Balance℠ Plan 1000 - G

Blue Shield of California
Life & Health Insurance Company

Policy

Individual and Family Plan

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Balance Plan 1000- G

Policy for Individuals and Families

This Policy is issued by Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"), to the Insured whose identification cards are issued with this Policy. In consideration of statements made in the application and timely payment of Premiums, Blue Shield Life agrees to provide the benefits of this Policy.

NOTICE TO NEW SUBSCRIBERS

Please read this Policy carefully. If you have questions, contact Blue Shield Life. You may surrender this Policy by delivering or mailing it with the Identification Cards, within ten (10) days from the date it is received by you, to BLUE SHIELD LIFE 601 12TH STREET, OAKLAND, CA 94607 Immediately upon such delivery or mailing, the Policy shall be deemed void from the beginning, and Premiums paid will be refunded.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your policy 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 become a policyholder or select a network provider. Call your prospective doctor or clinic, or call the health plan at Blue Shield Life's Customer Service telephone number on the Subscriber's Identification Card to ensure that you can obtain the health care services that you need.

IMPORTANT!

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

IFP-DOIAS-000GF

Grandfathered Health Plan Notice

Blue Shield Life believes this policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield Life at the Customer Service telephone number on your identification card. You may also contact the U. S. Department of Health and Human Services at www.healthcare.gov.

The Balance Plan 1000- G

Subscriber Bill of Rights

As a Balance Plan 1000 – G 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 Balance Plan 1000 - G, 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 that 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 Life grievance procedure and understand how to use it without fear of interruption of health care.

15. Voice complaints or grievances about the Balance Plan 1000 – G or the care provided to you.

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Subscriber Responsibilities

As a Balance Plan 1000 – G Subscriber, you have the responsibility to:

1. Carefully read all Balance Plan 1000 – G 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 Balance Plan 1000 – G membership as explained in the Policy.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.

4. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.

7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.

8. Offer suggestions to improve the Balance Plan 1000 - G.

9. Help Blue Shield Life to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

10. Notify Blue Shield Life as soon as possible if you are billed inappropriately or if you have any complaints.

11. Treat all Plan personnel respectfully and courteously as partners in good health care.

12. Pay your Premiums, Copayment, Coinsurance, and charges for non-covered Services on time.

13. For all Mental Health and Substance Use Disorder Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Non-Emergency Inpatient Mental Health and Substance Use Disorder Services.

14. Follow the provisions of the Blue Shield Life Benefits Management Program.

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PPO Summary of Benefits

Note: The SUMMARY OF BENEFITS represents only a brief description of the Benefits. Please read this Policy carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this Plan.

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

Note that certain services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in no payment by Blue Shield Life for services. Please read this Summary of Benefits and the section entitled Covered Services so you will know from which providers health care may be obtained. The Preferred Provider Directory can be located online at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the last page of this Policy.

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

Summary of Benefits	**Balance Plan 1000 - G**
Insured Calendar Year Deductible [1] (Medical Plan Deductible)	**Deductible Responsibility**
	Services by Preferred and Participating Providers
Calendar Year Medical Deductible	$1,000 per Insured / $2,000 per Family

Insured Calendar Year Brand Name Drug Deductible [2]	**Insured Responsibility**	
	Participating Pharmacy	**Non- Participating Pharmacy**
Per Insured **Applicable to all Covered Brand Name Drugs, including Brand Name Home Self-Administered Injectables**	$500	Not covered

Insured Maximum Calendar Year Copayment Responsibility [3]	**Insured Maximum Calendar Year Copayment Responsibility [3, 4]**	
	Services by Preferred and Participating Providers	**Services by any combination of Preferred, Participating, Non-Preferred and Non-Participating Providers**
Calendar Year Copayment Maximum	$5,500 per Insured / $11,000 per Family	$8,500 per Insured / $17,000 per Family

Insured Maximum Lifetime Benefits	**Maximum Blue Shield Life Payment**	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Acupuncture Benefits		
Acupuncture Covered Services. Up to a maximum of 15 visits per Insured, per Calendar Year for any combination of acupuncture and chiropractic Services. Whether these Services are provided in an office location or a Hospital's outpatient department, all visits count towards the Calendar Year visit maximum. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Covered Services	50% of up to $50 per visit	50% of up to $50 per visit
Allergy Testing and Treatment Benefits		
Allergy serum purchased separately for treatment	30%	50%
Office visits (includes visits for allergy serum injections)	30%	50%
Ambulance Benefits		
Emergency or authorized transport	30% [6]	30% [6]
Ambulatory Surgical Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.		
Ambulatory Surgery Center Outpatient Surgery facility Services	30%	50% of up to $300 per day
Ambulatory Surgery Center Outpatient Surgery Physician Services	30%	50%

Benefit	Insured Copayment/Coinsurance [4]	
Bariatric Surgery All bariatric surgery Services must be prior-authorized, in writing, from Blue Shield Life's Medical Director. Prior authorization is required for all Insureds, whether residents of a designated or non-designated county.	**Services by Preferred and Participating Providers**	**Services by Non-Preferred and Non-Participating Providers [5]**
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	30%	Not covered [8]
Hospital Outpatient Services	**$**250 per Surgery plus 30%	Not covered [8]
Physician bariatric surgery Services	30%	Not covered [8]
Bariatric Surgery Benefits for residents of non-designated counties in California		
Hospital Inpatient Services	30%	50% of up to $500 per day [8]
Hospital Outpatient Services	**$**250 per Surgery plus 30%	50% of up to $500 per day [7]
Physician bariatric surgery Services	30%	50% [7]
Chiropractic Benefits [8]		
Chiropractic Services Covered Services . Up to a maximum of 15 visits per Insured, per Calendar Year for any combination of acupuncture and chiropractic Services. Whether these Services are provided in an office location or a Hospital's outpatient department, all visits count towards the Calendar Year visit maximum. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	50% of up to $50 per visit	Not covered
Clinical Trial for Cancer Benefits		
Clinical Trial for Cancer Services Covered Services for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by the Plan. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in this Summary of Benefits.	You pay nothing	You pay nothing

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Diabetes Care Benefits		
Devices, equipment and supplies	30%	50%
Diabetes self-management training in an office setting	$30 per visit [9]	50% [9]
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.	30%	50% of up to $300 per day
Durable Medical Equipment Benefits		
Durable Medical Equipment	30%	50%
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 Outpatient Physician Services Benefits in this Summary of Benefits and will be subject to any Calendar Year medical Deductible.	30%	30%
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 and will be subject to any Calendar Year medical Deductible.	$100 per visit plus 30%	$100 per visit plus 30%
Emergency room Services resulting in admission (billed as part of Inpatient Hospital Services)	30%	30% [10]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Family Planning Benefits [11] 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 the Summary of Benefits will also apply.		
Counseling and consulting (Including Physician office visits for diaphragm fitting or injectable contraceptives)	30%	Not covered
Diaphragm fitting procedure When administered in an office location, this is in addition to the Physician office visit Copayment.	30%	Not covered
Injectable contraceptives When administered in an office location, this is in addition to the Physician office visit Copayment.	$25 per injection	Not covered
Tubal ligation In an Inpatient facility, this Coinsurance is billed as part of Inpatient Hospital Services for a delivery/abdominal surgery.	30%	Not covered
Vasectomy	30%	Not covered
Home Health Care Benefits Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Home health care agency Services, including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.	30%	Not covered [12]
Medical supplies	30%	Not covered [12]
Home Infusion/Home Injectable Therapy Benefits Note: There is a combined Benefit maximum of 90 visits per Insured, per Calendar Year for all Home Health and Home Infusion/Home Injectable Services. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.		
Hemophilia home infusion Services provided by a hemophilia infusion provider and prior authorized by the Plan. Includes blood factor product.	30%	Not covered [12]
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency Note: Home non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit.	30%	Not covered [12]
Home visits by an infusion nurse (Home infusion agency nursing visits are not subject to the Home Health Care and Home Infusion/Home Health Injectable Services Calendar Year visit limitation.)	30%	Not covered [12]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Hospice Program Benefits Covered Services for Insureds 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	30%	Not covered [13]
General Inpatient care	30%	Not covered [13]
Inpatient Respite Care	You pay nothing	Not covered [13]
Pre-hospice consultation	You pay nothing	Not covered [13]
Routine home care	You pay nothing	Not covered [13]
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	30%	30% [14]
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.	30%	50% of up to $500 per day
Inpatient Medically Necessary skilled nursing Services including Subacute Care. Up to a Benefit maximum of 100 days per Insured, per Calendar Year. These Services have a Calendar Year day maximum 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 medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	30%	50%
Inpatient Services to treat acute medical complications of detoxification	30%	50% of up to $500 per day
Outpatient diagnostic testing X-Ray, diagnostic examination and clinical laboratory services	30%	50% of up to $500 per day [14]
Outpatient dialysis Services	30%	50% of up to $300 per day [14]
Outpatient Services for surgery and necessary supplies	$250 per Surgery plus 30%	50% of up to $500 per day [14]
Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	30%	50% of up to $500 per day [14]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Medical Treatment for 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	30%	50% of up to $300 per day
Inpatient Hospital Services	30%	50% of up to $500 per day [14]
Office location	$30 per visit	50%
Outpatient department of a Hospital	$250 per Surgery plus 30%	50% of up to $500 per day [14]

Benefit	Insured Copayment/Coinsurance [4]	
Mental Health and Substance Use Disorder Benefits (All Services provided through the Plan's Mental Health Service Administrator (MHSA))	**Services by MHSA Participating Providers**	**Services by MHSA Non-Participating Providers [15]**
Inpatient Mental Health and Substance Use Disorder Services[15]		
Inpatient Hospital services	30%	50% of up to $500 per day [15]
Inpatient Professional services	30%	50%
Residential care for Mental Health and Substance Use Disorder	30%	50% of up to $500 per day
Other Outpatient Mental Health and Substance Use Disorder Services		
Behavioral Health Treatment in home or other non-institutional setting	30%	50%
Behavioral Health Treatment in an office setting	30%	50%
Electroconvulsive Therapy (ECT) [16]	30%	50%
Intensive Outpatient Program [16]	30%	50%
Partial Hospitalization Program [17]	30% per episode	50% of up to $500 per day
Psychological testing to determine mental health diagnosis (outpatient diagnostic testing) Note: For diagnostic laboratory services, see the "Outpatient diagnostic laboratory services, including Papanicolaou test" section of this Summary of Benefits. And for diagnostic X-ray and imaging services, see the "Outpatient diagnostic X-ray and imaging services, including mammography" section of this Summary of Benefits.	30%	50%
Transcranial magnetic stimulation	30%	50%
Mental Health and Substance Use Disorder Services – Office Visits		
Professional (Physician) office visit	$30 per visit	50%

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Orthotics Benefits		
Office visits	$30 per visit	50%
Orthotic equipment and devices	30%	50%

Benefit	Insured Copayment/Coinsurance [4]	
Outpatient Prescription Drug Benefits [18, 19, 20]	**Participating Pharmacy [20]**	**Non-Participating Pharmacy [21]**
Retail Prescriptions		
Generic Drugs	$10 per prescription	Not covered
Formulary Brand Name Drugs [21, 22]	$35 per prescription	Not covered
Non-Formulary Brand Name Drugs [21, 23]	The greater of $50 or 50% of Blue Shield Life's contracted rate	Not covered
Mail Service Prescriptions		
Generic Drugs	$20 per prescription	Not covered
Formulary Brand Name Drugs [21, 22]	$70 per prescription	Not covered
Non-Formulary Brand Name Drugs [21, 22]	The greater of $100 or 50% of Blue Shield Life's contracted rate	Not covered
Home Self-Administered Injectables	30% per prescription	Not covered
Oral Anticancer Medication	30% ($200 maximum per prescription)	Not covered
Outpatient X-Ray, Pathology, 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 X-Ray, pathology and laboratory	30% [9, 24]	50% [9, 24]
Outpatient laboratory services, California Prenatal Screening Program	You pay nothing	You pay nothing
PKU Related Formulas and Special Food Products Benefits		
PKU	30%	Not covered
Podiatric Benefits		
Podiatric Services	$30 per visit	50%

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the 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.	30%	50% up to $500 per day [14]
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/Copayment may apply.	30%	50%
Prenatal and postnatal Physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.	30%	50%
Preventive Care Benefits [24]		
Annual Physical Examination including only the annual routine physical examination office visit; urinalysis; eye and ear screening; and pediatric and adult immunizations and the immunizing agent	$30 per visit	Not covered
Annual Gynecological Examination including only the annual gynecological examination office visit; mammography; routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer screening test; and the human papillomavirus (HPV) screening test	$30 per visit	Not covered
Well Baby Examinations including only the well baby examination office visit; tuberculin test; and pediatric immunizations and the immunizing agent	$30 per visit	Not covered
Colorectal Cancer Screening Services	You pay nothing	Not covered
Osteoporosis Screening Services	30%	Not covered
NurseHelp 24/7	You pay nothing	Not covered

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Professional (Physician) Benefits		
Inpatient Physician Services For bariatric surgery Services for residents of designated counties in California, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.	30%	50%
Outpatient Physician Services, other than an office setting	30%	50%
Physician home visits	30%	50%
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 medical Deductible. Additionally, certain Physician office visits may have a Copayment or Coinsurance amount that is different than the one stated here. For those Physician office visits, the Copayment or Coinsurance will be as stated elsewhere in this Summary of Benefits.	$30 per visit	50%
Prosthetic Appliance Benefits		
Office visits	$30 per visit	50%
Prosthetic equipment and devices	30%	50%
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. Blue Shield Life requires prior authorization for all these Services.	30% [23]	50% of up to $500 per day [23]

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) Up to a maximum of 20 visits per Insured, per Calendar Year for any combination of Rehabilitation Benefits and Speech Therapy Services. Whether these Services are provided in an office location or a Hospital's outpatient department, all visits count towards the Calendar Year visit maximum. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met. Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:		
Office location	30% [9, 25]	50%
Outpatient department of a Hospital	30% [9, 25]	50% of up to $500 per day
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	30%	50% of up to $500 per day
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days	30%	50%
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility Up to a Benefit maximum of 100 days per Insured, per Calendar Year. These Services have a Calendar Year day maximum 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 medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met.	30% [26]	30% [27]
Speech Therapy Benefits Up to a maximum of 20 visits per Insured, per Calendar Year for any combination of Rehabilitation Benefits and Speech Therapy Services. Whether these Services are provided in an office location or a Hospital's outpatient department, all visits count towards the Calendar Year visit maximum. If your Plan has a Calendar Year medical Deductible the number of visits start counting toward the maximum when Services are first provided even if the Calendar Year medical Deductible has not been met. Speech Therapy Services in the following settings:		
Office location	30% [9, 27]	50%
Outpatient department of a Hospital	30% [9, 27]	50% of up to $500 per day
Rehabilitation unit of a Hospital for Medically Necessary days In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services	30%	50% of up to $500 per day
Skilled Nursing Facility Rehabilitation Unit for Medically Necessary days	30%	50%

Benefit	Insured Copayment/Coinsurance [4]	
	Services by Preferred and Participating Providers	**Services by Non-Preferred and Non-Participating Providers [5]**
Transplant Benefits - Cornea, Kidney or Skin Organ Transplant Benefits for transplant of a cornea, kidney or skin.		
Hospital Services	30%	50% of up to $500 per day
Professional (Physician) Services	30%	50%
Transplant Benefits – Special [28] Note: The Plan requires prior authorization from Blue Shield Life's Medical Director for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield Life. Please see the Transplant Benefits portion of the Principal Benefits (Covered Services) section in the Policy for important information on this benefit.		
Facility Services in a Special Transplant Facility	30%	Not covered
Professional (Physician) Services	30%	Not covered

Summary of Benefits

Footnotes:

[1] The Calendar Year Deductible (Medical Plan Deductible) may include Services on both a Copayment or Coinsurance basis and applies to all applicable Services except the Services listed below.

Covered travel expenses for bariatric surgery Services;
Diabetes Self-Management Training by Preferred Providers, a registered dietician, or a registered nurse who is a certified diabetes educator;
Emergency Room Facility Services not resulting in an admission;
Injectable contraceptive when administered by a Physician as specified in the Family Planning Services section.
Internet Based Consultations;
Outpatient laboratory services, California Prenatal Screening Program;
Preferred Physician office visits;
Preventive Health Benefits; and
Services provided under the Outpatient Prescription Drug benefit.

[2] Charges for covered Brand Name Drugs in excess of the Participating Pharmacy contracted rate do not apply to the Insured Calendar Year Brand Name Drug Deductible.

The Insured Calendar Year Brand Name Drug Deductible must be satisfied once during each Calendar Year by or on behalf of the Insured.

The Insured Calendar Year Brand Name Drug Deductible is separate from the Insured Calendar Year Deductible (Medical Plan Deductible). The Insured Calendar Year Brand Name Drug Deductible does not count towards the Insured Calendar Year Deductible (Medical Plan Deductible) nor toward the Insured Maximum Calendar Year Copayment responsibility.

[3] The following are not included in the maximum Calendar Year Copayment amount:

Additional and reduced payments under the Benefits Management Program;
Charges in excess of specified benefit maximums;
Charges for Services which are not covered and charges by Non-Preferred Provider and MHSA Non-Participating Providers in excess of covered amounts;
Covered Non-Emergency Services provided by a Non-Participating Dialysis Center
Covered travel expenses for bariatric surgery Services;
Family Planning injectable contraceptives administered by a Physician;
Non-Emergency Services from a Non-Participating Hospital;
Outpatient Surgery from a Non-Participating Ambulatory Surgery Center;
Preventive Health Benefits
Physician office visit Copayment/Coinsurance;
Non-Preferred Hospital-based Inpatient Medically Necessary skilled nursing Services including Subacute Care;
Services provided under the Outpatient Prescription Drug benefit;
The Calendar Year Brand Name Drug Deductible;

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

[4] Unless otherwise specified, Copayments/Coinsurance are calculated based on the Allowable Amount.

[5] For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[6] The Copayment 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.

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

[8] No Benefits are provided for Chiropractic Services by Non-Preferred or Non-Participating Providers.

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

[10] For emergency room Services directly resulting in admission as an Inpatient to a Non-Preferred Hospital which the Plan determines are not Emergencies, your Copayment/Coinsurance will be the Non-Preferred Hospital Inpatient Services Copayment/Coinsurance.

[11] No Benefits are provided for Family Planning Services by Non-Preferred or Non-Participating Providers.

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

[13] Services by Non-Participating Hospice Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be the Participating Agency Copayment/Coinsurance.

[14] For Emergency Services by Non-Preferred Providers, your Copayment/Coinsurance will be the Preferred Provider Copayment/Coinsurance.

[15] For Emergency Services from a MHSA Non-Participating Hospital, the Insured's Copayment/Coinsurance will be the MHSA Participating level, based on Allowable Amount.

[16] The Insured's Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.

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

[18] This plan's prescription drug coverage is less than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may enroll in a Part D plan from October 15th through December 7th of each year, and if you do not enroll when first eligible you may be subject to payment of higher Part D premiums when you enroll at a later date. For more information about drug coverage, call Customer Service at the telephone number indicated on your Member Identification Card, Monday through Thursday 8:00 a.m. and 5:00 p.m., or Friday 9:00 a.m. to 5:00 p.m.

[19] The Insured Maximum Calendar Year Copayment responsibility does not apply to the Outpatient Prescription Drug benefit.

[20] Copayment/Coinsurance is calculated based on the Allowable Amount for covered prescriptions between the Plan and the Participating Pharmacy, including Specialty Pharmacies, or the Participating Mail Order Pharmacy.

[21] Except for covered emergencies, including Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

[22] Benefits for covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits.

[23] Your Copayment/Coinsurance will be assessed per provider per date of service.

[24] No Benefits are provided for Preventive Health Benefits by Non-Preferred or Non-Participating Providers.

[25] For Services by certified occupational therapists and certified respiratory therapists, you are responsible for all charges above the Allowable Amount.

[26] For Services by free-standing skilled nursing facilities (nursing homes), you are responsible for all charges above the Allowable Amount.

[27] For Services by licensed speech therapists, you are responsible for all charges above the Allowable Amount.

[28] Special Transplant Benefits are limited to the procedures listed in the Covered Services section. See the Transplant Benefits - Special Covered Services section for information on Services and requirements.

Your Balance Plan 1000 – G and How to Use It -

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

The Balance Plan 1000 – G has a common goal with you and with health care professionals - quality health care coverage at a reasonable cost. You can control your out-of-pocket costs by carefully choosing the providers from whom you receive covered Services.

This Plan has two different payment levels depending on the Physician or Hospital from which you receive covered Services. Blue Shield Life has a statewide network of nearly 50,000 Physician Members and contracted Hospitals known as Preferred Providers. Many other health care professionals, including optometrists and podiatrists are also Preferred Providers.

The highest benefits of the Balance Plan 1000 – G are provided when you receive covered Services from a Preferred Provider. You will incur higher out-of-pocket costs when you receive covered Services from a Non-Preferred Provider.

Note: choosing a Preferred Provider will assure the lowest level of Insured's payments available under this Plan. See the "Definitions" section for more information.

Preferred Providers have agreed to accept the Plan's payment, plus payment for any applicable Deductibles, the Insured's Copayments and Coinsurances, or amounts in excess of specified benefit maximums as payment-in-full for covered Services, except as provided under the section entitled Acts of Third Parties. This is not true of Non-Preferred Providers. If you receive Services from a Non-Preferred Provider, the Plan's payment may be substantially less than the amount the provider bills. You are responsible for the difference between the amount the Non-Preferred Provider bills and the amount the Plan pays.

If you receive services at a Participating Provider facility (Hospital, Ambulatory Surgery Center or other outpatient settings, laboratory, radiology center, or imaging center) at which or as a result of which you receive Covered Services provided by a Non-Participating Provider, covered services provided by a Non-Participating Provider will be payable at the Participating Provider level of benefits. Your share of cost will not exceed the copayment or coinsurance due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above the Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms. Consent must be obtained at least 24 hours in advance of care. Notice and consent forms must be provided no later than 72 hours prior to the day of the appointment if scheduled at least 72 hours in advance, and no later than 24 hours prior to the appointment if scheduled 24-72 hours in advance. This notice and consent exception does not apply when the Non-Participating Provider furnishes items and services identified in 45 CFR section 149.20(b), which includes ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is provided. The Non-Participating Provider will be subject to the limitations of this section, and you will not be responsible for additional charges above the Allowable Amount. For the purposes of this section, ancillary services are:

a. Items and services related to Emergency Services, anesthesiology, pathology, radiology, and neonatology, whether provided by a Participating or Non-Participating Provider, or Health Care Provider;
b. Items and services provided by assistant surgeons, hospitalists, and intensivists;
c. Diagnostic X-Ray Services, diagnostic examinations, clinical pathology, and laboratory Ser- vices; and
d. Items and services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

In addition, certain services are not covered when received from Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

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.

Blue Shield Life, or the MHSA, will render a decision on all requests for prior authorization, and pre-admission review within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within two (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 an Insured, or when the Insured is experiencing severe pain, Blue Shield Life, or the MHSA, will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

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.

Providers do not receive financial incentives or bonuses from the Plan.

When you need health care, present your Blue Shield Life Identification Card to your Physician, Hospital or other licensed health care provider. Your Identification Card has your Subscriber and group number on it. Be sure to include

your Insured and group numbers on all claims you submit to Blue Shield Life. Preferred Providers usually bill the Plan directly. See section on Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

The Balance Plan 1000 – G is specifically designed for you to use the Blue Shield Life Provider Network of Preferred Providers. Refer to the "Covered Services" section of this Policy for Copayment and Coinsurance information. Preferred Providers are listed in the Preferred Provider Directories.

If you wish to obtain a copy of the Preferred Provider Directory, you may request a copy by contacting the Plan's Customer Service Department at the telephone number on the Subscriber's Identification Card. You may also verify this information by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

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 has been published.

Insureds 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.

For all Mental Health and Substance Use Disorder Services: The MHSA is a specialized health care service plan that will deliver the Plan's Mental Health and Substance Use Disorder Services through a separate network of Mental Health Service Administrator (MHSA) Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health and Substance Use Disorder Services to Insureds. A Blue Shield Life Provider Network Preferred/Participating Provider may not be an MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of any applicable Deductible, Copayment, Coinsurance or amounts in excess of benefit maximums specified, as payment-in-full for covered Mental Health and Substance Use Disorder Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health and Substance Use Disorder Services from MHSA Participating Providers.

If you receive services at a MHSA Participating Provider facility, MHSA's payment for Mental Health and Substance Use Disorder covered services provided by a health professional at the MHSA Participating Provider facility will be paid at the MHSA Participating Provider level of benefits, whether the health professional is a MHSA Participating Provider or MHSA Non-Participating Provider. Your share of cost will not exceed the copayment or coinsurance due to a MHSA Participating Provider under similar circumstances, and the Insured will not be responsible for additional charges above the Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms. Consent must be obtained at least 24 hours in advance of care. Notice and consent forms must be provided no later than 72 hours prior to the day of the appointment if scheduled at least 72 hours in advance, and no later than 24 hours prior to the appointment if scheduled 24-72 hours in advance. This notice and consent exception does not apply when the Non-Participating Provider furnishes items and services identified in 45 CFR section 149.20(b), which includes ancillary services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is provided. The Non-Participating Provider will be subject to the limitations of this section, and you will not be responsible for additional charges above the Allowable Amount. For the purposes of this section, ancillary services are:

a. Items and services related to Emergency Services, anesthesiology, pathology, radiology, and neonatology, whether provided by a Participating or Non-Participating Provider, or Health Care Provider;
b. Items and services provided by assistant surgeons, hospitalists, and intensivists;
c. Diagnostic X-Ray Services, diagnostic examinations, clinical pathology, and laboratory Ser- vices; and
d. Items and services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

It is your responsibility to ensure that the Provider you select for Mental Health and Substance Use Disorder Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Behavioral Health Provider Directory. Additionally, Insureds may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-263-9952. You may also search for an MHSA Participating Provider by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Blue Shield Life Network of Preferred Providers

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

The California Department of Insurance has regulations that establish access standards for a plan's provider network in California. For purposes of these provide network access standards, the service area for this Plan is the State of California.

This Plan is most effective and advantageous when covered Services are received from Preferred Providers. You receive the maximum benefits of the Plan when you receive Services from these providers.

Insureds are paid directly by Blue Shield Life if Services are received from a Non-Preferred Provider. Payments to Insureds for Services are in amounts identical to those made directly to providers. See the section entitled Notice and Proof of Claim in this Policy for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within thirty (30) days after receipt of the claim.

Insureds are not responsible to Preferred Providers for payment for covered Services, except for payment of any applicable Deductibles, Copayments, Coinsurances, or amounts in excess of specified benefit maximums, once the Insured's Calendar Year Deductible has been satisfied, except as provided under the section entitled Acts of Third Parties.

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 the Plan within 24 hours, or by the end of the first business day, following an emergency admission at a Non-Preferred Hospital, or as soon as is reasonably possible to do so.

Continuity of Care

Continuity of care with a Former Participating Provider may be available if: Blue Shield Life or the MHSA no longer contracts with the Insured's Former Participating Provider for the services he or she is receiving; or for newly-covered Insureds whose previous health plan was withdrawn from the market.

If the Insured's Former Participating Provider is no longer available to you for one of the reasons noted above, Blue Shield Life or the MHSA will notify the Insured of the option to continue treatment with the Former Participating Provider.

Insureds who meet the eligibility requirements listed above may request continuity of care if they are currently being treated for:

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

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

To request continuity of care, visit www.blueshieldca.com and fill out the Continuity of Care Application. Blue Shield Life may review the request for Medical Necessity.

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

TIMELY ACCESS TO CARE

Blue Shield Life provides the following guidelines to provide Insureds timely access to care from Preferred Providers.

Urgent Care	Wait Time
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	Wait Time
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days

Appointment with a mental health and substance use disorder health provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	Wait Time
Access to a health professional to determine if the Insured's problem is urgent	24 hours/day 7 days/week
If arrangements are made to call the Insured back	Within 30 minutes

Note: For availability of interpreter services at the time of the Insured's appointment, consult the online Preferred Provider Directory available at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the back page of this Policy. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this Policy.

Premiums

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

Payments by mail are to be sent to:

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

Additional Premiums may be charged in the event that a state or any other taxing authority imposes upon Blue Shield Life a tax or license fee, which is calculated upon, base Premiums or Blue Shield Life's gross receipts or any portion of either. Premiums increase according to the Subscriber's age, as stated in the Appendix. Premiums may also increase from time to time as determined by Blue Shield Life in accordance with federal and state law and regulations. Blue Shield Life will give the Subscriber written notice at least 60 days prior to plan renewal of any changes in the monthly Premiums.

Your premiums may change without written notice when:

- You move to a new geographic rating region. Your new premiums are effective the first of the month after your last billing cycle.
- You add or drop a Dependent. For more information about changing Dependents, see the *Eligibility and Enrollment* section.

Plan Changes

The benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, Coinsurance, and annual copayment/coinsurance maximum amounts, are subject to change as permitted by law. Blue Shield Life will give the Subscriber written notice of coverage changes. We will send this notice at least 30 days prior to plan renewal.

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

Conditions of Coverage
Eligibility and Enrollment

1. To enroll and continue enrollment, an Insured must meet all of the eligibility requirements of the Plan.

2. Enrollment of Subscribers or Dependents is not effective until Blue Shield Life approves an application and accepts the applicable Premiums. Only Blue Shield Life's Underwriting Department can approve applications.

3. An applicant, upon completion and approval by Blue Shield Life of the application, is entitled to the benefits of this Policy upon the Effective Date.

   By completing an application, the Subscriber and/or Dependent(s) agrees to cooperate with Blue Shield Life by providing, or providing access to, documents and other information that the Plan may request to corroborate the information for coverage. If the Subscriber and/or Dependent(s) fail or refuse to provide these documents or information to Blue Shield Life, coverage under this plan may be cancelled.

4. The Effective Date of the benefits of a newborn child will be the date of birth if the Subscriber contacts Blue Shield Life at the Customer Service telephone number on the Subscriber's Identification Card to have the newborn child added to this Policy as a Dependent. Such request must be made within 31 days of the newborn child's date of birth. If a request to add the child as a Dependent is not made within 31 days of birth, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

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

5. The Effective Date of benefits for an adopted child will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, if the Subscriber requests the child be added to this Policy as a Dependent. Such request must be made within 31 days of the date the

Subscriber, spouse, or Domestic Partner has the right to control the child's health care. If a request to add the child as a Dependent is not made within 31 days of the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care, the coverage for that child shall terminate on the 31st day at 11:59 p.m. Pacific Time.

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

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

6. If a court has ordered that you provide coverage for your spouse or Domestic Partner, or Dependent child, under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 of the Welfare and Institutions Code or Medi-Cal program.

Limitation on Enrollment

1. Subscribers must be Residents of California. Upon change of residence to another jurisdiction, this Policy will terminate. Coverage may be transferred to a Blue Cross or Blue Shield Plan for that jurisdiction, if any. See the section entitled Transfer of Coverage.

2. Dependent benefits shall be discontinued as of the following, except as specifically set forth in the definition of Dependent in the section entitled Definitions:

   a. The date the Dependent child attains age 26; and

   b. The date the Dependent spouse or Domestic Partner enters a final decree of divorce, annulment or dissolution of marriage, or domestic partnership from the Subscriber.

Duration of the Policy

This Policy shall be renewed upon receipt of prepaid Premiums unless otherwise terminated as described herein. Renewal is subject to Blue Shield Life's right to amend this Policy. Any change in Premiums or benefits, are effective after 60 days notice to the Subscriber's address of record with Blue Shield Life.

Termination / Reinstatement of the Policy

This Policy may be rescinded or terminated as follows. There is no right to receive the Benefits of this plan after coverage ends, except as described in the Continuity of care section.

1. Termination by the Subscriber:
   A Subscriber desiring to terminate this Policy shall give Blue Shield Life 30 days written notice.

2. Rescission by Blue Shield Life:
   By signing the enrollment application, you represented that all responses contained in your application for coverage were true, complete and accurate, to the best of your knowledge, and you were advised regarding the consequences of intentionally submitting materially false or incomplete information to Blue Shield Life in your application for coverage, which included rescission of this Policy.
   To determine whether or not you would be offered enrollment through this Agreement, Blue Shield Life reviewed your medical history based upon the information you provided in your enrollment application, including the health history portion of your enrollment application and any supplemental information that Blue Shield Life determined was necessary to evaluate your medical history and status. This process is called underwriting.

   Blue Shield Life has the right to rescind this Policy if the information contained in the application or otherwise provided to Blue Shield Life by your or anyone acting on your behalf in connection with the application was intentionally and materially inaccurate or incomplete. This Policy also may be rescinded if you or anyone acting on your behalf failed to disclose to Blue Shield Life any new or changed facts arising after the application was submitted but before this Policy was issued, when those facts pertained to matters inquired about in the application. However, after 24 months following issuance of the Policy, Blue Shield Life will not rescind the Policy for any reason.

   If after enrollment, Blue Shield Life investigates your application information, we will not rescind this Policy without first notifying you of the investigation and offering you an opportunity to respond.

If this Policy is rescinded, it means that the Policy is voided retroactive to its inception as if it never existed. This means that you will lose coverage back to the original Effective Date. If the Policy is properly rescinded, Blue Shield Life will refund any Premiums payments you made, but, to the extent permitted by applicable law, may reduce that refund by the amount of any medical expenses that Blue Shield Life paid under the Policy or is otherwise obligated to pay. In addition, Blue Shield Life may, to the extent permitted by California law, be entitled to recoup from you all amounts paid by Blue Shield Life under this Policy.

If this Policy is rescinded, Blue Shield Life will provide a 30 day advance written notice that will: (a) explain the basis of the decision and your appeal rights, including your right to request assistance from the California Department of Insurance; (b) clarify that those Insureds whose application information was not false or incomplete are entitled to new coverage without medical underwriting and will explain how those Insureds may obtain this coverage; and (c) explain that the monthly Premiums for those Insureds will be determined based on the number of Insureds that remain as Blue Shield Life Insureds.

3. Termination by Blue Shield Life through cancellation:
Blue Shield Life may cancel this Policy immediately upon written notice for the following:

   a. Fraud or deception in obtaining, or attempting to obtain, benefits under this Policy;

   b. Knowingly permitting fraud or deception by another person in connection with this Policy, such as, without limitation, permitting someone to seek benefits under this Policy, or improperly seeking payment from Blue Shield Life for benefits provided;

   c. Rescission of this Policy otherwise would be permitted under California law, but rescission of this Policy would not be permitted under Federal law.

   Cancellation of the Policy under this section will terminate the Policy effective as of the date that written notice of termination is mailed to the Subscriber. It is not retroactive to the original Effective date of the Policy.

4. Termination by Blue Shield Life if Subscriber moves out of service area:
Blue Shield Life may cancel this Policy upon thirty (30) days written notice if the Subscriber moves out of California. See the section entitled Transfer of Coverage for additional information.

   Within 30 days of the notice of cancellation under sections 3 or 4 above, Blue Shield Life shall refund the prepaid Premiums, if any, that Blue Shield Life determines will not have been earned as of the termination date. Blue Shield Life reserves the right to subtract from any such Premiums refund any amounts paid by Blue Shield Life for benefits paid or payable by Blue Shield Life prior to the termination date.

5. Termination by Blue Shield Life due to withdrawal of the Policy from the Market:
Blue Shield Life may terminate this Policy together with all like Policy to withdraw it from the market. In such instances you will be given 90 days written notice and the opportunity to enroll in any other individual Policy without regard to health status-related factors.

6. Cancellation of the Policy for Nonpayment of Premiums:
Blue Shield Life may cancel this Policy for failure to pay the required Premiums when due. If the Policy is being cancelled because you failed to pay the required Premiums when due, then coverage will end 30 days ager the date for which these Premiums are due. You will be liable for all Premiums accrued while this Policy continues in force including those accrued during this 30 day grace period.

   Within five (5) business days of canceling the Policy, the Plan will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

   a. That the Policy has been cancelled, and the reasons for cancellation; and

   b. The specific date and time when coverage for you ended.

7. Reinstatement of the Policy after Termination for Non-Payment:
If the Policy is cancelled for nonpayment of Premiums the Plan will permit reinstatement of the Policy or coverage twice during any twelve-month period, without a change in Premiums and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you.

   If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Policy is cancelled more than twice during the preceding twelve-month period, then the Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Plan may impose different Premiums and consider your medical condition.

Transfer of Coverage

1. If a Subscriber moves out of California, coverage under this Policy will terminate. If a Subscriber moves to an area served by another Blue Cross and/or Blue Shield Plan and notifies Blue Shield Life of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.

2. The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to subscribers who leave a group and apply for new coverage as individuals.

3. Conversion policies provide coverage without a medical examination or health statement.

4. If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this Plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this Plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.

5. The required dues or Premium amount and benefits available from the new plan may vary significantly from this Plan.

6. In addition, the new plan may offer other types of coverage outside the transfer program, which may:
   a. Require a medical examination or health statement to exclude coverage for pre-existing conditions, and

   b. Not credit the time enrolled in this Plan.

Renewal of the Policy

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

1. Non-payment of Premiums;

2. Fraud, misrepresentation, or omission;

3. Termination of plan type by Blue Shield Life;

4. Subscriber moves out of the service area or the Subscriber is no longer a Resident of California;

5. If a bona fide association arranged for the Subscriber's coverage under this Policy, when that Subscriber's membership in the association ceases.

No Maximum Aggregate Payment

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

Medical Necessity (Medically Necessary)

Benefits are provided only for Services that are Medically Necessary.

1. Services that 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;

   d. Furnished at the most appropriate level that can be provided safely and effectively to the patient; and

   e. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured's illness, injury, or disease.

2. Hospital Inpatient Services that are Medically Necessary include only those Services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and that could not have been provided in a Physician's office, the Outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient admission is not Medically Necessary for certain services, including, but not limited, to the following:

   a. Diagnostic studies that can be provided on an Outpatient basis;

   b. Medical observation or evaluation;

   c. Personal comfort;

   d. Pain management that can be provided on an Outpatient basis; and

   e. Inpatient Rehabilitation that can be provided on an Outpatient basis.

3. The Plan reserves the right to review all Services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

This definition does not apply to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.

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 Policy benefit limitations and exclusions. Additionally, please see the section on "Your Balance Plan 1000 – G and How to Use It" regarding advantages from selecting a Preferred Physician for these services.

Utilization Review

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny health care services under the Plan. The Plan has completed documentation of this as required under Section 10123.135 of the California Insurance Code. The document describing Blue Shield's Utilization Management Program is available online at www. Blueshieldca.com or Members may call the Plan's Customer Service Department at the telephone number provided on the back of the policy to request a copy.

Health Education and Health Promotion

Health education and health promotion services provided by Blue Shield Life include the Member Newsletter. Additionally, Blue Shield Life's website is located at http://www.blueshieldca.com. Insureds using a personal computer with internet access may view and download healthcare information.

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. See the Blue Shield Life Preferred Providers section for information on the advantages of choosing a Preferred Provider

NurseHelp 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, seven days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

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

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

The NurseHelp 24/7 program provides Insured with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health issues. Insured may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for this service.

This program includes:

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

Benefits Management Program

The Benefits Management Program applies utilization management and case management principles to assist Insureds and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this health 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 Insured 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 Insured and provider to verify with Blue Shield or Blue Shield's MHSA that (1) the proposed services are a Benefit of the Insured's plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Insured and provider when Benefits are limited to services rendered by Participating Provider or MHSA 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 Insured 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 Insured or when the Insured is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Insured's condition, not to exceed 72 hours from receipt of the request. (See the *Outpatient Prescription Drug Benefits* section for specific information about prior authorization for outpatient prescription drugs).

If prior authorization is not obtained by a Participating Provider when required, Blue Shield Life may deny payment to the Provider. The Insured will only be responsible for any applicable Deductibles, Copayment and Coinsurance.

If prior authorization was not obtained by a Non-Participating Provider when required and services provided to the Insured 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 Insured or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed on an outpatient, non-emergency 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 procedure utilizing Nuclear Medicine

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

Prior Authorization for Medical Services and Drugs Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical services and Drugs that require prior authorization. Insureds are encouraged to work with their providers to obtain prior authorization. Insureds and providers may call Customer Service at the telephone number provided on the back page of this Policy to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

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 disease or condition will result in a denial of coverage. To obtain prior authorization, the Insured or provider should call Customer Service at the telephone number listed on the back page of this Policy.

For authorized services and Drugs from a Non-Participating Provider, the Insured 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 the medical services or Drugs provided to the Insured are not provided by a Participating Provider when required, coverage will be denied.

For Prior Authorizations of prescription Drugs covered under the medical Benefit: Drugs administered in the office, infusion center or provided by a home infusion agency are covered as a medical Benefit. For these prescription Drugs, once all required supporting information is received, Blue Shield Life will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when an Insured has a health condition that may seriously jeopardize the Insured's life, health, or ability to regain maximum function or when an Insured is undergoing a current course of treatment using a Non-Formulary Drug or step therapy.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, special transplant and bariatric surgery. The Insured 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 admission is authorized to a Non-Participating Hospital, the Insured will be responsible for applicable Deductible,

Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

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

Prior Authorization for Mental Health and Substance Use Disorder Hospital Admissions

Prior authorization is required for all non-emergency Mental Health and Substance Use Disorder Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission.

For an authorized admission to a Non-Participating Hospital, the Insured is responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

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

Emergency Admission Notification

When an Insured 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 Insured's condition. When a determination is made that the Insured no longer requires an inpatient level of care, written notification is given to the attending Physician and the Insured. If discharge does not occur within 24 hours of notification, the Insured 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 Insured.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield or Blue Shield's MHSA will work with the Insured, the attending Physician, and the Hospital discharge planners 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 Insured access necessary services and to make the most efficient use of plan Benefits. The Insured'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 Insured, the provider, and Blue Shield or Blue Shield's MHSA, and will not exceed the standard Benefits available under this plan.

The approval of alternative case benefits is specific to each Insured for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this health 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 person in any other instance.

Palliative Care Services

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

Deductible

Calendar Year Medical Plan Deductible

The Calendar Year per Insured medical plan Deductible amounts are shown in the Summary of Benefits. After the Calendar Year per Insured medical plan Deductible is satisfied for those Services to which the appropriate Deductible applies, Benefits will be provided for covered Services. The Calendar Year per Insured medical plan Deductible amount must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductibles. The medical plan Deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately, except that the medical plan Deductible shall be deemed satisfied with respect to the Subscriber and all of his covered Dependents collectively after the Family Deductible amount has been satisfied. Note: The Deductible also applies to a newborn child or a child placed for adoption who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan. The Calendar Year medical

plan Deductible amounts do count toward the Maximum Calendar Year Copayment/Coinsurance responsibility.

Calendar Year Brand Name Drug Deductible

The Calendar Year per Insured Brand Name Drug Deductible is shown in the Summary of Benefits. After the Calendar Year per Insured Brand Name Drug Deductible is satisfied for those Drugs to which the Deductible applies, Benefits will be provided for covered Drugs. The Calendar Year Brand Name Drug Deductible amount is made up of charges covered by the Plan. Charges in excess of the contracted rate do not apply toward the Deductible and the Deductible must be satisfied once during each Calendar Year by or on behalf of each Insured separately.

Note: The Calendar Year Deductible is separate from the Brand Name Drug Deductible included in the Outpatient Prescription Drug Benefit.

The Brand Name Drug Deductible does not count toward the Medical Plan Deductible nor toward the Insured's Maximum Calendar Year Copayment / Coinsurance responsibility.

Payment

The Insured's Copayment and Coinsurance 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/Coinsurance 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.

Accrual balance

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

Out-of-Area Services
Overview

Blue Shield Life has a variety of relationships with other Blue Cross and/or Blue Shield licensees. Generally, these relationships are called Inter-Plan Arrangements And they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive covered services outside of California, the claims for those services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you the care from one of two kinds of providers Participating providers contract with the local Blue Cross and/or Blue Shield licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. Blue Shield Life's payment practices in both instances are described below.

Inter-Plan Arrangements

Emergency Services

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

BlueCard Program

Under the BlueCard® Program, benefits will be provided for covered services received outside of California, but within the BlueCard Service Area. When you receive covered services within the geographic area served by a Host Blue Shield Life will remain responsible for the provisions of this Policy. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

Whenever you receive covered services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, your Insured share of cost for these services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed charges for covered services; or

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue 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 of claims as noted above. However, such adjustments will not affect the price Blue Shield used for your claim because these adjustments will not be applied retroactively to claims already paid.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-emergency services. Please see the *Benefits Management Program* section for additional information on prior authorization and emergency admission notification.

Non-participating Providers Outside of California

When covered services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield Life pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield Life will make for covered services as set forth in this paragraph.

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

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. Blue Shield Life pays claims for covered Emergency Services based on the Allowable Amount as defined in this Policy.

Blue Shield Global Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

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

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please see the *Benefits Management Program* section for additional information on emergency admission notification.

Submitting a Blue Shield Global Core Claim

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

Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility

1. The per Insured and Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by Preferred Providers, and/or MHSA Participating Providers is shown in the Summary of Benefits.

2. The per Insured and Family maximum Copayment/Coinsurance responsibility each Calendar Year for covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers, and/or MHSA Participating and Non-Participating Providers is shown in the Summary of Benefits.

Preferred Providers include covered services provided at a Participating Provider facility by health professionals who are Non-Preferred Providers.

Once the Insured's maximum responsibility has been met *, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met *, the Plan will pay 100% of the Allowable Amount for the Subscriber's and all covered Dependents' covered Services for the remainder of that Calendar Year, except as noted below.

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

Charges for these items may cause an Insured's payment responsibility to exceed the maximums.

Copayments, Coinsurance, and charges for Services not accruing to the Insured's maximum Calendar Year Copayment/Coinsurance Responsibility continue to be the Insured's responsibility after the Calendar Year Copayment/Coinsurance Maximum is reached.

Principal Benefits and Coverages (Covered Services)

Benefits are provided for the following Medically Necessary covered Services, subject to the applicable Deductibles, Copayments and Coinsurance, and charges in excess of the 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 Policy, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions, and Reductions listed in this Policy.

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

Note: Except as may be specifically indicated, for Services received from Non- Preferred and Non-Participating Providers, Insureds will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Insured 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, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.. Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Ambulance Benefits

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport an Insured from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

For air ambulance services from either a Participating Provider or a Non-Participating Provider, Blue Shield Life will pay the Allowable Amount. The Insured is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits.

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 routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine circumcisions are circumcisions performed within 18 months of birth.

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 Insured is under the age of seven or developmentally disabled regardless of age or when the Insured'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.

Note: 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 Woman'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 Blue Shield Life and developed in conjunction with plastic and reconstructive surgeons.

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

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;

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

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

Bariatric Surgery Benefits

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

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

Services for Residents of Designated Counties in California

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

1. Services are performed at a Preferred Bariatric Surgery Services Hospital or an Ambulatory Surgery Center and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shield Life to provide the procedure; and

2. Services are consistent with Blue Shield Life's medical policy; and

3. Prior authorization is obtained, in writing, from Blue Shield Life's Medical Director.

* See the list of designated counties below.

The Plan 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 the Plan's medical policy.

For Insureds 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 in the Preferred Bariatric Services Physician's office.

The following are designated counties in which the Plan has contracted with facilities to provide bariatric Services:

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

Bariatric Travel Expenses Reimbursement for Residents of Designated Counties in California

Insureds who reside in designated counties and who have obtained written authorization from Blue Shield Life 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 Insured'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 Life. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. For the Person for a maximum of three (3) trips;
      i. One (1) trip for a pre-surgical visit,
      ii. One (1) trip for the surgery, and
      iii. One (1) trip for a follow-up visit.

   b. For one (1) companion for a maximum of two (2) trips;
      i. One (1) trip for the surgery, and
      ii. One (1) trip for a follow-up visit.

2. Hotel accommodations not to exceed $100 per day:
   a. For the Person and one (1) companion for a maximum of two (2) days per trip,
      i. One (1) trip for a pre-surgical visit, and
      ii. One (1) trip for a follow-up visit.

   b. For one (1) companion for a maximum of four (4) days for the duration of the surgery admission.

   All hotel accommodation is limited to one (1), double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

3. Related expenses judged reasonable by Blue Shield Life not to exceed $25 per day per Person up to a maximum of four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

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

Covered bariatric travel expenses are not subject to the Calendar Year Deductible and do not accrue to the maximum Calendar Year Copayment responsibility.

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 the Plan's medical policy; and,

2. Prior authorization is obtained, in writing, from the Plan's Medical Director.

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

Chiropractic Benefits

Benefits are provided for 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, and conjunctive therapy and X-ray services.
Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Covered X-Ray Services provided in conjunction with this Benefit have an additional Copayment/Coinsurance as shown in the section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

Clinical Trial for Cancer Benefits

Benefits are provided for routine patient care for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by Blue Shield Life, and:

1. The clinical trial has a therapeutic intent and the Insured's treating Physician determines that Participation in the clinical trial has a meaningful potential to benefit the Person with a therapeutic intent; and

2. The Insured's treating Physician recommends participation in the clinical trial; and

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

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

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

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

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

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

An approved clinical trial is limited to a trial that is approved by one of the following:

1. One of the National Institutes of Health;

2. The federal Food and Drug Administration (FDA), in the form of an investigational new drug application;

3. The United States Department of Defense;

4. The United States Department of Veterans Affairs; or

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

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices, equipment, and supplies, 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/or urine testing strips or tablets, lancets and lancet puncture devices and pen delivery systems for the administration of Insulin, refer to the section entitled Outpatient Prescription Drugs.

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 an Insured 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 Insured's Physician. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

Dialysis Benefits

Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis, and 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 (DME) for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function are covered. When authorized as DME, other covered items include peak flow monitor for self-management of diabetes, apnea monitor for management of newborn apnea, and home prothrombin monitor for specific conditions as determined by Blue Shield Life. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards or practice. See General Exclusions under the Principal Limitation, Exceptions, and Reductions section.

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.

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifies, 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 section for devices, equipment and supplies for the management and treatment of diabetes.

For Insureds 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 or other emergency room licensed under state law.

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.

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 Insured Copayment/Coinsurance 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 Insured is responsible for the emergency room Insured Copayment/Coinsurance plus the appropriate admitting Hospital Services Insured Copayment/Coinsurance as shown in the Summary of Benefits.

Family Planning and Infertility Benefits

Family Planning Benefits

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

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fittings or injectable contraceptives:
2. Injectable contraceptives when administered by a Physician;

3. Voluntary sterilization (tubal ligation and vasectomy) No benefits are provided for contraceptives, except as may be provided under the Outpatient Prescription Drug Benefit section;

4. Diaphragm fitting procedure.

Note: No benefits are provided for Family Planning Services from Non-Participating Providers.

See also the *Preventive Health Benefits* section for additional family planning services.

Infertility Benefits
Benefits are provided for the diagnosis and treatment of the cause of Infertility, including professional, Hospital, Ambulatory Surgery Center, and ancillary services to diagnose and treat the cause of Infertility, with the exception of what is excluded in the *Principal Limitations, Exceptions, Exclusions and Reductions* section.

Home Health Care Benefits

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by an attending 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 heath aide services must be prior authorized by Blue Shield Life.

Covered Services are subject to any applicable Deductible, Copayments, and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Insured, 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 purposes of this Benefit, visits from home health aides of 4 hours or less shall be considered 1 visit.
In conjunction with professional Services by a home health agency, medical supplies used during covered visits by a home health agency necessary for the home health care treatment plan and related laboratory Services are covered to the extent the Benefits would have been provided had the Insured 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 supplemental Benefit for Outpatient Prescription Drugs.

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

(Note: See the Hospice Program Services Benefits section for information about when an Insured 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 and FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency.

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

This Benefit does not include medications, drugs, Insulin, disposable Insulin syringes, certain Home Self-Administered Injectables covered under the Outpatient Prescription Drug Benefit, 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 Life.

Hemophilia home infusion and 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 Life (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 on the Subscriber's Identification Card.

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 Life. Once prior authorized by Blue Shield Life, 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 Insured, 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 Coverage (Covered Services) section. Please note, not all the Services listed above may be covered under this Plan. You should read the Principal Benefits and Coverage (Covered Services) section for full benefit information.

Hospice Program Benefits

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Insured requests admission to and is formally admitted to an approved Hospice Program. The Insured must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Plan. (Note: Insured 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. Insureds 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 authorized by the Plan.

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

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning (Persons 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 Insured to the extent that these needs are not met by the Insured's other providers.

7. Volunteer Services.

8. Short-term Inpatient care arrangements.

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

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

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

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

Insureds are allowed to change their Participating Hospice Agency only once during each Period of Care. Persons can receive care for two (2) 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Insured is Terminally Ill.

Definitions:

Bereavement Services – services available to the immediate surviving family members for a period of at least one (1) year after the death of the Insured 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 Insured.

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

Home Health Aide Services - services providing for the personal care of the Terminally Ill Insured and the performance of related tasks in the Insured'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 Insured to carry out the treatment plan.

Hospice Service or Hospice Program – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physician, emotional, social, and spiritual discomforts of a Insured 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:

a. Considers the Insured and the Insured's family in addition of the Insured, as the unit of care.

b. Utilizes and Interdisciplinary Team to assess the physical, medical, psychological, and social and spiritual needs of the Insured and their family.

c. 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 Persons who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d. 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.

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

f. Actively utilizes volunteers in the delivery of Hospice Services

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

h. Is provided through a Participating Hospice.

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

Medical Direction – Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Insured'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 Insured still needs and remains eligible for hospice care even if the Insured lives longer than one (1) year. A Period of Care starts the day the Insured begins to receive hospice care and ends when the 90 or 60-day period has ended.

Period of Crisis – a period in which the Insured 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 an Insured 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 Insured only when necessary to relieve the family members or other persons caring for the Insured.

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 Insured's provider to the Insured and his family that pertain to the palliative, supportive services required by the Insured 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 Insured, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured 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 Insured 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 Insured and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilization appropriate community resources, and maximize positive aspects and opportunity for growth.

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

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

Hospital Care Benefits (Facility Services)

Other than Mental Health and Substance Use Disorder Services, Skilled Nursing Facility Services, Skilled Nursing Facility Services, and Hospice Program Services which are described in subsequent sections.

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. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

   Emergency Services and Complications of Pregnancy are paid just as any other illness.

   No benefits are provided for services subsequent to termination of coverage under this Policy.

3. In conjunction with a covered delivery, routine nursery care for a newborn of the Insured or covered spouse or Domestic Partner.

4. Use of operating room and specialized treatment rooms.

5. Reconstructive Surgery is covered when there is no 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 repair 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 Blue Shield Life and developed in conjunction with plastic and reconstructive surgeons.

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

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

6. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital

7. Rehabilitation when furnished by the Hospital, and Rehabilitative Care when furnished by the Hospti9al and approved in advance by the Plan under its Benefits Management Program.

8. Drugs and oxygen.

9. Administration of blood and blood plasma, including the cost of blood, blood plasma, and blood processing.

10. X-Ray examination and laboratory tests.

11. Radiation therapy and chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

12. Use of medical appliances and equipment.

13. Subacute Care.

14. 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 Insured in under the age of seven or developmentally disables regardless of age or when the Insured's health is compromised ad for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and Services of a dentist or oral surgeon.

15. Medically Necessary Inpatient substance use disorder detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when an Insured is admitted through the emergency room, or when Medically Necessary Inpatient substance use disorder 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 function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to repair 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 Blue Shield Life and developed in conjunction with plastic and reconstructive surgeons.

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

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

6. Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine circumcisions are circumcisions performed within 18 months of birth.

Covered lab and X-Ray Services provided in an Outpatient Hospital setting are paid as descried under the Outpatient/Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits, Outpatient Rehabilitation Benefits, and Speech Therapy Benefits sections.

Medical Treatment of the Teeth, Gums, or Jaw Joints, and Jaw Bones Benefits

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

1. The treatment of tumors of the gums;

2. The treatment of damage to the natural teeth caused solely by an Accidental Injury is limited to Medically Necessary services until the services result in initial, palliative stabilization of the Insured as determined by the Plan;
   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and/or 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 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 Use Disorder Benefits

Blue Shield's Mental Health and Substance Use Disorder Service Administrator (MHSA) arranges and administers Mental Health and Substance Use Disorder Services for Blue Shield Insureds within California. See the *Out-Of- Area Program, BlueCard Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health and Substance Use Disorder Services, including Residential Care are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the Benefits Management Program section for complete information.

Telebehavioral health services

Online telebehavioral health services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers and are a Covered Service regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. If you are currently receiving telebehavorial health services for Mental Health and Substance Use Disorders, you can continue to receive those services with the MHSA Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider. Visit blueshieldca.com and click on Find a Doctor to access the MHSA network.

Mental Health and Substance Use Disorder Services – Office Visits

Benefits are provided for professional (Physician) office visits for the diagnosis and treatment of Mental Health and Substance Use Disorders in the individual, family or group setting. This Benefit includes office-based opioid treatment for opioid detoxification and/or maintenance therapy including methadone maintenance treatment.

Other Outpatient Mental Health and Substance Use Disorder Services

1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, prescribed by a Physician or licensed psychologist and provided under a treatment plan approved by the MHSA to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

   Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

2) Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure, used in the treatment of mental health conditions.

3) Intensive Outpatient Program - an outpatient care program for mental health or substance use disorders when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

4) Office-based opioid treatment substance use disorder maintenance therapy, including methadone maintenance treatment.

5) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Insureds may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

6) Psychological Testing - testing to diagnose a mental health disorder when referred by an MHSA Participating Provider.

7) Transcranial Magnetic Stimulation - a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Inpatient Services

Benefits are provided for inpatient Hospital and professional services in connection with acute hospitalization for the treatment of Mental Health or Substance Use Disorders.

Benefits are provided for inpatient and professional services in connection with a Residential Care admission for the treatment of Mental Health and Substance Use Disorders.

See *Hospital Benefits (Facility Services), Inpatient Services for Treatment of Illness or Injury* for information on Medically Necessary inpatient substance use disorder detoxification.

Orthoses Benefits

Benefits are provided for orthotic appliances, including:

- Shoes only when permanently attached to such appliances;
- 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;

- Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteo-arthritis;

- 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;

- 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 section for devices, equipment, and supplies for the management and treatment of diabetes.

Outpatient or Out-of-Hospital X-Ray, Pathology, and/or Laboratory Benefits

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

Benefits are also provided for genetic testing for certain conditions when the Insured 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 Life medical policy. See the section on Pregnancy Benefits for information on genetic testing disorders for the fetus.

Benefits are provided for COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing. Reimbursement is covered for over-the-counter at-home COVID-19 tests. For over-the-counter at-home COVID-19 tests obtained without any Health Care Provider involvement, there is a reimbursement limit of 8 tests per Insured per month. For over-the-counter at-home COVID-19 tests obtained with Health Care Provider involvement, including tests purchased directly by the Insured based on a Health Care Provider order, there is no monthly limit. .See the *Notice and Proof of Claim* section for information about how to submit a claim for repayment for this Service. Blue Shield will continue to provide coverage for COVID-19 tests that are administered by a Preferred Provider. For services provided by Preferred Providers, Blue Shield Life will waive Copayments, Coinsurance, and Deductibles for COVID-19 diagnostic testing, screening testing, and related services.

During the federal COVID-19 Public Health Emergency and for 6 months after the end of the federal COVID-19 Public Health Emergency, Blue Shield Life will waive Copayments, Coinsurance, and Deductibles for COVID-19 diagnostic testing and related services from Non-Preferred Providers.

Sexually transmitted disease home testing kits including any laboratory costs of processing the kit, are covered when ordered directly by a Physician or other Health Care Provider or when a Physician or Health Care Provider issues a standing order for patient use based on clinical guidelines and individual patient health needs.

See the section on Radiological and Nuclear Imaging Benefits and Benefits Management Program section for information on procedures that require prior authorization by Blue Shield Life.

Outpatient Rehabilitation Benefits

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan and up to the benefit maximum. Benefits for Speech Therapy are described in the section on Speech Therapy benefits.

Benefits are limited to a per Insured, per Calendar Year maximum as shown in the Summary of Benefits.

Blue Shield Life reserves the right to periodically review the provider's treatment plan and records for Medical Necessity.
Note: See the Home Health Care, Home Infusion Care Benefits and PKU Related Formulas and Special Food Products section for information on coverage for Outpatient Rehabilitation Services rendered in the home, including visit limits.

Note: Covered lab and X-Ray Services provided in conjunction with this Benefit, are paid as shown under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Outpatient Prescription Drug Benefits

This benefit includes access to Blue Shield's Participating Pharmacy Network. By presenting your Blue Shield Identification 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 the section entitled "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

The following prescription drug benefit is separate from the Balance Plan 1000 – G coverage.

The Calendar Year Maximum Copayment and Coinsurance and Medical Plan Deductible do not apply to the outpatient prescription drug benefit; however, the general provisions and exclusions of the Balance Plan 1000 – G shall apply.

Benefits for covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits except that this maximum shall not apply to Diabetic Drugs and Supplies..

Note: Except for covered emergencies and Drugs for emergency contraception, no benefits are provided for drugs received from Non-Participating Pharmacies.

1. Outpatient Prescription Drug Benefit

   Subject to the terms and conditions of this Section, benefits are provided for Outpatient prescription Drugs, which are prescribed by a licensed Physician and are obtained from a Participating Pharmacy. Benefits are provided for Formulary Drugs, which are Drugs listed on Blue Shield's Drug Formulary. Blue Shield's Pharmacy and Therapeutics Committee updates this Formulary on a periodic basis. Benefits may also be provided for Non-Formulary Drugs subject to higher Coinsurance/Copayments. Select Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield. Coverage for selected Drugs may be limited to specific quantity as described in the section entitled Limitation on Quantity of Drugs that May be Obtained per Prescription or Refill. All Medically Necessary outpatient prescription Drugs are covered.

   Benefits are provided for COVID-19 therapeutics, including therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without cost sharing for services provided by a Preferred Provider. For services provided by a Non-Preferred Provider, coverage is provided without cost sharing during the federal COVID-19 Public Health Emergency and for 6 months after the end of the federal COVID-19 Public Health Emergency.

   For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease. Coverage will be provided without cost sharing.

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

   Insureds may call Blue Shield's Customer Service Department at the number listed on their Blue Shield Life Identification Card to inquire if a specific drug is included in the Formulary. The Customer Service Department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the Blue Shield Life web site at http://www.blueshieldca.com.

3. **Definitions**

Brand Name Drugs —Drugs which are FDA approved either (1) after a new drug application or (2) an abbreviated new drug application and which has the same brand name as that of the manufacturer with the original FDA approval. Note: covered Brand Name Drugs are subject to a per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits.

Diabetic Drugs and Supplies – Medications and supplies used in the treatment and monitoring of Diabetes. These medications may be administered orally or by injection and supplies may include lancets, lancet puncture devices, blood and urine testing strips and test tablets.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin and disposable Insulin needles and syringes; (3) pen delivery systems for the administration of Insulin as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets); (5) oral contraceptives and diaphragms; (6) inhalers and inhaler spacers for the management and treatment of asthma.; (7) disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers; and (8) smoking cessation Drugs which require a prescription.

Coverage for such Drugs is limited to a single 12-week course of treatment per lifetime of the Insured.

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

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

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

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

There is a maximum of $200 per prescription for oral anti-cancer medications.

Non-Formulary Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits may be provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

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

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

To select a Participating Pharmacy, Insureds may access this information at http://www.blueshieldca.com or call the toll-free Customer Service telephone number on their Blue Shield Life Identification Card.

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

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

To select a Specialty Pharmacy, the Insured may access this information at http://www.blueshieldca.com or call the toll-free Customer Services telephone number on their Blue Shield Life Identification Card.

4. Obtaining Outpatient Prescription Drugs from Participating Pharmacies
   a. To obtain prescription Drugs, the Insured must present a Blue Shield Life 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.

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

   c. Formulary Drugs -
   The Insured is responsible for paying the Formulary Drug Copayment/Coinsurance for each new and refill Formulary Drug prescription. The pharmacist will collect from the Insured the Copayment/Coinsurance at the time the Drugs are obtained. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Formulary Drugs is shown in the Summary of Benefits.

   d. Brand Name Drugs -

Brand Name Drugs are subject to the per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits. Until the Brand Name Drug Deductible is satisfied, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Blue Shield Life Participating Pharmacy at the time the Drug is obtained. If the Blue Shield Life contracted rate for the prescription is less than the Subscriber's Copayment/Coinsurance amount, the Subscriber is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Brand Name Drugs is as shown in the Summary of Benefits.

Note: Both the Formulary Brand Name Drug Copayment/Coinsurance and the Brand Name Drug Deductible apply for diaphragms.

e. If the Insured or Physician requests a Brand Name Drug when a Generic Drug equivalent is available, and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.

f. Prescription drugs obtained at a non-participating pharmacy are not covered unless Medically Necessary for a covered emergency. If the Insured must obtain drugs from a non-participating pharmacy due to a covered emergency, the submission of a Prescription Drug Claim form noting "Emergency Request" on the form is required. Claim forms are provided upon request from the Blue Shield Life Service Center. Claims must be submitted to:

Blue Shield Life
P.O. Box 52136
Phoenix, AZ 85072-2136

Claims must be received within 1 year from the date of service to be considered for payment. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any Brand Name Drug Deductible and applicable Copayments(s)/Coinsurance.

When the Plan receives Notice of Claim, the Plan will send you an Insured's Statement of Claim form for filing proof of a claim. For consideration of a claim due to a covered emergency, you must note "Emergency Request" on the Insured's Statement of Claim form and it should be submitted to:

Blue Shield Life
P.O. Box 52136
Phoenix, AZ 85072-2136

The Plan must receive written proof of claim within 90 days after the date of service for which claim is being made. Send a copy of your itemized bill or pharmacy statement along with your completed Insured's Statement of Claim form.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify the Plan. Reimbursement for covered emergency claims will be made for the purchase price of covered prescription Drug(s) less any Brand Name Drug Deductible and applicable Copayments(s) and Coinsurance.

g. The Insured is responsible for paying the Copayment/Coinsurance as shown in the Summary of Benefits for Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs.

5. Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

a. For the Insured's convenience, when Drugs have been prescribed for a chronic condition, the Insured may obtain the Drugs through Mail Service Prescription Drug Program. The Insured should submit the applicable mail service Copayment/Coinsurance, an order form, and the Blue Shield Life Identification number to the address indicated on the Mail Service envelope. Insureds should allow 14 days to receive the Drugs. The Insured's Physician must indicate a prescription quantity, which is equal to the amount to be dispensed. Home Self-Administered Injectables, except for Insulin, are not covered through the Mail Service Prescription Drug Program.

b. Mail Service Drugs –
The Insured is responsible for the Mail Service Formulary Drug Copayment for each covered prescription. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Mail Service Drugs is as shown in the Summary of Benefits.

c. Mail Service Brand Name Drugs -
Mail Service Brand Name Drugs are subject to the per Insured, per Calendar Year Brand Name Drug Deductible as shown in the Summary of Benefits. Until the Brand Name Drug Deductible is satisfied, you are responsible for payment of 100% of the Participating Pharmacy contracted rate for the Drug to the Mail Service Pharmacy prior to your prescription being sent to you. To obtain the Participating Pharmacy contracted rate amount, please contact the Mail Service Pharmacy at 1-866-346-7200. The TTY telephone number is 1-866-346-7197. If the Plan's contracted rate for the prescription is less than the Insured's Copayment/Coinsurance amount, the Insured is responsible for payment of the contracted rate only. The Copayment/Coinsurance for Mail Service Brand Name Drugs is as shown in the Summary of Benefits.

Note: Both the Formulary Brand Name Drug Copayment/Coinsurance and the Brand Name Drug Deductible apply for diabetic supplies including disposable Insulin needles and syringes.

d. If the Insured or Physician requests a Brand Name Drug when a Generic Drug is available and the Brand Name Drug Deductible has been satisfied, the Insured is responsible for paying the difference between the contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.

6. Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables and Step Therapy

Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Non-Formulary Drugs may require prior authorization for Medical Necessity.

Compound drugs are covered only if the requirements listed under the Exclusions in the Outpatient Prescription Drug Benefits section are met.

You, your Physician, or your Health Care Provider may request prior authorization by submitting supporting information to Blue Shield Life. If the request does not include all necessary supporting information, Blue Shield Life with notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once all required supporting information is received, Blue Shield Life will provide prior authorization approval or denial within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a Non-Formulary Drug.

To request coverage for a Non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield Life. Once all required supporting information is received, Blue Shield Life will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

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

If Blue Shield Life denies an exception request for coverage of a Non-Formulary Drug, the Insured, representative, or the Provider may request an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

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

a. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. If a prescription Drug is packaged only in supplies exceeding 30 days, the applicable retail Copayment or Coinsurance will be assessed for each 30 day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield Life's Pharmacy and Therapeutics Committee.

b. If the Insured or Health Care Provider requests a partial fill of a Schedule II Controlled Substance prescription, your Copayment or Coinsurance will be pro-rated. The remaining balance of any partially

filled prescription cannot be dispensed more than 30 days from the date the prescription was written.

c. Mail Service Prescription Drugs are limited to a quantity not to exceed a 60 day supply. If the Insured's Physician indicates a prescription quantity of less than a 60-day supply that amount will be dispensed and refill authorizations cannot be combined to reach a 60-day supply.

d. Contraceptive Drugs are limited to a quantity not to exceed a 12-month supply.

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

8. Exclusions for Outpatient Prescription Drug Benefit - No benefits are provided under the Outpatient Prescription Drug Benefit for the following (please note, certain Services excluded below may be covered under other benefits/portions of your Policy - you should refer to the applicable section to determine if Drugs are covered under that Benefit):

a. Any Drugs provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefit and Hospital Benefits sections of your Policy);

b. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits and skilled Nursing Facilities Benefits sections of your Policy);

c. Drugs, (except as specifically listed as covered under this Outpatient Prescription Drug section), which can be obtained without a prescription or for which there is a non-prescription Drug that is an identical chemical equivalent (i.e. same active ingredient and dosage) to a prescription Drug;

d. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;

e. Drugs that are considered to be experimental or investigational;

f. Medical devices or supplies except as specifically listed as covered herein (see the Prosthetic Appliance and Durable Medical Equipment Benefits section and the Orthoses Benefits section of your Policy). This exclusion also includes topically applied prescription preparations that are approved by the FDA as medical devices.;

g. Blood or blood products (see the Hospital Benefits section of your Policy);

h. Drugs when prescribed for cosmetic purposes, including but not limited to Drugs used to retard or reverse the effects of skin aging or to treat hair loss;

i. Dietary or Nutritional Products see the PKU Related Formulas and Special Food Products Benefits section of your Policy;

j. Injectable Drugs which are not self-administered, and all injectable Drugs for the treatment of infertility. Other Injectable Medications may be covered under the Home Health Care Benefits, Family Planning Service, Hospice Program Services, and Home Infusion/Home Injectable Therapy Benefits sections of the Plan;

k. Appetite suppressants, or Drugs for 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 Life;

l. Contraceptive devices (except diaphragms), injections and implants;

m. Compounded medications unless: (1) the compound medication(s) includes at least one Drug, as defined; (2) there are no FDA-approved, commercially available medically appropriate alternative(s); and (3) is being prescribed for an FDA-approved indication;

n. Replacement of lost, stolen, or destroyed Prescription Drugs;

o. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage;

p. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;

q. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an Insured enrolled in a Hospice Program through a Participating Hospice Agency; or

r. Immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

s. 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.

PKU Related Formulas and Special Food Product 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

Podiatric Services include office visits and other covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services are customarily provided by a licensed doctor of podiatric medicine. Covered lab, pathology, and X-Ray Services provided in conjunction with this Benefit, are described under the Outpatient or Out-of-Hospital X-Ray, Pathology, and Laboratory Benefits section.

Pregnancy 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, abortion services, 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.

Note: See the section on Outpatient or Out-of-Hospital 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 the Plan.

Note: The Newborns' and Mothers' Health Protection Act requires individual and family health plans to provide a minimum hospital stay for the mother and newborn child of forty-eight (48) hours after a normal, vaginal delivery and ninety-six (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. A licensed Health Care Provider whose scope of practice includes postpartum and newborn care shall provide this visit. 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 Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

No benefits for Preventive Care Services are provided for Non-Preferred Providers except for COVID-19 diagnostic testing, screening testing, and related healthcare services.

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

1. Annual Physical Examination:
   For the Subscriber and Dependents age three (3) and over, benefits are provided for one (1) health appraisal examination in each Calendar Year.

   Benefits for the Annual Physical Examination include only the following Services:

   a. Annual routine physical examination office visit;

   b. Urinalysis;

   c. Eye and ear screenings, provided by a family practitioner or general practitioner, for Subscribers and dependent children through age 16 to determine the need for referral to a specialist for eye refraction or audiogram. No benefits are provided for routine examinations by Optometrists or Audiologists, or for routine eye refraction.; and

   d. Benefits for pediatric and adult immunizations and the immunizing agent, are provided based on Blue Shield Life's Preventive Health guidelines. These guidelines regarding immunizations and vaccinations are derived from the most recent recommendations of the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) including frequency and patient age recommendations. No Benefits are provided for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, laboratory, or pathology Services beyond those listed in this Annual

Physical Examination benefit, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in the section titled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

2. Annual Gynecological Examination:
Benefits for the annual gynecological exam include only the following Services:

   a. Annual gynecological examination office visit:

   b. Mammography, and

   c. Routine Papanicolaou (Pap) test or other Food and Drug Administration (FDA) approved cervical cancer and human papillomavirus virus (HPV) screening tests.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Annual Gynecological Examination benefit, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) or Coinsurance as outlined in section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

3. Colorectal Cancer Screening:
For Subscribers or Dependents age 45 and older, colorectal cancer screenings include:

   - High sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year;
   - Stool DNA-FIT every 1 to 3 years;
   - Computed tomography colonography every 5 years;
   - Flexible sigmoidoscopy every 5 years;
   - Flexible sigmoidoscopy every 10 years with annual FIT; and
   - Colonoscopy screening every 10 years.

   A colonoscopy following a positive result on a colorectal cancer screening examination or test is covered without cost sharing, except when the underlying colorectal cancer examination or procedure was a colonoscopy.

   Colorectal cancer examinations and test for diagnostic rather than preventive purposes, or any covered Outpatient or our-of-Hospital X-ray, laboratory, or pathology Services will be subject to the per Insured, per Calendar Year Deductible and the Insured will be responsible for additional Copayment(s)/Coinsurance as outlined in the Outpatient or Out-of-Hospital X-ray, Pathology, and Laboratory Benefits or Ambulatory Surgery Center Benefits sections.

4. Osteoporosis Screening:
Benefits are provided for osteoporosis screening for Subscribers and Dependents age 65 and older, or age 60 and older if the Insured is at increased risk.

5. Well-Baby Examination:
Benefits are provided when a Physician provides routine pediatric care to a Subscriber less than three (3) years of age.

   Benefits are provided when a Physician provides routine pediatric care to a newborn or Dependent child that is less than three (3) years of age, of the Subscriber or covered spouse or Domestic Partner.

   Well-baby examination benefits include only the following Services:

   a. Well baby examination office visits;

   b. Tuberculin test; and

   c. Pediatric immunizations and the immunizing agent, are provided based on Blue Shield Life's Preventive Health Guidelines. These guidelines regarding immunizations and vaccinations are derived from the most recent recommendations of the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) including frequency and patient age recommendations. No Benefits are provided for immunizations and vaccinations by any means of administration (oral, injection, or otherwise) solely for the purposes of travel.

   If the Insured's Physician provides or orders any covered Outpatient or out-of-Hospital X-Ray, pathology, or laboratory Services beyond those listed in this Well-Baby Examination, those Services will be subject to the per Insured Calendar Year Deductible and the Insured will be responsible for additional Copayment(s) and/or Coinsurance as outlined in the section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Benefits.

6. NurseHelp 24/7:
Insureds may call a registered nurse via 1-877-304-0504, a 24-hour, toll-free telephone number to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition, and other health related topics.

7. Adverse Childhood Experiences Screenings.

8. For COVID-19 preventive health benefits and preventive health benefits for a disease for which the Governor of the State of California has declared a public health emergency, evidence-based items, services, and immunizations that are intended to prevent or mitigate the disease and have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention. For new recommendations, coverage will be provided no later than 15 business days after the date on which the recommendation is made.

Professional (Physician) Benefits

Other than Preventive Care, Mental Health and Substance Use Disorder, Hospice Program Services which are described in subsequent sections.

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

Covered lab, pathology, and X-Ray Services provided in conjunction with these Professional Services listed below, are describe under the Outpatient or Out-of-Hospital 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 Blue Shield Life Preferred Provider Directory. This information may also be viewed by accessing the Plan's Internet site located at http://www.blueshieldca.com.

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 test or other FDA (Food and Drug Administration) approved cervical cancer screening tests;

4. Asthma self-management training and education to enable an Insured 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. 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 function or 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, including treatment of physical complications of a mastectomy and lymphedemas. Benefits will be provided in accordance with the guidelines established by Blue Shield Life and developed in conjunction with plastic and reconstructive surgeons.

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

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

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

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10. Extra time spent when a Physician is detained to treat an Insured in critical condition;

11. Necessary preoperative treatment;
12. Treatment of burns; and

13. Allergy testing and treatment.

14. Medically Necessary consultations with Internet Ready Preferred Physicians via Blue Shield Life approved Internet portal. Internet based consultations are available to Insured only through Preferred Physicians who have agreed to provide Internet based consultations via the Blue Shield Life approved Internet portal ("Internet Ready"). Insured must be current patients of the Preferred Physician. Refer to the Online Physician Directory to determine whether a Preferred Physician is Internet Ready and how to initial an Internet based consultation. This information may be accessed at http://www.blueshieldca.com. Coverage for these services will be on the same basis and to the same extent as a service conducted in person.

15. Benefits are provided for Services required to treat involuntary Complications of Pregnancy on the Insured's Effective Date of coverage. Complications of Pregnancy include, but are not limited to, Medically Necessary Cesarean Section, miscarriage, toxemia of pregnancy (preeclampsia and eclampsia), hyperemesis gravidarum, ectopic (tubal or extra-uterine) pregnancy, nephritis or pyelitis of pregnancy, placenta abruptio or puerperal infection.

    Emergency Services and Complications of Pregnancy are paid just as any other illness.

    No benefits are provided for services subsequent to termination of coverage under this Policy.

16. Diagnostic audiometry examination.

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

Prosthetic Appliance 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. 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. 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; and

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.

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.

Blom-Singer and artificial larynx prostheses for speech therapy 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 by the Plan under the Benefits Management Program.

1. CT (Computerized Tomography) scans;

2. MRIs (Magnetic Resonance Imaging);

3. MRAs (Magnetic Resonance Angiography);

4. PET (Positron Emission Tomography) scans; and/or

5. Any cardiac diagnostic procedure utilizing Nuclear Medicine.

Skilled Nursing Facility Benefits

(Other than Hospice Program Services which are described in a subsequent section.)

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 Insured 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 other 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 Medical Necessity.

Except as specified above and as stated in the sections under the Home Health Care Benefits and Hospice Program Benefits sections, no Benefits are provided for Speech Therapy, speech correction, or speech pathology Services.

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

Transplant Benefits

Organ Transplants

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".

Special Transplant Benefits

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting as a Blue Shield Life Provider to provide the procedure or in the case of Insureds accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield Life, (2) prior authorization is obtained, in writing, from the Plan's Medical Director, and (3) the recipient of the transplant is a Subscriber or Dependent.

The Plan reserves the right to review all requests for prior authorization of these Special Transplant Benefits, and to make a decision regarding benefits based on (1.) the medical circumstances of each Insured, and (2.) consistency between the treatment proposed and the Plan's 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.

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

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; and

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

Principal Limitations, Exceptions, Exclusions, and Reductions

General Exclusions

Unless exceptions to the following exclusions are specifically made elsewhere in this Policy, no benefits are provided for the following Services:

1. 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 extractions;

dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits;

2. For or incident to Services rendered in the home or hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except those benefits which would have been provided had the individual been treated on an Outpatient basis. For example, charges for room and board during such hospitalization are not a benefit except as Medically Necessary;

3. For Rehabilitation except as specifically provided under Home Health Care Benefits, Hospital Care Services Benefits, or Outpatient Rehabilitation Benefits;

4. 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 Services Benefits (see Hospice Program Services benefit for exception);

5. Performed in a Hospital by Hospital officers, residents, interns and others in training;

6. For routine eye refraction, surgery to correct refractive error (such as but not limited to radial keratotomy / refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided in the Prosthetic Appliances section), and video-assisted visual aids or video magnification equipment for any purpose;

7. For eyeglasses, and contact lenses except as specifically listed in the sections entitled Durable Medical Equipment Benefits, Prosthetic Appliances Equipment Benefits, or hearing aids, cochlear implants, bone-anchored hearing aids, and auditory brainstem implants;

8. For or incident to acupuncture except as specified in the section entitled Acupuncture Services Benefits;

9. For or incident to Speech Therapy, speech correction, or speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness except as specifically listed under Home Health Care Benefits and Speech Therapy Benefits;

10. For or incident to vocational, educational, recreational, art, dance, reading or music therapy; weight control; or exercise programs nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to services deemed Medically Necessary Treatment of Mental Health or Substance Use Disorder;

11. For callus, corn paring or excision, toenail trimming and 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 as covered herein; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;

12. Which are Experimental or Investigational in Nature, except for Services for Insureds who have been accepted into an approved clinical trial for cancer as provided under Covered Services;

13. For learning disabilities or behavioral problems or social skills training therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to servies deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder;

14. For or incident to hospitalization solely for radiological, laboratory, or any other diagnostic studies or medical observation;

15. For convenience items such as telephones, TVs, guest trays, and personal hygiene items;

16. Cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g. infections or hemorrhages);

17. Incident to an organ transplant, except as specifically listed;

18. Any form of assisted reproductive technology, including but not limited to the reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

19. For any services to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization. Gamete Intrafallopian Transfer (GIFT.) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, services incident to reversal of surgical sterilization, except for Medically Necessary treatment of

medical complications of the reversal procedure or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care Benefits under a Blue Shield Life Plan;

20. For routine health appraisals, well-baby care, vision and hearing tests, physical examinations and immunizations, except as specifically listed under Preventive Care Benefits; for immunizations and vaccinations by any mode of administration (oral, injection, or otherwise) solely for the purpose of travel; or for physical examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Physical Examination. This exclusion shall not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder;

21. For or incident to family planning, except as specifically listed;

22. 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 the sections entitled Hospital Care Services Benefits and Medical Treatment of Teeth, Gums, Jaw Joints, or Jaw Bones Benefits;

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

24. Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such Services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of such injury or disease;

25. In connection with private duty nursing, except as provided under the Home Health Care Benefits and Home Infusion/Home Injectable Therapy Benefits and except as provided through a Participating Hospice Agency;

26. For which the Insured is not legally obligated to pay or Services for which no charge is made to the Insured;

27. For or incident to out-of-country services; for medical equipment, drugs and other substances obtained outside the United States except as provided for covered emergency or urgent care;

28. 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 symptomology.

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

29. For prescription and non-prescription food and nutritional supplements, except as provided under the Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits, and except as provided through a Participating Hospice Agency;

30. 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 Insurance Code, Section 10123.195 have been met;

31. For home testing devices and monitoring equipment except as specifically provided in Durable Medical Equipment Benefits in the Covered Services section. This exclusion does not apply to COVID-19 at-home testing kits or to sexually transmitted disease home testing kits;

32. For contraceptives and contraceptive devices, except as specifically included in the sections entitled Family Planning Services Benefits and Outpatient Prescription Drug Benefits; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drug Benefits; no benefits are provided for contraceptive implants;

33. For genetic testing except as described in the section entitled Outpatient or Out-of-Hospital X-ray, Pathology, and/or Laboratory Services;

34. For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any

other language assistive devices, except as specifically listed under in the sections entitled Durable Medical Equipment Benefits and Prosthetic Appliance Benefits;

35. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, bath chairs, and breast pumps, that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Diabetes Care Benefits, Durable Medical Equipment Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and Prosthetic Appliance Benefits;

36. Incident to bariatric surgery services except as specifically provided under the section entitled Bariatric Surgery Services Benefits;

37. For services (except for services received under the Behavioral Health Treatment benefit under *Mental Health and Substance Use Disorder Benefits*) provided by an individual or entity that:

    - is not appropriately licensed, certified, or otherwise authorized by the state to provide health care services,
    - is not operating within the scope of such license, certification, or state authorization,
    - does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;

38. massage therapy that is not Physical Therapy or a component of a multiple-modality rehabilitation treatment plan; and

See the Grievance Process section for information on filing a grievance, your right to seek assistance from the State of California Department of Insurance, and your rights to external independent medical review.

Medical Necessity Exclusion

All services must be Medically Necessary. The fact that a Physician or Other Provider may prescribe, order, recommend, or approve a service does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The Plan may limit or exclude benefits for services that are not Medically Necessary.

Pre-Existing Conditions

Pre-existing Conditions are covered only after you have been continuously covered for six (6) consecutive months, including your waiting period. Your waiting period begins on the date the Plan receives your application.

However, if you or your Dependents had prior Creditable Coverage and you applied for this Plan within sixty-three (63) days after termination of the prior Creditable Coverage, then the Plan will credit the time you or your Dependents were covered under the prior Creditable Coverage toward this Plan's Pre-existing Condition exclusion.

To receive credit for your prior Creditable Coverage, submit to Blue Shield Life a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact the Plan's Customer Service area for assistance.

Limitations for Duplicate Coverage

When you are eligible for Medicare

After coverage in this plan has begun your Blue Shield Life plan will provide benefits if the Insured is enrolled under Medicare but Medicare will typically be the primary payor and Blue Shield Life will be the secondary payor as determined by Medicare regulations

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

When you are eligible for Medi-Cal

Your Blue Shield Life plan always provides benefits first.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield Life plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield Life plan will pay the reasonable value or Blue Shield Life'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 governmental agency

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

1. The combined benefits from that coverage and your Blue Shield Life plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to

receive benefits under that coverage (based on the reasonable value or Blue Shield Life's Allowable Amount).

2. Your Blue Shield Life plan Deductible, copayments, and/or coinsurance will be applied before payment of plan benefits.

Contact the Customer Service department at the telephone number on the Subscriber's Identification Card if you have any questions about how Blue Shield Life coordinates your 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 Policy.

Claims Review

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

Reductions - Third Parties Liability

If an Insured is injured or becomes ill due to the act or omission of another person (a "third party"), the Plan shall, with respect to services required as a result of that injury, provide the benefits of this Policy and have an equitable right to restitution, or reimbursement, or other available remedy to recover the amounts Blue Shield paid for Services provided to the Insured on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Insured 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 Insured 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 of third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Insured 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 paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The Insured is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured 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 with the Plan to execute any forms or documents needed to enable Blue Shield to enforce its 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 the Plan 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 ten (10) days after any Recovery has been obtained.

An Insured's failure to comply with items 1. through 5. above, shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

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

General Provisions

Non-Assignability

Coverage or any benefits of this Policy may not be assigned without the written consent of Blue Shield Life.

Possession of a Blue Shield Life identification care confers no right to Services or other benefits of this Policy. To be entitled to Services, the Insured must be a Subscriber who has been enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Policy.

Preferred Providers are paid directly by the Plan. The Insured or the provider of Service may not request that payment be made directly to any other party.

If the Insured receives covered Services from a Non-Preferred Provider, payment will be made directly to the Insured, and the

Insured is responsible for payment to the Non-Preferred Provider. The Insured or the provider of Service may not request that the payment be made directly to the provider of Service, except for non-emergency services the Insured received from a Non-Preferred Provider as a result of a visit to a facility that is a Preferred Provider.

Refer to the section entitled Payment of Claims for information on reimbursement of covered Services from a Non-Preferred Provider.

Confidentiality of Personal and Health Information

Blue Shield Life 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 Life will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield Life'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 telephone number on the Subscriber's Identification Card or accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life 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 Life Privacy Office
P. O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone Number:
1-888-266-8080
E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

Confidential Communication Requests

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

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

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

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

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

A confidential communication request may be submitted in writing to Blue Shield Life at the mailing address, **email** address, or fax number below. A confidential communication form, available by going to blueshieldca.com/privacy and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

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

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

Mail: Blue Shield Life Privacy Office, P.O. Box 272540, Chico CA, 95927-2540

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

Access to Information

Blue Shield Life 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 Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by

Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life 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 Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

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.

Entire Policy: Changes

This Policy, including the appendices, constitutes the entire agreement between parties. Any statement made by an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Policy shall be valid unless approved by a corporate officer of Blue Shield Life and a written endorsement issued. No representative has authority to change this Policy or to waive any of its provisions.

Benefits such as covered Services, Calendar Year Benefits, Deductible, Copayment, Coinsurance, Maximum per Insured Calendar Year Copayment/Coinsurance Responsibility, or Maximum per Insured and Family Calendar Year Copayment/Coinsurance Responsibility amounts are subject to change at any time. Blue Shield Life will provide at least 60 days written notice of any such change.

Benefits provided after the Effective Date of any change will be subject to the change. There is no vested right to obtain Benefits.

Time Limit on Certain Defenses

After an Insured has been covered under this Policy for two (2) consecutive years, Blue Shield Life will not use any omission, misrepresentation, or inaccuracy made by the Applicant in an individual application to limit, cancel or rescind the Policy, deny a claim, or raise Premiums.

Grace Period

After payment of the first Premium, the Subscriber is entitled to a grace period of 30 days for the payment of any Premium due. During this grace period, the Policy will remain in force. However, the Subscriber will be liable for payment of Premiums accruing during the period the Policy continues in force.

Notice and Proof of Claim

Notice and Claim Forms

In the event the provider of Services does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of Service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

Proof of Claim

Blue Shield Life must receive written proof of claim within 90 days after the date of service for which claim is being made from a contracted professional provider and no later than 180 days for claims from a non-contracted professional provider. Send a copy of your itemized bill to the Blue Shield Life service center listed on the last page of this Policy.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one (1) year after the date of loss, unless the Insured was legally unable to notify Blue Shield Life.

Payment of Benefits

Time of Payment of Claims

Claims will be paid immediately upon receipt of proper written proof and determination that benefits are payable.

Payment of Claims

Participating Providers and Preferred Providers are paid directly by Blue Shield Life. Blue Shield Life also pays benefits directly to a provider of Ambulance Benefits, and certified nurse midwife and nurse practitioner providing maternity services whether the Insured has authorized assignment of benefits or not.

If the Insured receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, except as set forth above. The Insured is responsible for payment to the Non-Preferred Provider, except that Hospital charges are generally paid directly to the Hospital.

Refer to the section entitled Outpatient Prescription Drug for information on reimbursement of prescription drug claims.

Legal Actions:

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished.

Organ and Tissue Donation

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

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

Notice about Telehealth

Insureds have the right to access their medical records. The records of any services provided through a Third-Party Corporate Telehealth Provider will be shared with the Insured's Physician, unless the Insured objects.

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

If your plan includes Covered Services from Non-Participating Providers, you can receive the Covered Service either on an in-person basis or via telehealth.

Please see the Your Blue Shield Life Balance Plan 1000 - G and How to Use It section for additional information.

Choice of Providers

An Insured may select any Hospital or Physician to provide covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Preferred Provider or a Non-Preferred Provider is selected. It is to the Insured's advantage to select Preferred Providers whenever possible. See the Definitions section for more information. A Directory of Preferred Physicians and Preferred Hospitals has been provided to the Insured. A listing of Participating Physicians and Preferred Hospitals may be viewed by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com. An extra copy is available upon request by calling the Plan at the telephone number on the Subscriber's Identification Card or writing to:

Blue Shield Life
PO Box 272610
Chico, CA 95927-2610

If the inability to perform by a Preferred Provider, the breach of the contract to furnish Services by a Preferred Provider, or the termination of a Preferred Provider's contract with Blue Shield Life may materially and adversely affect the Insured, Blue Shield Life will, within a reasonable time, advise the Insured in writing of such inability to perform, breach, or termination.

Coverage of Medically Necessary Treatment of a Mental Health or Substance Use Disorder

Coverage is provided for Medically Necessary Treatment of a Mental Health or Substance Use Disorder, including basic health care services, intermediate services, and prescription drugs, under the same terms and conditions applied to other medical conditions, consistent with Section 10144.5 of the California Insurance Code.

Endorsements and Appendices

Attached to and incorporated in this Policy by reference are appendices pertaining to Deductibles and Premiums. Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Policy. Nothing contained in any endorsement shall affect this Policy, except as expressly provided in the endorsement.

Notices

Any notice required by this Policy may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield Life and notice to Blue Shield Life may be mailed to:

Blue Shield Life
601 12th Street
Oakland, CA 94607

Commencement or Termination of Coverage

Whenever this Policy provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 A.M. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Identification Cards

Identification cards will be issued by Blue Shield Life to all Insureds.

Legal Process

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

Notice

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

The Subscriber further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than the Plan and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

Customer Service

For all Services other than Mental Health and Substance Use Disorder -

An Insured who has 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, may call the Plan's Customer Service Department at the telephone number on the Subscriber's Identification Card.

The hearing impaired may contact the Plan's Customer Service Department through the Plan's toll-free TTY telephone number at:

1-800-241-1823

Customer Service can answer many questions over the telephone. Insureds may also submit questions to Customer Service by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com.

Note: Blue Shield Life has established a procedure for our Subscribers and Dependents to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured'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 telephone number on the Subscriber's Identification Card.

Blue Shield Life may refer inquiries or appeals to a local medical society, hospital utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer review committee for an opinion to assist in the resolution of these matters.

For all Mental Health and Substance Use Disorder Services -

The Plan's Mental Health Service Administrator (MHSA) should be contacted for questions about Mental Health and Substance Use Disorder Services, MHSA network Providers, or Mental Health and Substance Use Disorder benefits. You may contact the MHSA at the telephone number or address, which appear below:

1-877-263-9952

Blue Shield of California
Life & Health Insurance Company
Mental Health Service Administrator
PO Box 719002
San Diego, CA 92171-9002

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

Grievance Process

Blue Shield Life has established a grievance procedure for receiving, resolving and tracking Insured's grievances with Blue Shield Life.

For all grievances except denial of coverage for a Non-Formulary Drug or step therapy

Blue Shield Life will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days.

Insureds can request an expedited decision when the routine decision-making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured'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. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service.

For grievances due to denial of coverage for a Non-Formulary Drug or step therapy

If your Employer selected the optional Outpatient Prescription Drug Benefit Rider as a Benefit and Blue Shield denies an exception request for coverage of a Non-Formulary Drug or step therapy, the Insured, representative, or the Provider may request an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

For all Services other than Mental Health and Substance Use Disorder -

The Insured, a designated representative, or a provider on behalf of the Insured, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim of Service. The Insured may contact Blue Shield Life at the telephone number on the Subscriber's Identification Card. If the telephone inquiry to Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or completed "Grievance Form". The Insured may request this Form from Customer Service at the address as noted in this Policy. The completed Form should be submitted to:

Blue Shield Life
Customer Service Appeals and Grievance
P.O. Box 5588
El Dorado Hills, CA 95762-0011

The Insured may also submit the grievance online by visiting the web site at http://www.blueshieldca.com.

Blue Shield Life will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances within 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health and Substance Use Disorder Services -

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

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

1-877-263-9952

Blue Shield of California
Life & Health Insurance Company
Mental Health Service Administrator
Attn: Customer Services
PO Box 719002
San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days. The grievance system allows the Insured to file grievances within 180 days following any incident or action that is the subject of the Insured's dissatisfaction.

If the grievance involves an MHSA Non-Participating Provider, the Insured should contact the appropriate Blue Shield Life Customer Service Department.

For all Services - External Independent Medical Review

If your grievance involves a claim or services for which coverage was denied by Blue Shield Life 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 Insurance 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 Life 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 Insurance 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 Life; if the external reviewer determines that the service is Medically Necessary, Blue Shield Life 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 Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

California Department of Insurance Review

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8:00 a.m. to 6:00 p.m., Monday through Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013 or through the website www.insurance.ca.gov..

Definitions

Plan Provider Definitions

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

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

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.).

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

1) A provider who is no longer available to the Insured as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield Life or the MHSA, the Insured was receiving Covered Services from that provider for one of the conditions listed in the "Continuity of care with a Former Participating Provider" table in the Continuity of Care section.
2) A Non-Participating Provider to a newly-covered Insured whose health plan was withdrawn from the market, and at the time the Insured's coverage with Blue Shield Life became effective, the Insured was receiving Covered Services from that provider for one of the conditions listed in the "Continuity of care with a Former Participating Provider" table in the Continuity of Care section.
3) A provider who is a Participating Provider with Blue Shield Life or the MHSA but no longer available to the Insured as a Participating Provider or an MHSA Participating Provider because Blue Shield Life or the MHSA no longer contracts with the Insured's Former Participating Provider for the services they are receiving.

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; 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; healing aid supplier; licensed clinical social worker; associate clinical social worker; psychologist; registered psychological assistant; marriage and family therapist; associate marriage and family therapist or marriage and family therapist trainee; qualified autism service provider or qualified autism service professional certified by a national entity; psychology trainee or person supervised as required by law; board certified behavior analyst (BCBA); licensed professional clinical counselor (LPCC); associate professional clinical counselor or professional clinical counselor trainee; massage therapist.

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.

3. A "psychiatric health facility" as defined in Section 1250.2 of the California Health and Safety Code.

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

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

Non-Participating Home Health Care and Home Infusion Agency — agencies which have not contracted with Blue Shield Life Provider Network and whose services are not covered unless prior authorized by the Plan.

Non-Participating / Non-Preferred Provider — any provider who has not contracted with Blue Shield Life to accept Blue Shield Life's payment, plus any applicable Deductible, Copayment, Coinsurance or amount in excess of specified benefit maximums, as payment-in-full for covered Services, except as provided in the section entitled Preventive Care Benefits.

Note: this definition does not apply to Mental Health and Substance Use Disorder Services. For Non-Participating Providers for Mental Health and Services see the Mental Health and Substance Use Disorder Service Administrator (MHSA) Non-Participating Providers definition.

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

Note: bariatric surgery services are not covered for Persons who reside in designated counties in California if the service is provided by a Non-Preferred Bariatric Surgery Services Provider. (See the section entitled Bariatric Surgery Benefits for more information.)

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

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 licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and

3. Has contracted with Blue Shield Life to provide Services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted with Blue Shield Life Provider Network to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion Agency by the Plan. (See Non-Participating Home Health Care and Home Infusion Agency definition.

Participating Provider — All Preferred Providers are Participating Providers. These providers include Physicians, Hospitals, Alternate Care Services Providers, Ambulatory Surgery Centers, a Certified Registered Nurse Anesthetist, and Home Health Care and Home Infusion agencies that have contracted with Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, plus applicable Deductibles, Copayments and Coinsurance, or amounts in excess of specified benefit maximums, as payment in full for covered Services, except as provided in the section entitled Professional (Physician) Benefits.

Note: this definition does not apply to Mental Health and Substance Use Disorder Services or Hospice Program Services. For Participating Providers for Mental Health and Services and Substance Use Disorder and Hospice Program Services, see the Mental Health Service Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definition.

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.

Physician Member — a Doctor of Medicine who has contracted with Blue Shield Life Provider Network, has agreed to furnish Services to Insureds covered by Blue Shield Life, and has agreed to accept Blue Shield Life's payment as payment-in-full for covered Services, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

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

Preferred Dialysis Center – a dialysis services facility contracted as a Blue Shield Life Network Provider to provide dialysis services on an Outpatient basis and accept reimbursement at negotiated rates.

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

Preferred Hospital — a Hospital which has contracted with Blue Shield Life Provider Network and which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Plan.

Preferred Provider – A Preferred Provider is a Participating Provider who has contracted with the Blue Shield Life Provider Network to furnish Services and to accept the Plan's payment, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided in the section entitled Preventive Care Benefits.

Note, for Participating Providers for Mental Health and Substance Use Disorder Services, see the Mental Health Service Administrator (MHSA) Participating Providers definition.

Preferred Physicians — a Physician who has agreed to accept Blue Shield Life's payment, plus any Insured payments of any applicable Deductible, Copayment, and/or Coinsurance as payment-in-full for covered Services. Please refer to the Summary of Benefits for Copayment and/or Coinsurance information.

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

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

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 Life Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Blue Shield Life Allowance, unless otherwise specified for a particular Service elsewhere in this Policy, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield Life 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 Out-of-Network-Emergency Allowable;
    b. For other providers – (1) the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under state and federal laws; or

3. For a non-participating provider in California, who provides Services on other than an emergency basis, the amount Blue Shield Life 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 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 Life will assign the Allowable Amount used for a non-participating provider in California. Or, if applicable, the amount determined under the federal law.

Where required under federal law, the Allowable Amount used to determine your cost share may be based on Blue Shield Life's "qualifying payment amount," which may differ from the amount Blue Shield Life pays the Non-Participating Provider or facility for covered Services.

Benefits (Services) — Medically Necessary health care Services and Medically Necessary supplies furnished incident to those Services.

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

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

Blue Shield Life — the Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

Calendar Year — a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

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

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

Coinsurance — the percentage of the Allowable Amount or billed charges that an Insured is required to pay for certain Services after meeting any applicable Deductible.

Copayment — the dollar amount that an Insured is required to pay for certain Services after meeting any applicable Deductible.

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

Creditable Coverage —

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

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Doctor of Medicine); or care furnished to an Insured 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 individual to live outside an institution providing such care; or

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

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

Dependent —

1. A Subscriber's legally married spouse who is:
   a. Resident of California; and
   b. Not covered for benefits as a Subscriber; and
   c. Not legally separated from the Subscriber; or

2. A Subscriber's Domestic Partner, who is:
   a. Not covered for Benefits as a Subscriber; and
   b. A Resident of California.

3. A Subscriber's, spouse's, or Domestic Partner's child (including any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction), not covered for benefits as a Subscriber who is:

   a. A Resident of California (unless a full-time student); and

   b. Less than 26 years of age,

   c. And who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with this Policy.

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

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

   a. The child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance and be incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition;

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

   c. Thereafter, certification from a Physician is submitted to the Plan on the following schedule:
      i. Within 24 months after the month when the Dependent would otherwise have been terminated; and

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

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

1. Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

2. The partners share have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

3. The partners are:

   a. Not currently married to someone else or a member of another domestic partnership; and

   b. Not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited

4. Both partners are capable of consenting to the domestic partnership; and.

5. Both Partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

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

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

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 individual's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield Life.

Emergency Medical Condition (including a psychiatric emergency) – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1) placing the Insured's health in serious jeopardy;

2) serious impairment to bodily functions;

3) serious dysfunction of any bodily organ or part.

Emergency Services — the following services provided for an Emergency Medical Condition, including a psychiatric emergency medical condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition;

2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the Insured; and

3) Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the Plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

"Stabilize" means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

"Post-Stabilization Care" means Medically Necessary services received after the treating physician determines the emergency medical condition is stabilized.

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.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care – standards of care and clinical practice that are generally recognized by Health Care

Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include:

1) Peer-reviewed scientific studies and medical literature;
2) Clinical practice guidelines and recommendations of nonprofit health care provider professional associations;
3) Specialty societies and federal government agencies; and
4) Drug labeling approved by the United States Food and Drug Administration.

Hospital Services — Services provided under the direction of a Physician, in a licensed Hospital to treat illness or injury and which require the facilities of a Hospital.

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

Incurred — a charge shall be deemed to be "Incurred" on the date the particular Service, which gives rise to it, is provided or obtained.

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

Insured — either a Subscriber or Dependent.

Intensive Outpatient Program — an outpatient care program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

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

Medically Necessary Treatment of a Mental Health and Substance Use Disorder – a Covered Service or product addressing the specific needs of an Insured, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

1) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder care;
2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and
3) Not primarily for the economic benefit of the disability insurer and Insureds or for the convenience of the patient, treating Physician, or other Health Care Provider.

Mental Health and Substance Use Disorder(s) – a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Mental Health Service Administrator (MHSA) —The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

Negotiated Rate — the amount a Preferred Hospital has agreed to accept as payment-in-full for covered Services, except for applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified benefit maximums, and except as provided under the section entitled Covered Services.

Other Outpatient Mental Health and Substance Use Disorder Services – Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorder and the following:

1) Partial Hospitalization

2) Intensive Outpatient Program

3) Electroconvulsive therapy

5) Transcranial magnetics stimulation;

6) Behavioral Health Treatment; and

7) Psychological Testing.

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

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

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

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

Out-of-Area Follow-up Care – non-emergent Medically Necessary services to evaluate the Insured's progress after Emergency or Urgent Services provided outside the service area.

Out-of-Country Services — Medical services received outside the United States of America.

Out-of-Network Emergency Allowable – In California: The lower of (1) the provider's billed charge, (2) the amount determined by Blue Shield Life 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 geographical area where the services are rendered, or (3) if applicable, the amount determined under state and federal law; Outside of California: The lower of (1) the provider's billed charge, or (2) the amount, if any, established by state and federal law to be paid for Emergency Services.

Outpatient — an Insured receiving Services, but not as an Inpatient.

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

Physical Therapy - treatment provided by a physical therapist, occupational therapist, or other appropriately licensed or certified 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 Life and Health Insurance Company and/or the Balance Plan 1000 - G.

Plan Service Area - A geographical area designated by the Plan within which a plan shall provide health care services.

Policy — this Policy, the appendices, all endorsements to it, and all applications for coverage and health statements.

Pre-Existing Condition — an illness, injury, or condition (including disability) which existed during the six (6) months prior to the Effective Date with Blue Shield Life if, during that time, any medical advice, diagnosis, care, or treatment was recommended or received from a licensed health practitioner.

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

Psychological Testing — testing to diagnose a mental health disorder when referred by an MHSA Participating Provider.

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

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

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

Residential Care – Mental Health and Substance Use Disorder Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Insured who do not require acute inpatient care. 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 respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Services (Benefits) — Medically Necessary health care 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 Doctor of Medicine and provided by a licensed speech pathologist or

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 a diagnosed illness or injury.

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

Subscriber — an individual who is a Resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield Life, and has maintained Blue Shield Life membership in accord with this Policy.

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

Notice Informing Individuals about Nondiscriminationand Accessibility Requirements

Discrimination is against the law

Blue Shield of California Life & Health Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield Life does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield Life:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield Life Civil Rights Coordinator.

If you believe that Blue Shield Life has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield Life & Health Insurance Company Civil
Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (916) 350-7405
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

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. For more help call the CA Dept. of Insurance at 1-800-927-4357. 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. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. 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。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。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. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. 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: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 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. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. 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: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: 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. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. 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。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویند 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.برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. 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। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ
សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត
សូមទូរស័ព្ទទៅក្រសួងធានាក៉ប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. 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. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo báàh íílnígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̧o̧doo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíídooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos doot'ízhígí bee néího'dílzinígí bine'dééʼ bikáá' éí doodagó éí (866) 346-7198jį' hodíilnih. Hózho̧ shíká anáá'doowoł nínízingo éí díí Akéé——shíį̄h Béeso Ách'a̧ah Naa'nil bił haz'á̧ajį' 1-800-927-4357jį' hodíilnih. Navajo

IN WITNESS WHEREOF, Blue Shield of California Life & Health Insurance Company, through its duly authorized Officers, execute this Policy, to take effect on the Subscriber's Effective Date.

Hope H. Scott
Secretary
Blue Shield of California Life & Health
Insurance Company

Patrice Bergman
Vice President and General Manager
Individual and Family Plans
Blue Shield of California Life & Health
Insurance Company

For claims submission and information contact:

Blue Shield of California Life and Health Insurance Company
P. O. Box 272540
Chico, CA 95927-2540

You may call Customer Service toll free at 1-800-431-2809

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

Benefits Management Program
for Pre-admission and/or Prior Authorization,
please call the Customer Service telephone number
as indicated on the back of the Insured's identification card.

Benefits Management Program
for Prior-Authorization of Radiological Services:
1-888-642-2583

For Prior Authorization for Inpatient Mental Health and Substance Use Disorder Services,
contact the Mental Health Service Administrator at:
1-877-263-9952

Please refer to the section entitled Benefits Management Program
for additional information.

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NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。