plan for the recommended or requested service.

5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in the Independent Medical Review section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the California Department of Managed Health Care review section.

10. Vision Care. This Plan does not cover Vision Services, except as described in this EOC in the *Durable Medical Equipment, Prostheses and Orthoses and Other Services* section or as required by law.

11. Hearing Aids. This Plan does not cover hearing aids, except as described in the *Hearing Aid Services* section if selected by your Employer as an optional Benefit, or as required by law.

12. Immunizations. This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

13. Non-licensed or Non-certified Providers. This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in the *Mental Health or Substance Use Disorder Benefits* sections or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
14. Private Duty Nursing. This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in the *Hospice Program Benefits* section or as required by law.
15. Personal or Comfort Items. This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
16. Reversal of Voluntary Sterilization. This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
17. Surrogate Pregnancy. This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.
18. Therapies. This Plan does not cover the following physical and occupational therapies, except as described in this EOC in the *Physical and Occupational Therapy* section or as required by law:
    a. Massage therapy, unless it is a component of a treatment plan;
    b. Training or therapy for the treatment of learning disabilities or behavioral problems;
    c. Social skills training or therapy; and
    d. Vocational, educational, recreational, art, dance, music, or reading therapy.
19. Routine Physical Examination. The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.
20. Travel and Lodging. This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in the *Ambulance services* section, as otherwise described in this EOC in the *Bariatric surgery Benefits, Transplant services,* and *Travel expense reimbursement* sections, or as required by law.
21. Weight Control Programs and Exercise Programs. This Plan does not cover weight control programs and exercise programs, except as described in this EOC in the *Diabetes care services* section or as required by law.

Medical Necessity Exclusion

Benefits are only available for services and supplies that are Medically Necessary, as determined by Blue Shield and consistent with Blue Shield medical policies and medication policies. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary. If two or more services or sequence of services are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease, coverage is provided for the least costly service or sequence of services.

Limitations for Duplicate Coverage

In the event that you are covered under the Plan and are also entitled to benefits under any of the conditions listed below, Blue Shield's liability for services (including room and board) provided to the Member for the treatment of any one illness or injury shall be reduced by the amount of benefits paid, or the reasonable value or the amount of Blue Shield's fee-for-service payment to the provider, whichever is less, of the services provided without any cost to you, because of your entitlement to such other benefits. This limitation is applicable to benefits received from any of the following sources:

1. Benefits provided under Title 18 of the Social Security Act ("Medicare"). If a Member receives services to which the Member is entitled under Medicare and those services are also covered under this Plan, the Participating Provider may recover the amount paid for the services under Medicare. This provision does not apply to Medicare Part D (outpatient prescription drug) benefits. This exclusion for Medicare does not apply when the employer is subject to the Medicare Secondary Payor Laws and the employer maintains:

   a. an employer group health plan that covers

      1) persons entitled to Medicare solely because of end-stage renal disease, and

      2) active employees or spouses or domestic partners entitled to Medicare by reason of age, and/or

   b. a large group health plan as defined under the Medicare Secondary Payor laws that covers persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to a Member who becomes eligible for Medicare on the date that the Member received notice of his eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision, except that this exclusion does not apply to Medi-Cal; or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the reasonable costs of services provided to the person at a Veterans Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.

Exception for Other Coverage

Participating Providers and Preferred Providers may seek reimbursement from other third party payors for the balance of their 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.

Services Not Charged

Blue Shield will not cover services that you are not legally obligated to pay, or for which you are not charged.

General Provisions

Grievance Process

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

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 as noted on the back cover of this booklet. If the telephone inquiry to Member Services does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Member Services Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed "Grievance Form." The Member may request this form from Member Services. The completed form should be submitted to Member Services at the address as noted on the back cover of this booklet. 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 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 Member Services Department section for information on the expedited decision process.

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 under the Member Services Department section 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. In addition, you have six months from the date you receive a written denial from Blue Shield or a contracting provider that your claim or services was denied to request an external review from the Department of Managed Health Care. For more information regarding the external review process, or to request an application form, please contact Member Services.

Appeal Procedure Following Disposition of Plan Grievance Procedure

If no resolution of your complaint is achieved by the internal grievance process described above, you have several options depending on the nature of your complaint.

1. **Eligibility Issues.** CCPOA Members may refer these matters directly to CalPERS. Contact CalPERS Health Account Management Division at P.O. Box 942715, Sacramento, CA 94229-2714, Fax (916) 795-2545, or telephone CalPERS at **888 CalPERS** (or **888**-225-7377), TTY (877) 249-7442.

2. **Coverage Issues.** A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care service.

If you are dissatisfied with the outcome of Blue Shield's internal grievance process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care, proceed to court or Small Claims Court, if your coverage dispute is within the jurisdictional limits of Small Claims Court.

3. **Malpractice.** *You must proceed directly to court.*

4. **Bad Faith.** *You must proceed directly to court.*

5. **Disputed Health Care Service Issue.** A disputed health care service issue concerns any health care service eligible for coverage and payment under this Evidence of Coverage booklet that has been denied, modified, or delayed in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is experimental or investigational.

   If you are dissatisfied with the outcome of Blue Shield's internal grievance process or if you have been in the process for 30 days or more, you may request an external independent medical review from the Department of Managed Health Care.

   If you are dissatisfied with the outcome of Blue Shield's internal grievance process or the external independent medical review process, you may proceed to court.

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 **1-800-257-6213** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891**) for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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

Matters of eligibility should be referred directly to CalPERS – contact:

CalPERS Health Account Management Division
Attn: Enrollment Administration
P.O. Box 942715
Sacramento, CA 94229-2715

888 CalPERS (or **888**-225-7377) CalPERS Customer Service and Outreach Division toll free telephone number
1-916-795-1277 fax number

Alternate Arrangements

Blue Shield will make a reasonable effort to secure alternate arrangements for the provision of care by another Participating Provider without additional expense to you in the event a Participating Provider's contract is terminated, or a Participating Provider is unable or unwilling to provide care to you.

If such alternate arrangements are not made available, or are not deemed satisfactory to the

CCPOA Board of Trustees, then Blue Shield will provide all services and/or benefits of the Agreement to you on a fee-for-service basis (less any applicable copayments), and the limitation contained herein with respect to use of a Participating Provider shall be of no force or effect.

Such fee-for-service arrangements shall continue until any affected treatment plan has been completed or until such time as you agree to obtain services from another Participating Provider, your enrollment is terminated, or your enrollment is transferred to another plan administered by the Board, whichever occurs first. In no case, however, will such fee-for-service arrangements continue beyond the term of the Plan, unless the Continuity of Care or Extension of Benefits provisions apply to you.

Physician-Patient or Plan-Member Relationship

In the event that Blue Shield of California shall be unable to establish satisfactory physician-patient or plan-member relationship with any member, after reasonable efforts to do so, then Blue Shield may either submit the matter for consideration under Blue Shield's grievance procedures or submit the matter for consideration to the CCPOA Board of Trustees. In any event, if it is determined that a satisfactory physician-patient or plan-member relationship cannot be maintained, then the member shall be provided with the opportunity to change enrollment to another plan.

Advance Directives

It is important that you know about your rights to make health care decisions on your own behalf and to execute advance directives. An advance directive is a formal document written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, health care providers will honor your wishes. But, if you become so ill that you cannot speak for yourself, then this directive will guide your health care providers in treating you and will save your family, friends, and health care providers from having to guess what you would have wanted. We suggest you set aside some time to review and discuss your wishes with your Physician and family members.

There are three types of advance directives to choose from. They are: (1) Durable Power of Attorney for Health Care (DPAHC), (2) Living Wills, and (3) Natural Death Act Declarations. In California, the preferred document is DPAHC, which allows you to appoint an agent (family, friend, or other person) whom you trust to make treatment decisions for you should there come a time you are unable to make them yourself. You can purchase the DPAHC from a stationery store or from the California Medical Association.

You should provide copies of your completed directive to: (1) your Physician, (2) your agent, and (3) your family. Be sure to keep a copy with you and take a copy to the hospital if you are hospitalized for medical care.

Termination of Group Membership - Continuation of Coverage

Termination of Benefits

Coverage for you or your dependents terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the group Agreement is discontinued, (2) the last day of the month in which the subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your employer, (3) the end of the period for which the premium is paid, or (4) the last day of the month in which you or your dependents become ineligible. A spouse also becomes ineligible following legal separation from the subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the subscriber. A domestic partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the Continuity of Care, Extension of Benefits and COBRA provisions, there is no right to receive benefits for services provided following termination of this group Agreement.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see your employer about possibly continuing group coverage. Also, see the COBRA and/or Cal-COBRA provisions described

in this booklet for information on continuation of coverage.

If the subscriber no longer lives or works in the Service Area, coverage will be terminated for him and all his dependents. If a dependent no longer lives or works in the Service Area, then that dependent's coverage will be terminated. (Special arrangements may be available for dependents who are full-time students, dependents of subscribers who are required by court order to provide coverage, and dependents and subscribers who are long-term travelers. Please contact the Member Services Department to request a brochure which explains these arrangements including how long coverage is available. This brochure is also available at http://www.blueshieldca.com for EPO Members.)

If the relationship between a Plan physician and a Member is unsatisfactory, or if the relationship between Blue Shield and a Member is unsatisfactory, then the Member may submit the matter to CalPERS under the change of enrollment procedure in Section 22841 of the Government Code. If the Member does not access the change of enrollment procedure, Blue Shield will undertake reasonable efforts to make a Plan physician available to the Member with whom a satisfactory relationship may be developed.

In the event any Member believes that his or her benefits under this Agreement have been terminated because of his or her health status or health requirements, the Member may seek from the Department of Managed Health Care, review of the termination as provided in California Health & Safety Code Section 1365(b).

Reinstatement

If you cancel or your coverage is terminated, refer to the CalPERS "Health Program Guide."

Cancellation

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Continuity of Care, Extension of Benefits and COBRA provisions in this booklet.

The group Agreement also may be cancelled by CalPERS at any time provided written notice is given to Blue Shield to become effective upon receipt, or on a later date as may be specified on the notice. Information pertaining to cancellation can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS.

Extension of Benefits

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

No extension will be granted unless Blue Shield receives written certification by a Plan physician of such total disability within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Blue Shield.

COBRA and/or Cal-COBRA

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

COBRA

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled family member who lose their regular

group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her family member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months. The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

1. The covered employee's separation from employment for reasons other than gross misconduct.

2. Reduction in the covered employee's hours to less than half-time.

Four "qualifying events" allow an active or retired employee's enrolled family member(s) to elect the continuation coverage for up to 36 months. Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

1. The employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS).

2. Divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.

3. A dependent child ceases to be a dependent child.

4. The primary COBRA subscriber becomes entitled to Medicare.

If elected, COBRA continuation coverage is effective on the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the specified time, or until one of the following events terminates the coverage:

1. The termination of all employer provided group health plans, or

2. The enrollee fails to pay the required premium(s) on a timely basis, or

3. The enrollee becomes covered by another health plan without limitations as to pre-existing conditions, or

4. The enrollee becomes eligible for Medicare benefits, or

5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.

You will receive notice from your employer of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact CCPOA directly if you need more information about your eligibility for COBRA group continuation coverage.

Cal-COBRA

COBRA enrollees who became eligible for COBRA coverage on or after January 1, 2003, and who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If

elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

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

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the qualifying event has occurred which originally entitled the Member to continue group coverage under this Plan.

Monthly rates for Cal-COBRA coverage shall be 110% of the applicable group monthly rates.

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

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

Continuation of Group Coverage for Members on Military Leave

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

Payment by Third Parties

Third Party Recovery Process and the Member's Responsibility

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for the services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage. Notwithstanding the foregoing, no coverage is provided under the Plan for services incident to any injury or disease arising out of, or in the course of, 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, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.

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

The Member is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for benefits paid by Blue Shield from any recovery when the recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within 10 days after any recovery has been obtained.

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

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

Workers' Compensation

No benefits are provided 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.

Coordination of Benefits

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

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

If the covered person is also entitled to benefits under any of the conditions as outlined under the Limitations for Duplicate Coverage provision, benefits received under any such condition will not be coordinated with the benefits of this Plan. The following rules determine the order of benefit payments:

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

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

1. In the case of a claim involving expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding 1. above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

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

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

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

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

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

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

Blue Shield may release to or obtain from any organization or person any information which Blue Shield considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any

provisions of similar purpose of any other Plan. Any person claiming benefits under this Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.

Definitions

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

Advanced Health Care Directive – means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

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

Adverse Childhood Experiences - An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Agreement - see Agreement for Group Coverage.

Agreement for Group Coverage (Agreement) - the Agreement issued by the Plan to the contractholder that establishes the services Members are entitled to from the Plan.

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

1. For a Participating Provider, the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the services rendered; or

2. For a Non-Participating Provider who provides emergency services:

   a. For physicians and hospitals - the reasonable and customary charge;

   b. All other providers – (1) the provider's billed charge for Covered Benefits, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under state and federal laws; or

3. For a Non-Participating Provider in California, who provides services other than Emergency Services, the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area but not exceeding any stated Benefit maximum; or

4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for services rendered; or

5. For a Non-Participating Provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a Non-Participating Provider performing the same services. If the local plan has no Non-Participating Provider allowance, Blue Shield will assign the allowable amount used for a Non-Participating Provider in California. Or, if applicable, the amount determined under federal law.

Where required under federal law, the Allowable Amount used to determine your Cost Share may be based on the plan's "qualifying payment amount," which may differ from the amount Blue Shield pays the Non-Participating Provider or facility for Covered Benefits.

Alternate Care Services Provider - durable medical equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

American Specialty Health Plans of California, Inc. (ASHP) - ASHP is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of chiropractic services.

Appropriately Qualified Health Care Provider – means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial – Means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    - The National Institutes of Health.
    - The federal Centers for Disease Control and Prevention.
    - The Agency for Healthcare Research and Quality.
    - The federal Centers for Medicare and Medicaid Services.
    - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

ASH Participating Provider - a participating chiropractor or other licensed health care provider under contract with ASHP to provide Covered Benefits to Members.

Behavioral Health Crisis Services – the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, Mobile

Crisis Teams, and crisis receiving and stabilization services.

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

Benefits (Covered Benefits) - means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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

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.

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

Close Relative - the spouse, domestic partner, child, brother, sister or parent of a Member.

Continuous Nursing Services — Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

Copayment - the amount that a Member is required to pay for specific Covered Benefits.

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

Covered Benefits (Benefits) - means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

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.

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 – a Subscriber's spouse, domestic partner, as defined in California Government Code section 22770, or child, as defined in Title 2, California Code of Regulations, Section 599.500.

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

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

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

Durable Medical Equipment - equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable medical equipment includes wheelchairs, hospital beds, respirators, required dialysis equipment and medical supplies, and other items that the Plan determines are durable medical equipment.

Emergency Medical Condition -
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:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care (Emergency Services) – means:

- medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or

- an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Employer - The State of California and any of its departments or agencies that employ individuals in the R06, S06, C06 or M06 classifications. In addition, the California Correctional Peace Officers Association (CCPOA) or the California Correctional Peace Officers Association Benefit Trust Fund (CCPOA BTF).

Evidence of Coverage - means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Exclusive Provider Organization (EPO) - This is an Exclusive Provider Organization (EPO) plan. Members can choose from any of the doctors and hospitals in Blue Shield's Preferred Provider network. Out-of-network services are not covered except for urgent care outside California and emergency care.

Experimental Services (Experimental) - means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family - the subscriber and all enrolled dependents.

Former Participating Provider - A Former Participating Provider is a provider of services to the Member under any of the following conditions:

1. A provider who is no longer available to the Member as a Participating Provider, but at the time of the provider's contract termination with Blue Shield, the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Participating Provider" table in the Continuity of Care section.
2. A Non- Participating Provider to a newly-covered Member whose health plan was withdrawn from the market,

and at the time the Member's coverage with Blue Shield became effective, the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Participating Provider" table in the Continuity of Care section.

3. A provider who is a Participating Provider with Blue Shield but no longer available to the Member as a Participating Provider because:
   a) The Employer has terminated its contract with Blue Shield; and
   b) The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider in its network; and
   c) At the time of the Employer's contract termination the Member was receiving Covered Benefits from that provider for one of the conditions listed in the "Continuity of care with a Former Participating Provider table" in the Continuity of Care section.

Generally Accepted Standards of Mental Health or Substance Use Disorder Care - Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health or Substance Use Disorder care include:

- Peer-reviewed scientific studies and medical literature;
- Clinical practice guidelines and recommendations of nonprofit health care provider professional associations;
- Specialty societies and federal government agencies; and
- Drug labeling approved by the U.S. Food and Drug Administration.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Health Care Provider - means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

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

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

Hospital - either 1., 2. or 3. below:

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

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

Independent Medical Review (IMR) - means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to 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. Your Plan must pay for the services if an IMR decides you need it.

Infertility –

1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or

2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Inpatient - an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Intensive Outpatient Program - an outpatient mental health (or substance use disorder) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week.

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

Investigational Services (Investigational) - Means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage.

Life-Threatening – means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medically Necessary (Medical Necessity) - means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medicare - refers to the program of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member - means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder(s) - means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral chapter of the most recent edition of the

International Statistical Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Mobile Crisis Team - a multidisciplinary team of trained behavioral health professionals who provide Behavioral Health Crisis Services in the least restrictive setting 24 hours a day, 7 days a week, 365 days per year.

Neuromusculo-skeletal Disorders - conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Neuromusculo-skeletal disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves ligaments/capsules, discs, and synovial structures) and related to neurological manifestations or conditions.

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

Non-Participating/Non-Preferred Provider - any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable copayment or amount in excess of specified benefit maximums, as payment in full for Covered Benefits. Note: This definition does not apply to Mental Health or Substance Use Disorder services.

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

Office Visits for Outpatient Mental Health or Substance Use Disorder Services – Professional (Physician) office visits for the diagnosis and treatment of Mental Health or Substance Use Disorder Conditions, including the individual, Family or group setting.

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

Open Enrollment Period - a fixed time period designated by CalPERS to initiate enrollment or change enrollment from one plan to another.

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

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

1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
4) Office-Based Opioid Treatment
5) Transcranial Magnetic Stimulation
6) Behavioral Health Treatment
7) Neuropsychological and Psychological Testing

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

Out-of-Area Follow-up Care - non-emergent medically necessary services to evaluate the

Member's progress after Emergency or Urgent Services provided outside the Service Area.

Outpatient - an individual receiving services, but not as an inpatient.

Outpatient Department of a Hospital — any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Outpatient Facility - a licensed facility, not a physician's office, or a hospital that provides medical and/or surgical services on an outpatient basis.

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

Participating Ambulatory Surgery Center - a licensed ambulatory surgery facility which has contracted with Blue Shield of California to provide surgical services on an outpatient basis and accept reimbursement at negotiated rates.

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

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

Participating Provider - a physician, a hospital, an ambulatory surgery center, an alternate care services provider, or a home health care and home infusion agency that has contracted with Blue Shield of California to furnish services and to accept Blue Shield of California's payment, plus applicable copayments, as payment in full for Covered Benefits.

Physical Therapy - treatment provided by a physician or under the direction of a physician and 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 osteopathy.

Plan - the CCPOA Medical Plan and/or Blue Shield of California.

Preferred Hospital - a hospital which has contracted with Blue Shield to furnish services and accept reimbursement at negotiated rates, and which has been designated as a preferred hospital by Blue Shield.

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

Preferred Provider - a physician member, a preferred hospital, or a Participating Provider.

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Includes immunizations required for travel and immunizations, such as Hepatitis B, for individuals at occupational risk;

3. Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit (a Physician or other Health Care Provider's order must be provided for coverage).

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

5. Adverse Childhood Experiences screenings;

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

Preventive health services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered preventive health services is available in Blue Shield's Preventive Health Guidelines. The Guidelines are available at http://www.blueshieldca.com/preventive or by calling Member Services and requesting that a copy be mailed to you.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1. through 4. above, the new recommendation will be covered as a preventive health service no later than 12 months following the issuance of the recommendation. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

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

Psychiatric Emergency Medical Condition - means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Reasonable and Customary Charge - in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Plan to be the reasonable and customary value for the services rendered by a Non-Participating 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 state and federal laws to be paid for emergency services.

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

Rehabilitative Services - inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitative services may consist of physical therapy, occupational therapy, and/or respiratory therapy. Benefits for speech therapy are described in the section on Speech Therapy.

Residential Care – mental health services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

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

Seriously Debilitating – means diseases or conditions that cause major irreversible morbidity.

Service Area - the designated geographical area, approved by the CCPOA Board of Trustees, within which a Member must live or work to be eligible for enrollment in this Plan.

Services - includes medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Nursing Facility - a facility licensed by the California Department of Health Services as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

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

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

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

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

Standard Fertility Preservation Services - means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Subacute Care - skilled nursing or skilled rehabilitative services provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Subscriber - the person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

Third-Party Corporate Telehealth Provider - A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.

Total Disability -

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

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

Trans-Inclusive Health Care - means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Urgent Services - those Covered Benefits rendered outside of the 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 Service Area.

Vision Services - Services or materials related to orthoptics, vision training, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses.

Members Rights and Responsibilities

You, as a CCPOA Medical Plan Member, have the right to:

1. Receive information about your rights and responsibilities.

2. Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.

3. Make recommendations regarding the Plan's member rights and responsibilities policy.

4. Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.

5. Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.

6. Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.

7. Receive timely and geographically accessible health care.

8. Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.

9. Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.

10. Certain accommodations for your disability, including:

    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.

    - Full and equal access, as other members of the public, to medical facilities.

    - Extra time for visits if you need it.

- Taking your service animal into exam rooms with you.

11. Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.

12. Receive considerate and courteous care and be treated with respect and dignity.

13. Receive culturally competent care, including but not limited to:

    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.

    - To be addressed by your preferred name and pronoun.

14. Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

15. Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.

16. A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.

17. Receive health care coverage even if you have a pre-existing condition.

18. Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.

19. Receive certain Preventive Health Services, including many without a co-pay, Coinsurance, or Deductible.

20. Have no annual or lifetime dollar limits on basic health care services.

21. Keep eligible Dependent(s) on your Plan.

22. Be notified of an unreasonable rate increase or change, as applicable.

23. Protection from illegal balance billing by a Health Care Provider.

24. Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.

25. Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.

26. Ask most Health Care Providers for information regarding who has received your personal health information.

27. Ask your Plan or your doctor to contact you only in certain ways or at certain locations.

28. Have your medical information related to sensitive services protected.

29. Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.

30. Have an interpreter who speaks your language at all points of contact when you receive health care services.

31. Have an interpreter provided at no cost to you.

32. Receive written materials in your preferred language where required by law.

33. Have health information provided in a usable format if you are blind, deaf, or have low vision.

34. Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.

35. Have an Advanced Health Care Directive.

36. Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.

37. File a complaint, grievance, or appeal in your preferred language about:

    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.

38. Know why your Plan denies a service or treatment.

39. Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.

40. Ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

You, as a CCPOA Medical Plan Member, have the responsibility to:

1. Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.

2. Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.

3. Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.

4. To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.

5. Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.

6. Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.

7. Timely pay any premiums, copayments, and charges for non-covered services.

8. Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy for 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 & 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
601 12th Street
Oakland, CA 94607
Phone Number: 510-607-2065

Please follow these procedures:

- Your recommendations, suggestions or comments should be submitted in writing to the Director, Consumer Affairs, 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 10 business days after the minutes have been approved.

Confidentiality of Medical Records and Personal Health Information

Blue Shield of California protects the confidentiality/privacy of your personal 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 state or federal law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either by calling the Member Services Department at the number listed on the back cover 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 272530
Chico, CA 95927

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 that information that is reasonably needed by Blue Shield. You agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the

necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Non-Assignability

Benefits of this Plan are not assignable.

Possession of a Blue Shield identification card confers no right to services or other benefits of this Agreement. To be entitled to services, the Member must be a subscriber who has been enrolled by Blue Shield and who has maintained enrollment under the terms of this Agreement.

Participating Providers are paid directly by Blue Shield. The Member or the provider of service may not request that payment be made directly to any other party.

Independent Contractors

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

Web Site

Blue Shield's Web site is located at http://www.blueshieldca.com. Members with Internet access and a Web browser may view and download health care information.

Utilization Review Process

State law requires that health plans disclose to Members 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 & Safety Code.

To request a copy of the document describing this Utilization Review, call the Member Services Department at 1-800-257-6213.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

DISCRIMINATION IS AGAINST THE LAW

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

Blue Shield of California:

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

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

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

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007

El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

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

Notice of the Availability of Language Assistance Services

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

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bííníghah? Doo bííníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hólǫ. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

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

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

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

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

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

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

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

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

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

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

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

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Service Area

The Service Areas and providers of this Plan are identified in the Blue Shield EPO Physician and Hospital Directories. **Contact the Plan for up-to-date confirmation**. You **must** live or work in the Service Area(s) identified below to enroll in this Plan and to maintain eligibility in this Plan. If you choose to enroll in the Plan based on your **work** ZIP code because your home is not within a Service Area, you and each enrolled dependent will be obligated to travel to providers located within the Service Area you have selected to receive non-emergency care. You, as the subscriber, and each of your enrolled dependents **must** select providers within the Service Area in which you enroll; however, if a dependent also works within the plan's Service Area, that dependent should select a provider which is near his place of work. A dependent who does not reside within the State of California cannot be enrolled in the Plan, except for a child covered by a support order.

The intent of this section is to provide flexibility for those CCPOA members who reside in a community that is not within the Service Area of the plan, but where the subscriber works in a **nearby** community that is within the plan's Service Area. However, providers cannot effectively coordinate care for patients who do not reside or work near the provider's Service Area, and may decline to accept a member due to lack of proximity.

Alameda County
(Entire County Served)
Butte County
(Entire County Served)
Contra Costa County
(Entire County Served)
El Dorado County
(Entire County Served)
Fresno County
(Entire County Served)
Imperial County
(Entire County Served)
Kern County
(Entire County Served)
Kings County
(Entire County Served)
Los Angeles County
(Entire County Served)
Madera County
(Entire County Served)
Marin County
(Entire County Served)
Merced County
(Entire County Served)
Monterey County
(Entire County Served)
Nevada County
(Entire County Served)
Orange County
(Entire County Served)
Placer County
(Entire County Served)
Riverside County
(Entire County Served)
Sacramento County
(Entire County Served)
San Bernardino County
(Entire County Served)
San Diego County
(Entire County Served)
San Francisco County
(Entire County Served)
San Joaquin County
(Entire County Served)
San Luis Obispo County
(Entire County Served)
San Mateo County
(Entire County Served)
Santa Barbara County
(Entire County Served)
Santa Clara County
(Entire County Served)
Santa Cruz County
(Entire County Served)
Solano County
(Entire County Served)
Sonoma County
(Entire County Served)
Stanislaus County
(Entire County Served)
Tulare County
(Entire County Served)
Ventura County
(Entire County Served)
Yolo County
(Entire County Served)

Notes

CCPOA Medical Plan service areas

Blue Shield of California

Exclusive Provider Organization

For inquiries, issues, or requests, please contact Blue Shield of California Member Services: **(800) 257-6213**

CalPERS

blue CALIFORNIA

CCPOA Benefit Trust Fund

FPO union bug

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