Health Savings Plan

Combined Evidence of Coverage and Disclosure Form

University of California

Group Number: W0051612

Plan ID: PPOX0003

Effective Date: January 1, 2016

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan. It is your right to view the Evidence of Coverage and Disclosure Form prior to enrollment in the health Plan.

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

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

PLEASE NOTE

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

This Plan is intended to qualify as a "high deductible health plan" for the purposes of qualifying for a health savings account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Although Blue Shield believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, Blue Shield will make efforts to amend this Plan, if necessary, to meet the requirements of a qualified plan. If Blue Shield determines that the amendment necessitates a change in the Plan provisions, Blue Shield will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

Important Information Regarding HSAs

The Health Savings Plan is not a "Health Savings Account" or an "HSA", but is designed as a "high deductible health plan" that may allow you, if you are eligible, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this Plan.

If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

NOTICE: Blue Shield does not provide tax advice. If you intend to purchase this Plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

The Blue Shield PPO Health Plan

Subscriber Bill of Rights

As a Blue Shield PPO Plan Subscriber, you have the right to:

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

The Blue Shield PPO Health Plan

Subscriber Responsibilities

As a Blue Shield PPO Plan Subscriber, you have the responsibility to:

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

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This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

The group contract is on file with your employer and a copy will be furnished upon request.

This is a Preferred Provider Plan. Benefits, particularly the payment provisions, differ from other Blue Shield of California plans. Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

Please read this Evidence of Coverage and Disclosure Form booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

Should you have any questions regarding your Blue Shield of California health Plan, see your employer or contact any of the Blue Shield of California offices listed on the last page of this booklet.

Capitalized words have specific definitions. These can be found in the section describing the term or in the Definitions section.

IMPORTANT

No Member has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Group Continuation Coverage provision in this booklet.

Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this group contract.

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

Note: The following Summary of Benefits contains the Benefits and applicable Co-payments of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, benefits and exclusions of the Plan.

Notice About California Integrated Data Exchange (Cal INDEX): Cal INDEX is an independent, not-for-profit organization that is creating a statewide database of electronic patient records that will include health information from doctors and health insurance companies. This allows your doctors, nurses, and hospitals throughout the state to securely access Members' health information so they can provide the safest, highest-quality care possible.

Cal INDEX respects Members' right to privacy and will follow all applicable state and federal privacy laws. Its privacy practices are based on the recommendations of consumer advocacy groups and best practices of other California health information exchanges. To protect Members' privacy and the security of Members' personal information, Cal INDEX uses advanced security systems and modern data encryption techniques.

Participation in Cal INDEX for Blue Shield members is completely free and voluntary to the Member and the other individuals covered under the Member's policy. Each Member has a choice about participation and can ask that Cal INDEX not share health information with the Member's doctors or nurses at any time. However, this may limit their ability to access important healthcare information quickly.

Please note that no doctor or hospital participating in Cal INDEX will deny medical care to a patient who chooses not to participate. A Member's health insurance or health benefit coverage eligibility will not be affected.

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

Summary of Benefits

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

Summary of Benefits **Health Savings Plan**

Individual Coverage Calendar Year Deductible[1]	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other, Non-Preferred and Non-Participating Providers**
Calendar Year Deductible	$1,300 per Member	$2,500 per Member

Individual Coverage Member Maximum per Calendar Year Out-of-Pocket Responsibility[2]	Member Maximum Calendar Year Out-of-Pocket Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other, Non-Preferred and Non-Participating Providers**
Calendar Year Out-Of-Pocket Maximum	$4,000 per Member	$8,000 per Member

Family Coverage Calendar Year Deductible[1]	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other Non-Preferred and Non-Participating Providers**
Calendar Year Deductible	$2,600 per Family[3]	$5,000 per Family[3]

Family Coverage Family Maximum per Calendar Year Out-of-Pocket Responsibility[2]	Family Maximum Calendar Year Out-of-Pocket Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by any combination of Preferred, Participating, Other, Non-Preferred and Non-Participating Providers**
Calendar Year Out-Of-Pocket Maximum	$6,400 per Family	$16,000 per Family

Member Maximum Lifetime Benefits	Maximum Blue Shield Payment	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Reduced Payment(s)	
Reduced Payment(s) for Failure to Obtain Prior Authorization (applies to Services by Non-Participating Providers only)	
Failure to obtain Prior Authorization for each non-Emergency Hospital and Skilled Nursing Facility admission Refer to the Reduced Payment for Failure to Obtain Prior Authorization section for any reduced payments which may apply.	$250 per Hospital or Skilled Nursing Facility admission

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Acupuncture Benefits (24 combined visits with Chiropractic Benefits per Member per Calendar Year maximum) If your Plan has a Calendar Year Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.		
Acupuncture services – office location	20%	20%
Allergy Testing and Treatment Benefits		
Allergy serum purchased separately for treatment	20%	40%
Office visits (includes visits for allergy serum injections)	20%	40%
Ambulance Benefits		
Emergency or authorized transport	20%[7]	20%[7]
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) of this Summary of Benefits.		
Ambulatory Surgery Center Outpatient surgery facility Services	20%	40% of up to $350 per day
Ambulatory Surgery Center Outpatient surgery Physician Services[24]	20%	40%
Bariatric Surgery All bariatric surgery Services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.	**Services by Preferred and Participating Providers**	**Services by Non-Preferred and Non-Participating Providers**
Bariatric Surgery Benefits for residents of designated counties in California All bariatric surgery Services for residents of designated counties in California must be provided by a Preferred Bariatric Surgery Services Provider. Travel expenses may be covered under this Benefit for residents of designated counties in California. See the Bariatric Surgery Benefits section, the paragraphs under Bariatric Surgery Benefits for Residents of Designated Counties in California, in Principal Benefits and Coverages (Covered Services) for a description.		
Hospital Inpatient Services	20%	Not covered
Hospital Outpatient Services	20%	Not covered
Physician bariatric surgery Services	20%	Not covered
Bariatric Surgery Benefits for residents of non-designated counties in California		
Hospital Inpatient Services	20%	40% of up to $600 per day
Hospital Outpatient Services	20%	40% of up to $350 per day
Physician bariatric surgery Services	20%	40%

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Chiropractic Benefits (24 combined visits with Acupuncture Benefits per Member per Calendar Year maximum) If your Plan has a Calendar Year Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.		
Chiropractic Services – office location	20%	40%
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits		
Clinical trial for Treatment of Cancer or Life-Threatening Conditions Services for routine patient care, not including research costs, will be paid on the same basis and at the same Benefit levels as other Covered Services shown in this Summary of Benefits. The research costs may be covered by the clinical trial sponsor.	You pay nothing	You pay nothing
Diabetes Care Benefits		
Devices, equipment and supplies	20%[8]	40%
Diabetes self-management training – office location	20%	40%
Dialysis Center Benefits		
Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	20%	40% of up to $300 per day
Durable Medical Equipment Benefits		
Breast pump	You pay nothing	Not covered
Other Durable Medical Equipment	20%	40%

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Emergency Room Benefits		
Emergency room Physician Services Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Professional (Physician) Benefits, Outpatient Physician Services, other than an office setting in this Summary of Benefits. The Services will also be subject to any Calendar Year Deductible.	20%	20%
Emergency room Services not resulting in admission Note: After Services have been provided, Blue Shield may conduct a retrospective review. If this review determines that Services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Preferred and Non-Preferred Provider levels as specified under Hospital Benefits (Facility Services), Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies in this Summary of Benefits. The Services will also be subject to any Calendar Year Deductible.	20%	20%
Emergency room Services resulting in admission (Billed as part of Inpatient Hospital Services)	20%	20%[9]
Family Planning Benefits Note: Copayments listed in this section are for Outpatient Physician Services only. If Services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the appropriate facility Benefit in this Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), intrauterine device (IUD), and tubal ligation.		
Counseling and consulting (including Physician office visits for diaphragm fitting, injectable contraceptives, or implantable contraceptives)	You pay nothing	40%
Diaphragm fitting procedure	You pay nothing	40%
Implantable contraceptives	You pay nothing	40%
Infertility Services - Diagnosis of cause of Infertility (treatment of Infertility and in-vitro fertilization and artificial insemination not covered)	20%	40%
Injectable contraceptives	You pay nothing	40%
Insertion and/or removal of intrauterine device (IUD)	You pay nothing	40%
Intrauterine device (IUD)	You pay nothing	40%
Tubal ligation	You pay nothing	40%
Vasectomy	20%	40%
Hearing Aid Services Benefit		
Audiological evaluations	20%	40%
Hearing aids and ancillary equipment up to a maximum of $2,000 per Member in any 36-month period	50%	50%

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Home Health Care Benefits		
Home health care agency Services (including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist) Up to a maximum of 100 visits per Calendar Year per Member by home health care agency providers. If your Plan has a Calendar Year Deductible, the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.	20%	Not covered[10]
Medical supplies	20%	Not covered[10]
Home Infusion/Home Injectable Therapy Benefits		
Hemophilia home infusion Services provided by a hemophilia infusion provider and prior authorized by the Plan. Includes blood factor product.	20%	Not covered
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit.	20%	Not covered[10]
Home visits by an infusion nurse Home infusion agency nursing visits are not subject to the Home Health Care Calendar Year visit limitation	20%	Not covered[10]
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program. All Hospice Program Benefits must be prior authorized by the Plan and must be received from a Participating Hospice Agency.		
24-hour Continuous Home Care	20%	Not covered[11]
General Inpatient care	20%	Not covered[11]
Inpatient Respite Care	20%	Not covered[11]
Pre-hospice consultation	20%	Not covered[11]
Routine home care	20%	Not covered[11]

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	20%	20%
Inpatient non-Emergency Facility Services Semi-private room and board, and Medically Necessary Services and supplies, including Subacute Care. For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section. Prior authorization required by the Plan. (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $600 per day Allowable Amount times (x) 40% Subscriber contribution = Subscriber payment of up to $240.	20%	40% of up to $600 per day
Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.	20%	40% of up to $600 per day
Inpatient Services to treat acute medical complications of detoxification	20%	40% of up to $600 per day
Outpatient diagnostic testing X-ray, diagnostic examination and clinical laboratory services Note: These Benefits are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 per day Allowable Amount times (x) 40% Subscriber contribution = Subscriber payment of up to $140.	20%	40% of up to $350 per day
Outpatient dialysis Services (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $300 per day Allowable Amount times (x) 40% Subscriber contribution = Subscriber payment of up to $120.	20%	40% of up to $300 per day
Outpatient Services for surgery and necessary supplies (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 per day Allowable Amount times (x) 40% Subscriber contribution = Subscriber payment of up to $140.	20%	40% of up to $350 per day
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies (See Non-Preferred payment example below) Example: 1 day in the Hospital, up to the $350 per day Allowable Amount times (x) 40% Subscriber contribution=Subscriber payment of up to $140	20%	40% of up to $350 per day

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity. (Be sure to read the Principal Benefits and Coverages (Covered Services) section for a complete description.)		
Ambulatory Surgery Center Outpatient Surgery facility Services	20%	40% of up to $350 per day
Inpatient Hospital Services	20%	40% of up to $600 per day
Office location	20%	40%
Outpatient department of a Hospital	20%	40% of up to $350 per day
Mental Health and Substance Abuse Benefits Your benefits for mental health and substance abuse care are administered by UC's mental health vendor through a separate agreement. For further information, contact your Employer.		

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Orthotics Benefits		
Office visits	20%	40%
Orthotic equipment and devices	20%	40%
Outpatient Prescription Drug Benefits[12, 13, 14, 15, 16]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive Drugs and Devices[15]	You pay nothing	Not covered
Formulary Generic Drugs	20% per prescription	40% per prescription
Formulary Brand Drugs[17]	20% per prescription	40% per prescription
Non-Formulary Brand Drugs[17]	20% per prescription	40% per prescription
Smoking Cessation Drugs		
Over-the-counter Drugs with prescription	You pay nothing	Not covered
Prescription Drugs	You pay nothing	Not covered
Risk-Reducing Drugs	You pay nothing	Not covered
Diabetic testing supplies[18]		
Lancets and alcohol swabs	You pay nothing	Not covered
Needles and syringes	20% per prescription	40% per prescription
Formulary test strips	You pay nothing	Not covered
Non-Formulary test strips	20% per prescription	40% per prescription
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive Drugs and Devices[15]	You pay nothing	Not covered
Formulary Generic Drugs	20% per prescription	Not covered
Formulary Brand Drugs[17]	20% per prescription	Not covered
Non-Formulary Brand Drugs[17]	20% per prescription	Not covered
Specialty Pharmacies and Select UC Pharmacies (up to 30-day supply)[19]		

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Specialty Drugs	20% per prescription	Not covered
Oral Anticancer Medications[20]	20% up to a maximum of $200 per prescription	Not covered
ACA Preventive Travel Vaccinations		
Hepatitis A	You pay nothing[1]	40% per prescription
Hepatitis B	You pay nothing[1]	40% per prescription
Meningitis	You pay nothing[1]	40% per prescription
Polio	You pay nothing[1]	40% per prescription
Other Travel Vaccinations		
Japanese Encephalitis	20% per prescription	40% per prescription
Rabies	20% per prescription	40% per prescription
Typhoid	20% per prescription	40% per prescription
Yellow Fever	20% per prescription	40% per prescription
	Select UC Pharmacies and specified retail pharmacies[21]	**Non-Participating Pharmacy[13]**
UC Pharmacies and Specified Retail Pharmacies (a 31-90-day supply)		
Contraceptive Drugs and Devices[15]	You pay nothing	Not covered
Formulary Generic Drugs	20% per prescription	Not covered
Formulary Brand Drugs[17]	20% per prescription	Not covered
Non-Formulary Brand Drugs[17]	20% per prescription	Not covered

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Outpatient X-ray, Pathology and Laboratory Benefits Note: Benefits in this section are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. For Benefits for diagnostic radiological procedures such as CT scans, MRIs, MRAs, PET scans, etc. see the Radiological and Nuclear Imaging Benefits section of this Summary of Benefits. Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.		
Outpatient Laboratory Center or Outpatient Radiology Center Note: Preferred Laboratory Centers and Preferred Radiology Centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital. Laboratory and radiology Services obtained from a Hospital or Hospital affiliated laboratory and radiology center will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) of this Summary of Benefits.	20%[8, 22]	40%[8, 22]
PKU Related Formulas and Special Food Products Benefits		
PKU Related Formulas and Special Food Products	20%	20%
Podiatric Benefits		
Podiatric Services – office location	20%	40%
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Principal Benefits and Coverages (Covered Services) section. When covered, Services will pay as any other surgery as noted in this Summary of Benefits.		
All necessary Inpatient Hospital Services for normal delivery, Cesarean section, and complications of pregnancy	20%	40% of up to $600 per day
Pregnancy and preconception Physician office visit: initial office visit	20%	40%
Prenatal Physician office visits: subsequent visits See Outpatient X-Ray, Pathology, Laboratory Benefits for prenatal genetic testing	20%	40%
Postnatal Physician office visits	20%	40%
Abortion Services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility coinsurance may apply.	20%	40%
Preventive Health Benefits		

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Preventive Health Services See the description of Preventive Health Services in the Definitions section for more information.	You pay nothing	40%
ACA Preventive Travel Vaccinations		
Hepatitis A	You pay nothing[1]	40%
Hepatitis B	You pay nothing[1]	40%
Meningitis	You pay nothing[1]	40%
Polio	You pay nothing[1]	40%
Other Travel Vaccinations		
Japanese Encephalitis	20%	40%
Rabies	20%	40%
Typhoid	20%	40%
Yellow Fever	20%	40%

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Professional (Physician) Benefits[23]		
Inpatient Physician Services For bariatric surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section	20%	40%
Outpatient Physician Services, other than an office setting	20%	40%
Physician home visits	20%	40%
Physician office visits Note: For other Services with the office visit, you may incur an additional Benefit Copayment as listed for that Service within this Summary of Benefits. This additional Benefit Copayment may be subject to the Plan's Deductible. Additionally, certain Physician office visits may have a Copayment amount that is different from the one stated here. For those Physician office visits, the Copayment will be as stated elsewhere in this Summary of Benefits.	20%	40%
Teladoc Teladoc provides access to U.S. board-certified doctors 24/7/365 via phone or online video consults for urgent, non-emergency medical assistance, including the ability to write prescriptions, when you are unable to see your primary care physician. This service is available by calling 1-800-Teladoc (835-2362).	$40 before deductible has been met, then 20% after deductible	Not covered

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Prosthetic Appliances Benefits		
Office visits	20%	40%
Prosthetic equipment and devices	20%	40%
Radiological and Nuclear Imaging Benefits Note: Benefits in this section are for diagnostic, non-Preventive Health Services. For Benefits for Preventive Health Services, see the Preventive Health Benefits section of this Summary of Benefits. Outpatient non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Prior authorization required by the Plan.		
Outpatient department of a Hospital Prior authorization required by the Plan.	20%[22]	40% of up to $350 per day[22]
Radiology Center Note: Preferred Radiology Centers may not be available in all areas. Prior authorization required by the Plan.	20%[22]	40%[22]
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits		
Office location	20%[5, 8]	40%
Outpatient department of a Hospital	20%[5, 8]	40% of up to $350 per day
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Calendar Year per Member except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your Plan has a Calendar Year Deductible, the number of days start counting toward the maximum when Services are first provided even if the Calendar Year Deductible has not been met.	20%[5, 24]	20%[5, 24]

Benefit	Member Copayment or Coinsurance[4]	
	Services by Preferred, Participating, and Other Providers[5]	**Services by Non-Preferred and Non-Participating Providers[6]**
Speech Therapy Benefits Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.		
Office location	20%[8]	20%
Outpatient department of a Hospital	20%[5, 8]	40% of up to $350 per day
Transgender Benefits All Transgender surgical Services must be prior authorized, in writing, from Blue Shield's Medical Director. Services received from a non-network provider are not covered unless prior authorized by Blue Shield. When authorized, the non-network provider will be reimbursed at a rate determined by Blue Shield and the non-network provider. Authorized travel expenses may be covered under this Benefit. See the Transgender Benefits section, in Principal Benefits and Coverages (Covered Services) for a description. Benefits follow the World Professional Association for Transgender Health (WPATH) Standards of Care and are subject to the Claims Administrator's conditions of coverage, exclusions, and limitations (unless otherwise noted in the Transgender Benefits section).		
Ambulatory surgery center Outpatient surgery facility Services	20%	Not covered
Hospital Inpatient Services	20%	Not covered
Hospital Outpatient Services	20%	Not covered
Physician surgery Services	20%	Not covered
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin.		
Hospital Services	20% [24]	40% of up to $600 per day
Professional (Physician) Services	20% [24]	40%
Transplant Benefits - Special Note: Blue Shield requires prior authorization from Blue Shield's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield. Please see the Transplant Benefits – Special portion of the Principal Benefits (Covered Services) section in the Evidence of Coverage for important information on this benefit. Authorized travel expenses may be covered under this Benefit. See the Transplant Benefits - Special portion of the Principal Benefits (Covered Services) for a description.		
Facility Services in a Special Transplant Facility	20%	Not covered
Professional (Physician) Services	20%	Not covered

Summary of Benefits
Footnotes:

[1] The Calendar Year Deductible does not apply to the Services listed below:
Preventive Health Benefits by Preferred Providers.
Breast pump (listed under Durable Medical Equipment Benefits) by Preferred Providers.
Contraceptive Drugs and devices covered under the Outpatient Prescription Drug Benefits.
Family Planning Services by Preferred Providers, such as counseling or consultation Services, diaphragm fitting, injectable contraceptives administered by a Physician, implantable contraceptives, intrauterine device and insertion/ removal and tubal ligation.
Smoking cessation Drugs with prescription by Participating Pharmacies covered under the Outpatient Prescription Drug Benefits.
Travel vaccinations covered under the Affordable Care Act.
Note: Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.

[2] The Calendar Year maximum out-of-pocket responsibility includes the Calendar Year Deductible.

[3] Before benefits will be provided for Covered Services to any and all covered Members, the Calendar Year Family Coverage Deductible must be satisfied for those Services to which it applies. This Deductible must be made up of charges covered by the plan and must be satisfied once during each Calendar Year. For those Services to which the Family Coverage Deductible applies, charges Incurred by one or all of the covered Members in combination will be used to calculate the Calendar Year Family Coverage Deductible.

[4] Coinsurance is calculated based on the Allowable Amount, unless otherwise specified.

[5] For Covered Services from Other Providers, you are responsible for any applicable Deductible, Copayment/Coinsurance, and all charges above the Allowable Amount.

[6] For Covered Services from Non-Preferred and Non-Participating Providers, you are responsible for any Deductible, Copayment/Coinsurance, and all charges above the Allowable Amount.

[7] The Copayment or Coinsurance will be calculated based upon the provider's billed charges or the amount the provider has otherwise agreed to accept as payment in full from the Plan, whichever is less.

[8] If billed by your provider, you will also be responsible for an office visit Copayment.

[9] If you receive emergency room Services that are determined to not be Emergency Services and which result in admission as an Inpatient to a Non-Preferred Hospital, you will be responsible for a Non-Preferred Hospital Inpatient Services Copayment.

[10] Services from a Non-Participating Home Health Agency or Non-Participating Home Infusion Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[11] Services from a Non-Participating Hospice Agency are not covered unless prior authorized by the Plan. When Services are authorized, your Copayment will be calculated at the Participating Provider level based upon the agreed upon rate between the Plan and the agency.

[12] 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 Medicare Part D premium.

[13] To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. After the Calendar Year Deductible amount has been satisfied, the Member will be reimbursed as shown on the Summary of Benefits. Member Copayment not to exceed billed charges.

[14] Outpatient Prescription Drug Copayments for covered Drugs obtained from Non-Participating Pharmacies will accrue to the Preferred Provider maximum Calendar Year out-of-pocket responsibility.

[15] Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the Calendar Year Deductible. If a brand contraceptive is requested when a generic equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic equivalent. If the Brand contraceptive Drug is Medically Necessary, it may be covered without a Copayment with prior authorization. Select contraceptives may require prior authorization to be covered without cost share. The difference in cost does not accrue to the Calendar Year Deductible or Out-of-Pocket Maximum.

[16] All outpatient prescription Drugs accumulate to the Preferred and Participating Deductible and the Preferred and Participating Out-of-Pocket Maximum unless otherwise specified.

[17] If the Member or Physician requests a Brand 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 Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

[18] Syringes, needles and insulin are covered at the applicable Formulary Brand Drug Copayment, and Non-Formulary test strips are covered at the applicable Non-Formulary Brand Drug Copayment.

[19] Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the EOC. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated. Prior authorization required by the Plan.

[20] Subject to the Deductible, and Coinsurance shall not exceed $200 for an individual prescription for up to a 30-day supply of a prescribed orally administered anticancer medication.

[21] UC Pharmacies and Specified Retail Pharmacies allow Members to obtain up to a 90-day supply of prescribed maintenance Drugs at select UC Pharmacies and at specified retail pharmacies, as further described in the *University of California (UC) Pharmacies and Specified Retail Pharmacies* definition on page 42.

[22] A Copayment will apply for each provider and date of service.

[23] All Professional Physician Services rendered by a Non-Preferred Radiologist, Anesthesiologist, and Pathologist in a Preferred facility are paid at the Preferred level of benefits.

[24] Prior authorization for this service is required by the Plan.

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including Plan Deductibles and Copayments, as well as some medical expenses not covered by your health Plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

HOW A HEALTH SAVINGS ACCOUNT WORKS

An HSA is very similar to the flexible spending accounts currently offered by some employers. If you qualify for and set up an HSA with a qualified institution, the money deposited will be tax-deductible and can be used tax-free to reimburse you for many medical expenses. So, instead of using taxed income for medical care as you satisfy your Deductible, you may use 100% of every dollar invested (plus interest). And, as with an Individual Retirement Account, any amounts you do not use (or withdraw with penalty) can grow. Your principal and your returns may be rolled over from year to year to provide you with tax-deferred savings for future medical or other uses.

Please note that Blue Shield does not offer HSAs itself, and only offers high deductible health plans.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

INTRODUCTION TO THE BLUE SHIELD OF CALIFORNIA HEALTH SAVINGS PLAN

Benefits of this Plan differ substantially from traditional Blue Shield of California plans. 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 Subscriber. In order to reduce your costs, greater responsibility is placed on you.

You should read your booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your Blue Shield I.D. card to your Physician, Hospital, or other licensed healthcare provider. Your I.D. card has your Subscriber and group numbers on it. Be sure to include these numbers on all claims you submit to Blue Shield.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Blue Shield of California Preferred Providers" section).

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

1. You or your Physician must obtain 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. (See the "Blue Shield of California 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 review within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, Blue Shield will respond as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request.

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

BLUE SHIELD OF CALIFORNIA PREFERRED PROVIDERS

The Blue Shield of California Preferred Plan is specifically designed for you to use Blue Shield of California Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other Providers. Preferred Providers are listed in the Preferred Provider directories. To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing Blue Shield's Internet site located at http://www.blueshieldca.com/uc, or by calling Customer Service at the telephone number provided at the back of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the

Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by Blue Shield for services.

Blue Shield of California Preferred Providers agree to accept Blue Shield of California's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums as payment-in-full for Covered Services, except as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability. This is not true of Non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for Covered Services, except for the Copayments and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability.

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 Customer Service at the number provided on the back page of this booklet.

If you go to a Non-Preferred Provider, Blue Shield of California's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount Blue Shield of California pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying Blue Shield of California within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

Directories of Blue Shield of California Preferred Providers located in your area you are available online. If you need assistance finding a provider, please contact Blue Shield of California immediately and request them at the telephone number listed on the last page of this booklet.

Continuity of Care by a Terminated Provider

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

Financial Responsibility for Continuity of Care Services

If a Subscriber is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Subscriber 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.

Submitting a Claim Form

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by Blue Shield if Services are rendered by a Non-Preferred Provider, except in the case of Emergency Services. Requests for payment must be submitted to Blue Shield within 1 year after the month Services were provided. Special claim forms are not necessary, but each claim submission must contain your name, home address, group contract number, Subscriber's number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name. Blue Shield will notify you of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Blue Shield of California Subscriber's Statement of Claim form to the Blue Shield of California service center listed on the last page of this booklet.

Claim forms are available on Blue Shield's Internet site located at http://www.blueshieldca.com/uc or you may call Blue Shield of California Customer Service at the number provided on the back page of this booklet to ask for forms. If necessary, you may use a photocopy of the Blue Shield of California claim form.

Be sure to send in a claim for all Covered Services even if you have not yet met your Calendar Year Deductible. Blue Shield of California will keep track of the Deductible for you. Blue Shield of California uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

Eligibility and Enrollment

The University establishes its own Medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

ELIGIBILITY

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members " A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

ENROLLMENT

Employees

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Employees and Eligible Family Members." A copy of this fact sheet is available in the HR Forms section of (ucnet.universityofcalifornia.edu).

Retirees

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members . " A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu).

RENEWAL OF GROUP CONTRACT

Your Employer's group contract with Blue Shield is subject to renewal at certain intervals. The Dues or other terms of the Plan may change at any time.

PREPAYMENT FEE

The monthly Dues for you and your Dependents are indicated in your Employer's group Contract.

Your Employer is responsible for paying all Dues required for coverage provided to you and your Dependents. Your Employer may require that you contribute all or part of the costs of these Dues. Please consult your Employer for details.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, and annual Out-of-Pocket Maximum amounts, are subject to change at any time.

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

SERVICES FOR EMERGENCY CARE

The Benefits of this Plan will be provided for Covered Services received anywhere in the world for the emergency care of an illness or injury.

Subscribers who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

Note: For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up Services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

UTILIZATION REVIEW

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, as required under Section 1363.5 of the California Health and Safety Code.

The document describing Blue Shield's Utilization Management Program is available online at www.blueshieldca.com or Member may call the Customer Service Department at the number provided on the back page of this Evidence of Coverage and Disclosure Form to request a copy.

SECOND MEDICAL OPINION POLICY

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.

HEALTH EDUCATION AND HEALTH PROMOTION SERVICES

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 Subscriber newsletter and a prenatal health education program.

RETAIL-BASED HEALTH CLINICS

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com/uc. See the Blue Shield of California Preferred Providers section for information on the advantages of choosing a Preferred Provider.

NURSEHELP[SM] 24/7

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

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

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

NurseHelp 24/7 program provide Members with confidential telephone support for information, consultations, and referrals for health and psychosocial issues, at no charge. 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.

BLUE SHIELD ONLINE

Blue Shield's Internet site is located at http://www.blueshieldca.com/uc. Members with Internet access and a Web browser may view and download healthcare information.

BENEFITS MANAGEMENT PROGRAM

The Benefits Management Program applies utilization management and case management principles to assist Members and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this Plan.

The Benefits Management Program includes prior authorization requirements for Inpatient admissions, selected Inpatient and Outpatient Services, office-administered injectable drugs, and home infusion-administered drugs, as well as emergency admission notification, and Inpatient utilization management. The program also includes Member services such as, discharge planning, case management and palliative care Services.

The following sections outline the requirements of the Benefits Management Program.

PRIOR AUTHORIZATION

Prior authorization allows the Member and provider to verify with Blue Shield that (1) the proposed services are a Benefit of the Member's Plan; (2) the proposed Services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Member and provider when Benefits are limited to Services rendered by Participating Providers (See the Summary of Benefits).

A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Member and provider within two business days of the decision. For urgent Services when the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Member's condition, not to exceed 72 hours from receipt of the request. (See the Outpatient Prescription Drug Benefit section for specific information about prior authorization for outpatient prescription drugs).

If prior authorization is not obtained, and services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Member or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed within California on an Outpatient, nonemergency basis:

1) CT (Computerized Tomography) scan

2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedures utilizing nuclear medicine

For authorized Services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained and the radiological or nuclear imaging services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior Authorization for Medical Services Included on the Prior Authorization List

Failure to obtain prior authorization for hemophilia home infusion products and Services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage.

To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back page of this Evidence of Coverage and Disclosure Form.

For authorized Services and Drugs from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to Services rendered by a Participating Provider. If prior authorization was not obtained and the medical services or Drugs provided to the Member are determined not to be a Benefit of the Plan, were not medically necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all nonemergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, special transplant and bariatric surgery. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When inpatient Hospital admission is authorized to a Non-Participating Hospital, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained for an Inpatient Hospital admission and the services provided to the Member are determined not to be a Benefit of the Plan, or were not medically necessary, coverage will be denied.

Prior authorization is not required for an emergency Hospital admission; See the Emergency Admission Notification section for additional information.

Emergency Admission Notification

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most Inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an Inpatient Hospital stay may be extended or reduced as warranted by the Member's condition. When a determination is made that the Member no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Member. If discharge does not occur within 24 hours of notification, the Member is responsible for all Inpatient charges accrued beyond the 24 hour time frame.

Maternity Admissions: the minimum length of the Inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Inpatient stay is adequate.

Mastectomy: The length of the Inpatient stay is determined post-operatively by the attending Physician in consultation with the Member.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield will work with the Member, the attending Physician and the Hospital discharge planner to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Member access necessary Services and to make the most efficient use of

Plan Benefits. The Member's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Member, the provider, and Blue Shield, and will not exceed the standard Benefits available under this Plan.

The approval of alternative benefits is specific to each Member for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this Plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other Member in any other instance.

Palliative Care Services

In conjunction with Covered Services, Blue Shield provides palliative care Services for Members with serious illnesses. Palliative care Services include access to Physicians and nurse case managers who are trained to assist Members in managing symptoms, in maximizing comfort, safety, autonomy and well-being, and in navigating a course of care. Members can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Members may call the Customer Service Department to request more information about these services.

Reduced Payments for Failure to Obtain Prior Authorization (Applies to Services by Non-Participating Providers only)

For non-emergency Services, payments may be reduced, as described below, when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization and Hospital and Skilled Nursing Facility Admissions sections of the Benefits Management Program.

1. Failure to contact Blue Shield as described under the Prior Authorization section of the Benefits Management Program may result in a reduction in coverage of $250, in addition to the applicable Calendar Year Deductible, or may result in non-payment by Blue Shield if it is determined that the service is not a Covered Service. This reduction in coverage will be applicable to charges when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization section of the Benefits Management Program.

Only one $250 reduction in coverage will apply to each Hospital or Skilled Nursing Facility admission for failure to follow the Benefits Management Program notification requirements or recommendations.

Deductibles

Individual Coverage Deductible (applicable to 1 Member coverage)

There is a separate Deductible for services rendered by Preferred and Non-Preferred Providers. The Preferred Deductible must be met by charges by Preferred Providers only. The Non-Preferred Deductible is made up of charges by any combination of Preferred and Non-Preferred Providers.

The Calendar Year per Member Deductible amount is shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for Covered Services without regard to any Deductible.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

Note: If you are enrolled in an Individual Deductible Plan, and have a newborn or a child placed for adoption, the child is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan. While the child's coverage is provided, you and this Dependent will be enrolled in the Family Coverage Deductible Plan. The Family Deductible amount as described in the Family Coverage Deductible section below will apply to you and this Dependent.

Family Coverage Deductible (applicable to 2 or more Member coverage)

There is a separate Deductible for services rendered by Preferred and Non-Preferred Providers. The Preferred Deductible must be met by charges by Preferred Providers only. The Non-Preferred Deductible is made up of charges by any combination of Preferred and Non-Preferred Providers.

The Calendar Year per Family deductible amount is shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan, and must be satisfied once during each Calendar Year. Charges Incurred by one or all of the Family members in combination will be used to calculate the Calendar Year Family Coverage Deductible. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for Covered Services to any and all Family members without regard to any Deductible.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

These Calendar Year Deductibles will count towards the Calendar Year maximum out-of-pocket responsibility.

SERVICES NOT SUBJECT TO THE DEDUCTIBLE

The Calendar Year Deductible applies to all Covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

NO MEMBER MAXIMUM LIFETIME BENEFITS

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

NO ANNUAL DOLLAR LIMIT ON ESSENTIAL BENEFITS

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

PAYMENT

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

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Out-of-Area Programs

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

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

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Subscriber's responsibility and are not included in out-of-pocket calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

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

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

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

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

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

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for Covered Services received outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the BlueCard Worldwide Service Center through the toll-free BlueCard Access number at 1-800-600-4141 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call Blue Shield of California at the Customer Service telephone number indicated on the back of the Member's identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers or you can go on-line at www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide".

Inter-Plan Programs

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

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

BlueCard Program

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

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

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because they will not be applied retroactively to claims already paid.

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

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

CALENDAR YEAR MAXIMUM OUT-OF-POCKET RESPONSIBILITY

INDIVIDUAL COVERAGE (APPLICABLE TO 1 MEMBER COVERAGE) —

The per Member maximum out-of-pocket responsibility required each Calendar Year for Covered Services* is shown in the Summary of Benefits.

Once the maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for Covered Services for the remainder of that Calendar Year.

FAMILY COVERAGE (APPLICABLE TO 2 OR MORE MEMBER COVERAGE) —

The per Family maximum out-of-pocket responsibility required each Calendar Year for Covered Services* is Shown in the Summary of Benefits. The Family maximum out-of-pocket responsibility will be satisfied by the Member and all of his covered Dependents collectively.

Once the maximum out-of-pocket responsibility has been met*, the Plan will pay 100% of the Allowable Amount for Covered Services for the remainder of that Calendar Year.

*Note: Certain Services and amounts are not included in the Calendar Year maximum out-of-pocket responsibility calculations. These items are shown in the Summary of Benefits.

Charges for Services which are not covered, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and Reduced Payments Incurred under the Benefits Management Program are the Subscriber's responsibility and are not included in the Calendar Year maximum out-of-pocket responsibility calculations.

For the Outpatient Prescription Drugs Benefit, if the Subscriber requests a brand drug when a generic drug equivalent is available, the difference in cost that the Subscriber must pay is not included in the Calendar Year maximum out-of-

pocket responsibility calculations. See the Outpatient Prescription Drugs Benefit section for details.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary Covered Services, subject to applicable Deductibles, Copayments and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this booklet. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.

The Copayments, if applicable, are shown in the Summary of Benefits.

All Copayments will be calculated as described in the Payment section of this booklet.

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Subscribers will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Subscriber Copayment.

Except as specifically provided herein, Services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Acupuncture Benefits

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.) licensed acupuncturist, or other appropriately licensed or certified Health Care Provider up to a per Member per Calendar Year Benefit maximum combined with chiropractic Benefits as shown on the Summary of Benefits.

Allergy Testing and Treatment Benefits

Benefits are provided for allergy testing and treatment.

Ambulance Benefits

Benefits are provided for (1) emergency ambulance services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received; or (2) pre-authorized, non-emergency ambulance transportation to or from one medical facility to another.

Ambulatory Surgery Center Benefits

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

Note: Reconstructive Surgery is only covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the 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 or as authorized under the Transgender Benefit:

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

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

Bariatric Surgery Benefits for Residents of Designated Counties in California

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

All bariatric surgery services must be prior authorized, in writing, from Blue Shield's Medical Director. Prior authorization is required for all Members, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California

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

1) performed at a Preferred Bariatric Surgery Services Hospital or Ambulatory Surgery Center and by a Preferred Bariatric Surgery Services Physician that has contracted with Blue Shield to provide the procedure; and,

2) they are consistent with Blue Shield's medical policy; and,

3) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

*See the list of designated counties below.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and Blue Shield medical policy.

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

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

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

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

Bariatric Travel Expense Reimbursement for Residents of Designated Counties in California

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

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

1. travel to and from the Preferred bariatric surgery Services Hospital on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per Benefit, and
5. $5,000 one time maximum amount per surgery for recipient and companion expenses in total.

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

Note: Bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

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

For Members who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

CHIROPRACTIC BENEFITS

Benefits are provided for any Chiropractic Services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic benefit includes the initial examination subsequent office visits, adjustments, conjunctive therapy, and X-ray Services up to the Benefit maximum.

Benefits are limited to a per Member per Calendar Year visit maximum combined with acupuncture Benefits as shown in the Summary of Benefits.

Covered X-ray Services provided in conjunction with this Benefit have an additional Copayment as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS

Benefits are provided for routine patient care for a Member who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by Blue Shield, and:

1. the clinical trial has a therapeutic intent and a Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the 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 Services shown in the Summary of Benefits.

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

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

An "approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other life-threatening condition, and is limited to a trial that is:

1. federally funded and approved by one of the following:
   a) one of the National Institutes of Health;
   b) the Centers for Disease Control and Prevention;
   c) the Agency for Health Care Research and Quality;
   d) the Centers for Medicare & Medicaid Services;
   e) a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;
   f) qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
2. the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

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

DIABETES CARE BENEFITS

Diabetes Equipment

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

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

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drugs Benefits.

Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurses, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

DIALYSIS CENTER BENEFITS

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

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

DURABLE MEDICAL EQUIPMENT BENEFITS

Medically Necessary Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pumps and the home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

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

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item*.

   *This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: See the Outpatient Prescription Drugs Benefits section for benefits for asthma inhalers and inhaler spacers.)
3. 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 Customer Service or go to http://www.blueshieldca.com/uc.

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

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

For Members in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency.

EMERGENCY ROOM BENEFITS

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician's office.

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

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by the Blue Shield to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Plan determines are not emergencies, will be paid as part of the Inpatient Hospital Services. The Member Copayment for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown in the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Member is responsible for the emergency room Member Copayment plus the appropriate admitting Hospital Services Member Copayment as shown in the Summary of Benefits.

FAMILY PLANNING BENEFITS

Benefits are provided for the following Family Planning Services without illness or injury being present.

For Family Planning Services, the Calendar Year Deductible only applies to male sterilizations and to Services by Non-Preferred Providers.

No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fitting or injectable contraceptives;
2. Diaphragm fitting procedure;
3. Intrauterine devices (IUDs), including insertion and/or removal;
4. Implantable contraceptives;

5. Infertility Services. Infertility Services, except as excluded in the Principal Limitations, Exceptions, Exclusions and Reductions section, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose the cause of Infertility. Any services related to infertility treatment and to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service) are not covered.
6. Injectable contraceptives when administered by a Physician;
7. Voluntary sterilization (tubal ligation and vasectomy);

HEARING AID SERVICES BENEFIT

The hearing aid Services Benefit provides a combined maximum allowance of $2, 000 every 36 months as shown on the Summary of Benefits towards covered hearing aids and Services as specified below. The hearing aid Services Benefit is separate and apart from the other Benefits described in your Evidence of Coverage. You are not required to use a Blue Shield Preferred Provider to obtain these services as Blue Shield does not maintain a network of contracted providers for these services. You may obtain these services from any provider of your choosing and submit a claim to Blue Shield for reimbursement for Covered Services up to the combined maximum allowance. For information on submitting a claim, see the "Submitting a Claim Form" paragraphs in the Introduction section of your Evidence of Coverage and Disclosure Form.

Benefits

Hearing Aids and Ancillary Equipment

The Benefit allowance is provided for hearing aids and ancillary equipment up to the maximum per Member shown on the Summary of Benefits in any 36 month period. You are responsible for the cost of any hearing aid Services which are in excess of this Benefit allowance.

The hearing aid Benefit includes: a hearing aid instrument, monaural or binaural including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

1. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
2. Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
3. Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any 36-month period;
4. Surgically implanted hearing devices.

This Benefit is subject to the general provisions, limitations and exclusions listed in your Evidence of Coverage and Disclosure Form.

HOME HEALTH CARE BENEFITS

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the Member's Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by Blue Shield.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Member per Calendar Year visit maximum as shown in the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

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

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

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

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

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

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

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

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia

which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing must be prior authorized by Blue Shield.

This Benefit does not include medications, drugs, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drugs Benefits, and Services related to hemophilia which are described below.

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

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion agencies must be prior authorized by Blue Shield.

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 Blue Shield (see the Benefits Management Program section for specific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling Customer Service at the telephone number shown on the last page of this booklet.

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

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

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

This Benefit does not include:

1. Physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2. Services from a hemophilia treatment center or any Non-Preferred Hemophilia Infusion Provider; or,
3. Self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), Outpatient Prescription Drug Benefits, or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

HOSPICE PROGRAM BENEFITS

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from Blue Shield. (Note: Members with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Members can continue to receive Covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate 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 Member to the extent that these needs are not met by the Member's other providers.

7. Volunteer Services.

8. Short-term Inpatient care arrangements.

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

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

11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.

Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

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

DEFINITIONS APPLICABLE TO HOSPICE PROGRAM:

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

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

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

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

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

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

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

3. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

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

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

6. Actively utilizes volunteers in the delivery of Hospice Services.

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

8. Is provided through a Participating Hospice.

Interdisciplinary Team – the hospice care team that includes, but is not limited to, the Member and his or her fami-

ly, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

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

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

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

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

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

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

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

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

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

HOSPITAL BENEFITS (FACILITY SERVICES)

(Other than Hospice Program Benefits, Skilled Nursing Facility Benefits, Dialysis Centers Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services)

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3. In conjunction with a covered delivery, routine nursery care for a newborn of the Subscriber, covered spouse or Domestic Partner.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the 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 or as authorized under the Transgender Benefit:

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

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

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
6. Rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.
7. Drugs and oxygen.
8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
9. X-ray examination and laboratory tests.
10. Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
11. Use of medical appliances and equipment.
12. Subacute Care.
13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
14. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.
2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.
3. Radiation therapy and chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the 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 or as authorized under the Transgender Benefit:

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

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

Covered Services provided in an Outpatient Hospital setting are described under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) and Speech Therapy Benefits sections.

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

Benefits are provided for Hospital and professional Services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Member as determined by the Plan;

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

3. Medically Necessary 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 a skeletal deformity; or
7. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

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

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

Mental Health and Substance Abuse Benefits

Your benefits for mental health and substance abuse care are administered by UC's mental health vendor through a separate agreement. For further information, contact your Employer.

Orthotics Benefits

Benefits are provided for orthotic appliances, including:

1. shoes only when permanently attached to such appliances;
2. special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
3. Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
4. Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
5. initial fitting and replacement after the expected life of the orthosis is covered.

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

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

Outpatient Prescription Drug Benefits

Benefits are provided for Medically Necessary Outpatient prescription Drugs, which meet all the requirements specified in this section, are prescribed by a Physician, and, except as noted below, are obtained from a licensed pharmacy. Benefits are limited to Medically Necessary Drugs which are approved by the Food and Drug Administration (FDA), and which require a prescription under Federal or California law. 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. The Member or the Member's Physician may request prior authorization from Blue Shield.

Coverage for selected Drugs may be limited to a specific quantity as described in the section entitled "Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

Outpatient prescription Drugs are subject to the Calendar Year Deductible.

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.

Members may access the Drug Formulary at http://www.blueshieldca.com/uc. 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.

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

This benefit includes access to Blue Shield's Participating Pharmacy Network. By presenting your Blue Shield ID card to a Participating Pharmacy you will pay Blue Shield's contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see section entitled "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

Definitions

Anticancer Medications — Drugs used to kill or slow the growth of cancerous cells.

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

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, test tablets and alcohol swabs), (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B, (6) contraceptive drugs and devices, including female OTC contraceptive drugs and devices, diaphragms, cervical caps, contraceptive rings, contraceptive patches, oral contraceptives and emergency contraceptives when ordered by a Physician, (7) inhalers and inhaler spacers for the management and treatment of asthma.

Note: To be considered for coverage, all Drugs require a valid prescription by the Member's Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically.

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

Network Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Specialty Drugs.

To select a Specialty Pharmacy, you may go to http://www.blueshieldca.com/uc or call the toll-free Customer Service number on your Blue Shield Identification Card.

Non-Formulary Drugs — Drugs determined by the Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over formulary Drug alternatives. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

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

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

To select a Participating Pharmacy, you may go to http://www.blueshieldca.com/uc or call the toll-free Customer Service number on your Blue Shield Identification Card.

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.

University of California (UC) Pharmacies and Specified Retail Pharmacies

Members may obtain prescribed maintenance medications for up to a 3-month supply through Blue Shield's Mail Service Prescription Drug Program, select UC medical center pharmacies, or specified retail pharmacies. Location of available UC or specified retail pharmacies can be obtained by going to http://www.blueshieldca.com/uc or by calling the toll-free Customer Service number on your Blue Shield Identification Card.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain prescription Drugs at a Participating Pharmacy, the Member must present his Blue Shield Identification Card.

Note: Except for covered emergencies and Drugs for emergency contraception, claims for drugs obtained without using the Blue Shield Identification Card will be denied.

With the presentation of the Blue Shield Identification Card, outpatient prescription Drugs obtained at a Participating Pharmacy, or Specialty Drugs obtained from a Network Specialty Pharmacy through the use of your Blue Shield Identification Number, are paid as shown in the Summary of Benefits.

Once the Calendar Year Deductible has been satisfied, the Member is responsible for paying the applicable Coinsurance for each prescription Drug at the time the Drug is obtained.

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

Note: If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy's contracted rate.

If the Member or Physician requests a Brand 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 Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

The Member or prescribing provider may provide information supporting the Medical Necessity for using a Brand Drug versus an available Generic Drug equivalent through the Blue Shield prior authorization process. See the section on Prior Authorization Process for information on the approval process. If the request is approved, the Member is responsible for paying the applicable Drug tier Co-payment or Coinsurance.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

To obtain prescription Drugs at a Non-Participating Pharmacy, the Member must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. After the Calendar Year Deductible amount has been satisfied, the Member will be reimbursed as shown on the Summary of Benefits. Claims must be received within 1 year from the date of service to be considered for payment.

Drugs obtained at a Non-Participating Pharmacy for a covered emergency.

When Drugs are obtained at a Non-Participating Pharmacy for a covered emergency, including Drugs for emergency contraception, the Member must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services - Emergency Claims, P. O. Box 7168, San Francisco, CA 94120. The Member will be reimbursed the purchase price of covered prescription Drug(s) minus the any applicable Copayment(s). Claim forms may be obtained from the Blue Shield Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

When Drugs have been prescribed for a chronic condition, a Member may obtain the Drug through Blue Shield's Mail Service Prescription Drug Program by enrolling online or by phone or mail.

Members should allow up to 14 days to receive the drugs. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed.

Specialty Drugs are not available through the Mail Service Prescription Drug Program.

*Until the Calendar Year Deductible is satisfied, the Member is responsible for payment 100% of the contracted rate for the Drug to the mail service pharmacy prior to your prescription being sent (not applicable to contraceptive Drugs and devices).

Outpatient prescription Drugs obtained through the mail service prescription drug program are paid as shown in the Summary of Benefits.

Once the Calendar Year Deductible has been satisfied, the Member is responsible for the applicable mail service prescription drug Copayment for each prescription Drug.

For more information about the Mail Service Prescription Drug Program or to determine applicable cost share, Members may visit www.blueshieldca.com/uc or call the toll-free Customer Service number on your Blue Shield Identification Card .

Special Note for contraceptive Drugs and devices: No Copayment will be assessed. However, if a Brand contraceptive Drug is requested when a Generic Drug equivalent is available, the Member will be responsible for paying the difference between the cost to Blue Shield for the Brand contraceptive Drug and its Generic Drug equivalent. In addition, select contraceptives may require prior authorization for Medical Necessity to be covered without a Copayment.

If the Participating Pharmacy contracted rate is less than or equal to the Member's Copayment, the Member will only be required to pay the Participating Pharmacy's contracted rate.

If the Member or Physician requests a Mail Service Brand Drug when a Mail Service Generic Drug equivalent is available, the Member is responsible for paying the difference between the contracted rate for the Mail Service Brand Drug and its Mail Service Generic Drug equivalent, as well as the

applicable Mail Service Generic Drug Copayment. This difference in cost that the Member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

The Member or prescribing provider may provide information supporting the Medical Necessity for using a Brand Drug versus an available Generic Drug equivalent through the Blue Shield prior authorization process. See the section on Prior Authorization Process for information on the approval process. If the request is approved, the Member is responsible for paying the applicable Drug tier Co-payment or Coinsurance.

Submitting a Claim

The submission of a prescription drug claim is required for reimbursement if you utilized a Non-Participating Pharmacy.

Each claim submission should contain your name, home address, Member number, the patient's name and a copy of your pharmacy label receipt(s) for the prescription Drug(s) being claimed. Prescription drug claim forms are provided upon request from Blue Shield at the address and telephone number as listed at the back of this booklet. These forms are also available online at http://www.blueshieldca.com/uc. Prescription drug claim forms should be submitted to:

Argus Health Systems, Inc.
Department 191
PO Box 419019
Kansas City, MO 64141-6019

Claims must be received within 1 year from the date of service to be considered for payment.

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. Select contraceptives may require prior authorization for Medical Necessity in order to be covered without a Copayment. Compound Drugs are covered only if the requirements listed under the Exclusions section are met. If a compounded medication is approved for coverage, the Non-Formulary Brand Drug Copayment applies. You or your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within two business days.

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

1. Outpatient prescription Drugs are limited to a quantity not to exceed a 30-day supply except as otherwise noted below. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment will be assessed Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. 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 http://www.blueshieldca.com/uc or call the Customer Service number on the Blue Shield Member ID card.
3. Drugs through UC Pharmacies and Specified Retail Pharmacies are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.
4. Mail service prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.
5. 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;

6. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

No benefits are provided under the Outpatient Prescription Drugs Benefits for or on account of the following (please note, certain services excluded below may be covered under other benefits/portions of this booklet – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Any drugs provided or administered while the Member is an Inpatient, or in a Physician's office, Skilled Nursing Facility, or Outpatient Facility (see the Professional (Physician) Benefits and Hospital Benefits sections);
2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facility (see the Hospital Benefits (Facility Services) and Skilled Nursing Facility Benefits sections);
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drugs Benefit) which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
4. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered Experimental or Investigational in nature;
6. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices;
7. Blood or blood products (see the Hospital Benefits (Facility Services) section);
8. Drugs when prescribed for cosmetic purposes, such as those used to retard or reverse the effects of skin aging or to treat hair loss;
9. Dietary or nutritional products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections);
10. Any Drugs which are not self-administered. These medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, Hospice Program Benefits, and Family Planning Benefits sections;
11. All Drugs for the treatment of infertility;
12. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
13. Contraceptive injections and implants and any contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a Physician, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered. Note: Refer to your medical Benefits for coverage of other contraceptive methods;
14. Compounded medications unless: (1) the compounded medication(s) includes at least one Drug, as defined, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the Drug is self-administered, and (4) medical literature supports its use for requested diagnosis;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. For Members enrolled in a Hospice Program through a Participating Hospice Agency only pharmaceuticals that are medically necessary for the palliation and management of terminal illness and related conditions are excluded from coverage under the Outpatient Prescription Drug Benefits, and are covered under the Hospice Program Benefits;
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection, medications prescribed to treat pain, or drug treatment related to surgical procedures for conditions af-

fecting the upper/lower jawbone or associated bone joints;

18. Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered Emergency;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
21. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

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

OUTPATIENT X-RAY, PATHOLOGY AND LABORATORY BENEFITS

Benefits are provided for diagnostic X-ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Routine laboratory Services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Blue Shield of California medical policy. (Note: See the section on Pregnancy and Maternity Care Benefits for genetic testing for prenatal diagnosis of genetic disorders of the fetus.)

See the Radiological and Nuclear Imaging Benefits and Benefits Management Program section(s) for radiological procedures which require prior authorization by the Plan.

PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS BENEFITS

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

PODIATRIC BENEFITS

Benefits are provided for office visits, surgical procedures, and other Covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services, including, surgical procedures, are customarily provided by a licensed doctor of podiatric medicine. Covered lab and x-ray Services provided in conjunction with this Benefit are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

PREGNANCY AND MATERNITY CARE BENEFITS

Benefits are provided for maternity Services, which include prenatal care, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy, Outpatient maternity Services, involuntary complications of pregnancy, and Inpatient Hospital maternity care including labor, delivery and post-delivery care. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia. Benefits are also provided for abortion services. (Note: See the section on Outpatient X-ray, Pathology and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Member qualifies for an extension of Benefits as described elsewhere in this booklet.

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

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

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

PREVENTIVE HEALTH BENEFITS

Preventive Health Services, as defined, are covered.

PROFESSIONAL (PHYSICIAN) BENEFITS

(Other than Preventive Health Benefits, Hospice Program Benefits, Dialysis Center Benefits, and Bariatric

Surgery Benefits for Residents of Designated Counties in California, which are described elsewhere under Covered Services)

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician Office Visits. A list of urgent care providers may be found in the Online Physician Directory located at http://www.blueshieldca.com/uc.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
4. Asthma self-management training and education to enable a Subscriber to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;
5. Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room;
6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;
7. Surgical procedures. When multiple surgical procedures are performed during the same operation, Benefits for the secondary procedure(s) will be determined based on the Plan's Medical Policy. Information regarding the Blue Shield's Medical Policy can be obtained by going to http:// www.blueshieldca.com/uc or by calling the toll-free Customer Service number on your Identification Card. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;
8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Benefits will be provided in accordance with guidelines established by the 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 or as authorized under the Transgender Benefit:

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

   This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10. Extra time spent when a Physician is detained to treat a Subscriber in critical condition;
11. Necessary preoperative treatment;
12. Treatment of burns;
13. Diagnostic audiometry examination.
14. Teladoc consultations. Teladoc consultation Services provide confidential consultations using a network of board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. by secure online video, 7 days a week. If your Personal Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/uc. The Teladoc Physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications.

    Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation Services are not intended to replace services from your Personal Physician but are a supplemental service. You do not need to contact your Personal Physician before using Teladoc consultation Services.

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

Prosthetic Appliances Benefits

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

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

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

No benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided). No benefits are provided for backup or alternate items.

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

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. 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.

Radiological and Nuclear Imaging Benefits

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

See the Benefits Management Program section for complete information.

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

Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient department of a Hospital. Blue Shield reserves the right to periodically review the provider's treatment plan and records for medical necessity.

Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation Services rendered in the home.

Skilled Nursing Facility Benefits

(Other than Hospice Program Benefits, which are described elsewhere under Covered Services.)

Benefits are provided for Medically Necessary Services provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility or Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown in the Summary of Benefits. The Benefit maximum is per Member per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

Speech Therapy Benefits

Benefits are provided for Medically Necessary outpatient Speech Therapy Services when ordered by a Physician and provided by a licensed speech therapist/pathologist or appropriately licensed or certified Health Care Provider, 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 as long as 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 for medically necessity.

Except as specified above and as stated under the Home Health Care Benefits and Hospice Program Benefits sections,

no Outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See the Home Health Care Benefits and Hospice program Benefits section for information on coverage for Speech Therapy Services rendered in the home.

See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits.

TRANSGENDER BENEFITS

Benefits

Benefits are provided for the following Services and no others, for a physician diagnosis of gender identity disorder (gender dysphoria) to Members who meet recognized clinical criteria guidelines:

Transgender Surgical Services

Subject to the Plan hospital and professional physician service copayments as shown on the Summary of Benefits, Hospital and Professional Services are provided for transgender surgical services.

Benefits will be provided in accordance with guidelines established by Blue Shield. These services must be prior authorized by the Plan.

Blue Shield has a Plan transgender network of contracted hospital and transgender surgery providers. Services received from a non-network provider are not covered unless prior authorized by Blue Shield. When authorized, the non-network provider will be reimbursed at a rate determined by Blue Shield and the non-network provider.

Benefits are also provided for necessary travel and lodging expenses to receive these services when pre-authorized by the Plan.

Reimbursement for covered prior authorized travel expenses is limited to:

1. travel to and from the transgender surgery provider on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per Benefit, and
5. $5,000 one time maximum amount for recipient and companion expenses in total.

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

Plan Principal Limitations, Exceptions, Exclusions and Reductions

This Benefit is subject to the principal limitations, exceptions, exclusions and reductions listed in your booklet with the exception of the exclusions for:

- Reconstructive surgery;
- Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
- Hair removal by electrolysis or other means; and
- Reimplantation of breast implants originally pro-vided for cosmetic augmentation.

TRANSPLANT BENEFITS – CORNEA, KIDNEY OR SKIN

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants only to the extent that:

1. they are provided in connection with the transplant of a cornea, kidney, or skin; and
2. the recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

TRANSPLANT BENEFITS - SPECIAL

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield of California to provide the procedure or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield, (2) prior authorization is obtained, in writing, from Blue Shield's Medical Director and (3) the recipient of the transplant is a Subscriber or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

Blue Shield reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding benefits based on (1) the medical circumstances of each Member, and (2) consistency between the treatment proposed and Blue Shield medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;
2. Human lung transplants;
3. Human heart and lung transplants in combination;
4. Human liver transplants;
5. Human kidney and pancreas transplants in combination;

6. Human bone marrow transplants; including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
7. Pediatric human small bowel transplants;
8. Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank.

Benefits are also provided for necessary travel and lodging expenses to receive these services when pre-authorized by the Plan.

Reimbursement for covered prior authorized travel expenses is limited to:

1. travel to and from the transplant center on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per transplant, and
5. $5,000 per transplant maximum amount for recipient and companion expenses in total.

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

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

Unless exceptions to the following are specifically made elsewhere in this booklet, no benefits are provided for the following services:

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) and Hospice Program Benefits sections;
3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns, and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Member's home;
6. for mental health and substance abuse Benefits. Note: Your benefits for mental health and substance abuse care are administered by UC's mental health vendor through a separate agreement. For further information, contact your Employer;
7. for hearing aids, except as explicitly listed under Hearing Aid Services Benefit;
8. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
9. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
10. for routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;
11. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;
12. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diag-

nosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;

13. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health and Safety Code, Section 1367.21 have been met;
14. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits.
15. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
16. for or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except as specifically listed under Family Planning Benefits and for Medically Necessary treatment of medical complications, except as specifically listed;
17. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
18. which are Experimental or Investigational in Nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;
19. for learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities;
20. for hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
21. for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
22. for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
23. incident to organ transplant, except as explicitly listed under Transplant Benefits;
24. Cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages);
25. for Reconstructive Surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

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

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

26. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
27. for which the Member is not legally obligated to pay, or for services for which no charge is made;
28. 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 worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield of California provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield of California for the treatment of such injury or disease;
29. in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
30. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits and PKU Related Formulas and Special Food Products Benefits, and except as provided through a Participating Hospice Agency;
31. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
32. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits;
33. for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
34. incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits for Residents of Designated Counties in California;
35. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care under a Blue Shield health plan;
36. for services provided by an individual or entity that is not appropriately licensed, certified, or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification, or state authorization, except as specifically stated herein;
37. for massage therapy;
38. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and except as may

be provided under the Outpatient Prescription Drugs Supplement or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section;

39. not specifically listed as a Benefit.

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

MEDICAL NECESSITY EXCLUSION

The Benefits of this Plan are intended only for Services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. Blue Shield of California reserves the right to review all claims to determine if a service or supply is Medically Necessary. Blue Shield of California may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. Blue Shield of California may limit or exclude benefits for services which are not necessary.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

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

   When your Blue Shield group plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield group plan may be lower but will not exceed the Medicare allowed amount. Your Blue Shield group plan Deductible and Copayments will be waived.

When you are eligible for Medi-Cal

Medi-Cal always provides benefits last.

When you are a qualified veteran

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

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowable Amount).

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

EXCEPTION FOR OTHER COVERAGE

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Plan.

CLAIMS REVIEW

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

REDUCTIONS – THIRD PARTY LIABILITY

If a covered Member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield of California shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to the covered Member on a fee-for-service basis 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.

Blue Shield's 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. Blue Shield's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield for the Benefits it paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The covered Member is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such covered 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 Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within 10 days after any Recovery has been obtained.

A covered 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 Participating 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.

COORDINATION OF BENEFITS

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

When a Member 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 Member 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 Member 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 Member as an employee will provide its benefits before the plan covering the Member 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 Member 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 Member 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 will determine their respective benefits in the following order:

   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. 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 Member 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 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 of California 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 Member (1) assigns to Blue Shield of California the right to receive benefits from the other plan to the extent of the difference between the value of the Benefits which Blue Shield of California actually provides and the value of the Benefits that Blue Shield of California would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield of California in obtaining payment of benefits from the other plan, and (3) allows Blue Shield of California 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.

COB Savings. A COB Savings, if any, for a calendar year is created for a Member under this Plan when a Member is covered by more than one plan and this Plan is not the primary carrier based on this Coordination of Benefits (COB) provisions. The COB Savings is the amount saved by the Plan that is not the primary carrier for the benefit of the Member.

The following criteria are used to create a COB Savings:

1. If this Plan is not the primary carrier, then its benefits may be reduced so that the benefits and services of all the plans do not exceed allowable expense.
2. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered only under this Plan.
3. If this Plan is the primary carrier, the benefits under this Plan will be determined without taking into account the benefits or services of any other plan. When this Plan is the primary carrier, nothing will be applied to this Plan's COB Savings.

COB Savings for a Member are not carried forward from one year to the next. At the end of each calendar year, the COB Savings for a Member returns to zero and a new COB Savings is created for the next calendar year.

Effects of the COB Savings on the Plan Benefits

The COB Savings provisions will apply if this Plan is not the primary carrier and the benefits under this Plan and any other plan exceed the allowable expense for the calendar year.

The COB Savings is determined by subtracting the amount the primary carrier paid from the amount this Plan would have paid had it been the primary carrier.

When this Plan is not the primary carrier, the amounts saved, determined on a claim-by-claim basis, are recorded as a COB Savings and are used to pay allowable expenses, not otherwise paid, that are incurred by the member during the calendar year.

TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

TERMINATION OF BENEFITS

The University establishes its own termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this Plan.

De-enrollment Due to Loss of Eligible Status, Leave of Absence, Layoff, Change in Employment Status or Retirement

Coverage for you or your Dependents terminates at 11:59 p.m. Pacific Time on the last day of the month in which you or your Dependents become ineligible. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for Individual Conversion Plan, the benefits may not be the same as you had under this Plan.)

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 Individual Conversion Plan provision, and, if applicable, the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

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

Other De-enrollments

Coverage for you or your Dependents terminates on the (1) the date the contract between the University and Blue Shield is discontinued, or (2) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (see "Cancellation for Non-Payment of Dues – Notices").

Blue Shield may terminate your and your Dependent's coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or Blue Shield; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;

2. Permitting use of your Subscriber identification card by someone other than yourself or your Dependents to obtain Services; or
3. Obtaining or attempting to obtain Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS

Reinstatement

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

Cancellation Without Cause

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

Cancellation for Non-Payment of Dues - Notices

Blue Shield may cancel this group Plan for non-payment of Dues. If your Employer fails to pay the required Dues when due, coverage will end 31 days after the date for which Dues are due. Your Employer will be liable for all Dues accrued while this Plan continues in force including those accrued during the 31-day grace period.

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

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

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

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

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

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

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

Right of Cancellation

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

If your Employer does not meet the applicable eligibility, participation and contribution requirements of the Group Health Service Contract, Blue Shield will cancel this Plan after 30 days' written notice to your Employer.

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

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

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

GRACE PERIOD

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

EXTENSION OF BENEFITS

If a Subscriber becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Group Health Service Contract terminates, Blue Shield will extend the Benefits of this Plan, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) 12 months from the date coverage terminated; (2) the date the Subscriber is no longer Totally Disabled; (3) the date on which the Subscriber's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Subscriber. The time the Subscriber was covered under this Plan will apply toward the replacement plan's pre-existing condition exclusion.

No extension will be granted unless the Plan receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Plan.

GROUP CONTINUATION COVERAGE

COBRA and/or Cal-COBRA

Please examine your options carefully before declining this coverage.

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 employees or retirees and their enrolled family member who lose group coverage because of certain "qualifying events" to elect continuation coverage for 18, 29, or 36 months. Qualifying events are situations that would ordinarily cause an individual to lose group health coverage.

An eligible employee or retiree and his/her enrolled family member(s) is entitled to elect continuation 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. Any change in benefits under the plan will also apply to COBRA enrollees.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months.

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 the number of hours required for eligibility.

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 by the Social Security Administration (SSA) to be disabled 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).

Three "qualifying events" allow eligible employees or retirees and their enrolled family member(s) to elect the continuation coverage for up to 36 months.

1. The employee's or retiree's death.
2. Divorce, legal separation or annulment of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.
3. A dependent child's loss of eligibility.

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.

If elected, COBRA continuation coverage is effective the first day of the month following the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the maximum coverage period or until any of the following events occur:

1. The termination of all employer provided group health plans;
2. The required premium for the Member's coverage is not paid on a timely basis;
3. The Member becomes covered by another group health plan after electing COBRA without limitations as to pre-existing conditions;
4. The Member becomes eligible for Medicare benefits after electing COBRA;
5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.
6. The Member notifies the plan or COBRA administrator that he/she wishes to cancel overage.

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

Contact your Employer or your Employer's COBRA Administrator directly if you need more information about your eligibility for COBRA group continuation coverage.

Cal-COBRA

COBRA Member's who reach the 18-month or 29-month maximum coverage period 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 the first of the month after the COBRA coverage ends.

COBRA Members must exhaust the 18-month or 29-month federal COBRA coverage period 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 36 months from the date the qualifying event has occurred that originally entitled the Member to continue group coverage under this Plan.

The cost for Cal-COBRA coverage from the 19th-month to the 36th-month is 110% of the applicable group monthly premium.

Your Employer's COBRA administrator in conjunction with Blue Shield is responsible for notifying COBRA Member's of their right to continue coverage under Cal-COBRA if they have exhausted the 18-month or 29-month federal COBRA coverage period at least 90 calendar days before their COBRA coverage will end. The COBRA Member should contact Blue Shield or their COBRA administrator for more information about continuing coverage.

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.

General Provisions

Liability of Subscribers in the Event of Non-Payment by Blue Shield

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield of California and its Participating Providers and Preferred Providers stipulates that the Subscriber shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Subscriber's group contract. Participating Providers and Preferred Providers have agreed to accept the Plan's payment as payment-in-full for Covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Subscriber is responsible for all amounts Blue Shield of California does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Subscriber is responsible for any charges above the Benefit maximums.

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.

Non-Assignability

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield of California. Possession of a Blue Shield of California ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Member must be a Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield of California and who has maintained enrollment under the terms of this Plan.

Participating Providers and Preferred 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.

If the Member receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the Non-Preferred Provider. The Member or the provider of Service may not request that the payment be made directly to the provider of Service.

Plan Interpretation

Blue Shield of California shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine exception to participate in the Plan and eligibility to receive Benefits under this Plan. Blue Shield of California shall exercise this authority for the Benefits of all Members entitled to receive Benefits under this Plan. Claims to eligibility or enrollment requirements should be directed to:

University of California Human Resources
300 Lakeshore Drive
Oakland, CA 94612

Toll-Free Telephone:
(800) 888-8267

Public Policy Participation

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

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

At least one third of the Board of Directors of Blue Shield of California is comprised of Subscribers who are not Employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield.

Confidentiality of Personal and Health Information

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

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

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

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

Access to Information

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

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 Subscriber or 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 Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Customer Service

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact Blue Shield's Customer Service Department as noted on the last page of this booklet.

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

Customer Service can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Subscribers and Dependents to request an expedited decision. A Member, Physician, or representative of a Mem-

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

GRIEVANCE PROCESS

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

Subscribers, a designated representative, or a provider on behalf of the Subscriber may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Subscribers may contact the Plan at the telephone number as noted on the back page of this booklet. If the telephone inquiry to Customer Service does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Customer Service Representative will initiate on the Subscriber's behalf.

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

Blue Shield will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service 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 above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the Service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

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 **1-855-339-9973** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site, **(http://www.hmohelp.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

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

DEFINITIONS

PLAN PROVIDER DEFINITIONS

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

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

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

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

Hemophilia Infusion Provider — a provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

Note: A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

Home Health Aide — an individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the patient's home.

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 —

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

Non-Participating or Non-Preferred (Non-Participating Provider or Non-Preferred Provider) — refers to any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment-in-full for Covered Services provided to Members.

Other Providers —

1. Appropriately licensed or certified Independent Practitioners —licensed vocational nurse; registered nurses; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician, certified nurse midwife; licensed midwife; occupational therapist; acupuncturists; registered respiratory therapist; enterostomal therapist; speech therapists or speech pathologists; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.
2. Healthcare Organizations — nurses registries; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

Participating Ambulatory Surgery Center — an Outpatient surgery facility which:

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

Participating Hospice or Participating Hospice Agency — an entity which: 1) provides Hospice services to Terminally

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

Participating or Preferred (Participating Provider or Preferred Provider) — refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members.

Note: This definition does not apply to Hospice Program Services. For Participating Hospice or Participating Hospice Agency definitions above.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

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

ALL OTHER DEFINITIONS

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

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

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

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

Allowable Amount — 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 and Disclosure Form, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a Non-Participating Provider anywhere within or outside of the United States who provides Emergency Services:
   a. For Physicians and Hospitals – the Reasonable and Customary Charge;
   b. All other providers – the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield have agreed upon some other amount; or
3. For a Non-Participating Provider in California, including an Other Provider, who provides Services on other than an emergency basis:
   a. For Services prior authorized by Blue Shield to be received from a Non-Preferred Dialysis Center - the Reasonable and Customary Charge, as defined;
   b. For all other Non-Participating/Non-Preferred Providers including Other Providers - the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or
5. For a Non-Participating Provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield would have allowed for a non-participating provider performing the same services. If the local plan has no Non-Participating Provider allowance, Blue Shield will assign the Allowable Amount used for a Non-Participating Provider in California.

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

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

Calendar Year Deductible — the initial amount an Individual or Family must pay in a Calendar Year for certain Covered Services before becoming entitled to receive Benefit payments for those Services from the Plan.

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, children, brothers, sisters, or parents of a covered Member.

Copayment or Coinsurance — the dollar amount or percentage of the Allowable Amount that a Member is required to pay for specific Covered Services after meeting any applicable Deductible.

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

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

Creditable Coverage —

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

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care and/or supervisory care by a Physician) or care furnished to a 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 care; or
2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

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

Dependent and Domestic Partner—

Please refer to the "Eligible Family Members" section of the "Group Insurance Eligibility Fact Sheet for Employees (or Retirees) and Eligible Family Members". A copy of this fact sheet is available in the HR Forms section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the Compensation and Benefits section of UCnet to help you with your health and welfare plan decisions.

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 items such as wheelchairs, Hospital beds, respirators, and other items that Blue Shield of California determines are Durable Medical Equipment.

Emergency Services — Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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;
3. serious dysfunction of any bodily organ or part.

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

Employer (Contractholder) — The Regents of the University of California and its affiliate, Hastings College of the Law.

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

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any

State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Family Coverage — coverage provided for two or more Members, as defined herein.

Group Health Service Contract (Contract) — the contract issued by the Plan to the Contractholder that establishes the services that Subscribers and Dependents are entitled to receive from the Plan.

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

Individual (Self-only) Coverage — Coverage provided for only one Subscriber, as defined herein.

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

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

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

Medical Necessity (Medically Necessary) —

The Benefits of this Plan are provided only for Services which are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Plan, are:
    a. consistent with the Plan's medical policy;
    b. consistent with the symptoms or diagnosis;
    c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
    d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient Services not Medically Necessary include hospitalization:
    a. for diagnostic studies that could have been provided on an Outpatient basis;
    b. for medical observation or evaluation;
    c. for personal comfort;
    d. in a pain management center to treat or cure chronic pain; and
    e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.
4. The Plan reserves the right to review all claims to determine whether Services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member — either a Subscriber or Dependent.

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

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

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

Outpatient — an individual receiving services but not as an Inpatient.

Physical Therapy — treatment provided by a registered physical therapist, certified occupational therapist, or other

appropriately licensed Health Care Provider Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Blue Shield of California and/or Blue Shield Health Savings Plan.

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

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

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

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

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

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

Reasonable and Customary Charge — in California: The lower of (1) the provider's billed charge, or (2) the amount determined by Blue Shield 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 the laws of the state to be paid for Emergency Services.

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

Rehabilitation — Inpatient or Outpatient care furnished to an individual disabled by injury or illness to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

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

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

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

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

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

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

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients

who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Subscriber — an individual who satisfies the eligibility requirements of an Employee, who has been enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Blue Shield of California coverage under the group contract.

Total Disability (or Totally Disabled) —

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

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTES

NOTES

For claims submission and information contact your appropriate Blue Shield of California location.

Subscribers may call Customer Service toll free,

Monday through Friday, 7 a.m-7 p.m: 1-855-339-9973

The hearing impaired may call Blue Shield's Customer Service Department through Blue Shield's toll-free TTY number at 1-800-241-1823.

Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the Customer Service telephone number indicated on the back of the Member's identification card.

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

Please refer to the Benefits Management Program section of this Evidence of Coverage and Disclosure Form booklet for information.

Please direct correspondence to:

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