blue of california

601 12th Street
Oakland, CA 94607
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GROUP HEALTH SERVICE CONTRACT

Blue Shield of California Trio HMO Plan

between

Santa Clara Valley Water District
("Contractholder")

and

California Physicians' Service
dba Blue Shield of California
a not-for-profit corporation

IMPORTANT NOTE: This Trio HMO Health Plan may only be offered alongside an Access+ HMO® Health Plan, a Blue Shield PPO Health Plan, or both.

In consideration of the applications and the timely payment of Dues, Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **January 1, 2026**, for a term of 12 months, subject to the provisions entitled, "Changes: Entire Contract".

Jason Bleau
Vice President
Core Accounts
Blue Shield of California

Group Number: **W0051426-M0043930**

Original Effective Date: **April 1, 1990**

IMPORTANT

No person has the right to receive the Benefits of this Contract for Services or supplies furnished following termination of coverage, except as specifically provided in the *Continuation of group coverage, Extension of Benefits, and Continuity of Care* sections of the Evidence of Coverage and Disclosure Form (EOC). Other than noted exceptions, Benefits of this Contract are available only for Services and supplies as included in the applicable sections of the EOC, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in *Part V. Dues, Part VIII. General Provisions, D. Changes: Entire Contract*, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

TABLE OF CONTENTS

Page C-

PART I. INTRODUCTION 4
PART II. DEFINITIONS 4
PART III. ELIGIBILITY 5
A. Employee Eligibility, Waiting Periods and Open Enrollment 5
B. Associated Employers 6
C. Termination of Benefits 7
PART IV. GROUP RENEWAL PROVISIONS 8
A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract 8
B. Renewal of the Group Health Service Contract 8
PART V. DUES 9
PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS) 10
PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD 12
A. Cancellation Without Cause 12
B. Cancellation for Non-Payment of Dues 12
C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact 12
D. Cancellation of the Trio Health Plan 12
E. Grace Period 12
F. Payment or Refund of Dues Upon Cancellation 12
G. Termination of Benefits 12
H. Employer to Provide Subscribers with Notice of Cancellation, Rescission or Nonrenewal 12
PART VIII. GENERAL PROVISIONS 13
A. Choice of Providers 13
B. Use of Masculine Pronoun 13
C. Workers' Compensation 13
D. Changes: Entire Contract 13
E. Statutory Requirements 13
F. Legal Process 14
G. Time of Commencement or Termination 14
H. Records and Information to be Furnished 14
I. Inquiries and Complaints 14
J. Confidentiality 14
K. Termination of a Plan Provider Contract 14
L. Producer Service Fee 14
M. ERISA Plan Administrator 16
N. Continuity of Care 16
O. Prescription Drug and Health Care Spending Report 16
PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS 17
A. Obtaining Declinations or Waivers of Coverage 17
B. Distribution of Summary of Benefits and Coverage (SBC) 17
C. Distribution of Member ID Cards and EOC Booklets 17
D. Notice of Start of Grace Period or Notice of Cancellation, Rescission or Nonrenewal 18
E. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices 18
EVIDENCE OF COVERAGE AND DISCLOSURE FORM 20
Refer to the Table of Contents in the EOC
Supplements:
Outpatient Prescription Drugs
Acupuncture and Chiropractic Services

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations, and exclusions of this Group Health Service Contract.

Note: This Trio Health Plan has a special network of Independent Practice Associations (IPAs) and Medical Groups which includes only a limited number of Plan providers and a limited Service Area which includes only certain counties, cities, and zip codes. Please be aware there may only be one (1) IPA or Medical Group in certain counties, cities, and zip codes.

This Trio Health Plan is only available when offered alongside an Access+ HMO plan or a Blue Shield PPO Health Plan or both "multiple plans"). This multiple plan coverage must be maintained in order for coverage under Trio Health Plan to remain in effect.

The Evidence of Coverage and Disclosure Form (EOC) is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the "*Definitions*" section of the EOC, the following provisions apply to this Group Health Service Contract:

Employee - (1) an individual engaged on a full-time basis in the conduct of the business of the Employer, whose normal work week is at least 20 hours, and whose duties in such employment are performed at the Employer's regular places of business; and (2) an individual who is a retiree and who meets the eligibility requirements for retiree coverage as established by the Employer; or (3) a sole proprietor or partner of a partnership engaged on a full-time basis, at least 20 hours per week, in the Employer's business and who is included as an Employee under a health care Plan Contract of the Employer.

An individual is ineligible for coverage who works part-time, temporary, or is employed on a substitute basis.

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the *Eligibility for this plan* section of the EOC, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each individual in the employ of the Employer on the effective date of this Contract who was a Subscriber of Blue Shield by virtue of the Employer's previous Contract on the date immediately preceding the effective date of this Contract, who lives and/or works in the Service Area is eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the first of the month following the completion of any applicable waiting period established by the Employer. This waiting period shall be waived for part-time Employees upon attaining full-time status.

   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.

2. The date of eligibility of a former Employee, who has been re-employed, shall be determined as follows: The Employee's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:

   a. he has resumed active work within 6 months after such termination; or

   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights. However, there will be no waiting periods as prohibited by The Military & Veterans Code; or

   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Employee entering the employ of the Employer on the date he resumed work and shall be eligible on the date he completes the period of service specified in *A.1.b.*

3. If any class of Employees is not eligible under *A.1.*, and if an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Employer on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

4. The Employer agrees to offer health Benefits coverage to all eligible Employees during the initial enrollment period and distribute information as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*. In addition, the Employer agrees to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or at the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in *paragraph 1*. of the definition of *Late Enrollee*. Blue Shield will not consider applications for earlier effective dates.

5. An Employee may transfer enrollment for himself or his Dependent(s) from another group health plan sponsored by the Employer to the health Plan covered by this Contract only during the Employer's annual Open Enrollment Period. The effective date of Benefits for such Employee and Dependent(s) shall be the first day of each subsequent January. Submission of evidence of acceptability is not required when application is made during this Open Enrollment Period.

6. The Employer shall timely report any additions or terminations of Employees or Dependents so that retroactive Dues adjustments are avoided and claims are not paid for ineligible individuals. However, if the Employer determines that

it has made an administrative error in the processing of eligibility for an Employee or Dependent, Blue Shield will accept the retroactive changes subject to the following limitations:

a. Blue Shield will accept enrollment of the Employee or Dependent retroactively for a maximum of 90 days, as long as Dues are paid by the Employer for the entire retroactive enrollment period. If an Employee or Dependent is retroactively enrolled pursuant to this, and the Employee or Dependent received covered health care services during that retroactive period, Blue Shield will reimburse the Employee for payments made for Covered Benefits received in accordance with the rules of the EOC, minus the Member's Copayments or Coinsurance as stated in the EOC;

b. Blue Shield will accept termination/disenrollment of the Employee or Dependent retroactive for a maximum of 90 days and will refund appropriate Dues paid for the retroactive termination period. In such case, Blue Shield reserves the right to request refund from the Employee for any payments made for services rendered during the retroactive termination period. In making a request for retroactive termination or disenrollment, Contractholder shall comply with all applicable state and federal law, including, but not limited to, the Patient Protection & Affordable Care Act and any related regulations.

7. The Employer agrees to comply with the requirements of Section 2708 of the Patient Protection & Affordable Care Act (Section 2708), which prohibits an employer from imposing a prohibited waiting period. "Waiting period" means a period that is required to pass before an otherwise eligible Employee will be able to enroll in coverage under the Group Contract. Specifically, Employer agrees:

   a. Any conditions of eligibility or waiting periods imposed on the eligible Employee will comply with the requirements of Section 2708 and California state law and any rules and regulations implementing those requirements.

   b. Employer will notify Blue Shield if Employer imposes a waiting period on an eligible Employee that would exceed the time-period permitted by Section 2708.

   c. The Employer must ensure that any orientation period that may be imposed by the Employer prior to the start of the waiting period is consistent with federal regulations. The Employer will notify Blue Shield of the Employee's eligibility for coverage after the orientation period.

   d. Employer will notify Blue Shield if any changes are made regarding these representations.

   e. Employer will hold Blue Shield harmless for any violation of the requirements of Section 2708 or California state law.

B. Associated Employers

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

list of associated Employers

None

PART III. ELIGIBILITY

C. Termination of Benefits

In addition to the provisions contained in the *When coverage ends* section of the EOC, the following provisions apply to this Group Health Service Contract:

1. The Benefits of a Member shall cease on the first day of the month following the month in which the Subscriber leaves voluntarily, or is dismissed from the employ of the Contractholder (except for retirees who meet the eligibility requirements for retiree coverage as established by the Contractholder) or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:

    a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Dues for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,

    b. if the Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Dues for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.

2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31st day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written or electronic application for the addition of the Dependent is submitted to and received by Blue Shield within 31 days following the effective date of coverage.

PART IV. GROUP RENEWAL PROVISIONS

A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract

The Employer shall be notified by Blue Shield of its intent to renew this Group Health Service Contract at least 135 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in *Part V. Dues, Paragraph D., or in Part VIII. General Provisions, Paragraph D. Changes: Entire Contract*.

B. Renewal of the Group Health Service Contract

Blue Shield will renew this Group Health Service Contract at the option of the Contractholder except in the following instances:

1. the Contractholder violates a material contract provision relating to Employer or other group contributions or group participation rates by the Contractholder or Employer;
2. the Contractholder fails to pay the required Dues as specified under *Part V.* Dues;
3. the Contractholder commits fraud or other intentional misrepresentation of material fact;
4. the Contractholder relocates outside of California;
5. Blue Shield ceases to offer a plan type purchased by the Contractholder;
6. Blue Shield ceases to offer health benefit plans in the state (withdrawal of all products).

PART V. DUES

A. Dues

Monthly Dues

M0043930 - 1000/C100/C500

Subscriber	$1,016.33
Additional for one Dependent	$1,422.89
Additional for two or more Dependents	$1,829.32

M0043930 - 1001

Subscriber	$1,421.17
Additional for one Dependent	$1,989.59
Additional for two or more Dependents	$2,558.04

B. When and Where Payable

1. The first month's Dues must be paid to Blue Shield by the effective date of this Contract and subsequent Dues shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Dues payment has been received by Blue Shield.

2. Dues for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Dues for Employees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.

3. All Dues are payable by the Employer to Blue Shield of California. The payment of any Dues shall not maintain the Benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in *Part V. F.*

C. The terms of this Contract or the Dues payable therefor may be changed from time to time as set forth in *Part VIII., D. Changes: Entire Contract*.

D. The Employer shall remit to Blue Shield the amount specified in *Part V. A. ("the Dues")*. If a Federal, State or any other taxing or licensing authority imposes upon Blue Shield any tax or fee on account of any of the Employer's health benefit plans that is not included in the Dues, whether such tax or fee is based on Dues, gross receipts, enrollment or any other basis, Blue Shield may amend the Contract to increase the Dues by an amount sufficient to cover any such tax or fee rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice, which shall not be earlier than the date of the imposition of such tax or fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 60 days before the effective date of the amendment. In the case of Federal excise taxes, Blue Shield may also amend the Dues to include any increased Federal income taxes to Blue Shield associated with such Federal excise taxes.

E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax is levied under *Part V. D.*, the Dues charged therefor may be made, or the Dues credit therefor may be given, as of the effective date of such change.

F. A grace period of 30 days to pay all delinquent Dues and avoid cancellation will be granted for the payment of Dues accruing other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Dues accruing during the period the Contract continues in force during the grace period. Blue Shield will send a Notice of Start of Grace Period to the Employer after the last date of paid coverage. The 30-day grace period begins on the day the Notice of Start of Grace Period is dated. Cancellation for non-payment of Dues shall be in accordance with *PART VII.B.*

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Out-of-Area Services

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever a Member accesses services outside of California, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements available to Members under this agreement are described generally below.

When Members access services outside of California, they may obtain care from participating health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from non-participating health care providers in the Host Blue geographic area that do not have a contractual agreement with the Host Blue. Blue Shield's payment practices in both instances are described below.

The Blue Shield Trio HMO plan covers only limited health care services received outside of California. As used in this section, Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care obtained outside of California. Any other services will not be covered when processed through an Inter-Plan Arrangement, unless the services and out of state provider are authorized by Blue Shield.

BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Members access Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, the Host Blue will be responsible for contracting and handling substantially all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of Member liability on claims for Out-of-Area Covered Health Care Services processed through the BlueCard Program will be based on the lower of the provider's billed charges or the negotiated price made available to Blue Shield by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Blue Shield by the Host Blue may be represented by one of the following:

(i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed, without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed charges for Out-of-Area Covered Health Care Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether or not it will use an actual price, an estimated price, or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Blue Shield pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)

Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax, or other fee that applies to insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee in determining your premium.

Non-Participating Providers Outside of California

When Out-of-Area Covered Health Care Services are received from non-participating providers outside of California, but within the BlueCard Service Area, the amount(s) a Member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment Blue Shield will make for the Out-of-Area Covered Health Care Services as set forth in this paragraph.

Claims for covered Emergency Services are paid based on the Allowed Charges as defined in the EOC.

Blue Shield Global Core

If Members are outside the BlueCard Service Area, they 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 in the BlueCard Service Area. Although Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard Service Area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services. Details for Blue Shield Global Core claim submission are provided in the *Out-of-area services* section of the EOC.

PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD

A. Cancellation Without Cause

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

B. Cancellation for Non-Payment of Dues

Blue Shield may cancel this Contract for non-payment of Dues. If Dues are not received when due, coverage will end the day following the 30 day grace period, as described in Part V.F. hereof. The Employer will be liable for all Dues accrued while this Contract continues in force including those accrued during the 30-day grace period. In such case, Blue Shield will send a Notice of End of Coverage to the Employer and enrolled Employees no later than five calendar days after the date coverage ends. A new application for coverage will be required by the Employer and a new Contract will be issued only upon demonstration that the Employer meets all underwriting requirements at the time of application.

C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind this Contract within 24 months following issuance for fraud or intentional misrepresentation of material fact by the Employer; or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application or a health statement (if a health statement is required by the Employer) may, at the discretion of Blue Shield, result in the cancellation or rescission of this Contract. A rescission voids the Contract retroactively as if it was never effective. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to the Employer prior to any rescission. The Employer must provide enrolled Employees with a copy of the Notice of Cancellation, Rescission or Nonrenewal.

D. Cancellation of the Trio Health Plan

This Trio HMO Health Plan is only available when offered alongside an Access+ HMO plan or a Blue Shield PPO Health Plan or both ("multiple plans"). This multiple plan coverage must be maintained in order for coverage under the Trio HMO Health Plan to remain in effect, and any termination will be effective as of the same date.

E. Grace Period

The Employer shall be entitled to a grace period of 30 days for payment of Dues, as described in *PART V.F.* hereof. If during a grace period written notice is given by the Employer to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date, and the Employer shall be liable to Blue Shield for the full month's payment of Dues if discontinuance of coverage occurs on or after the 15th of the month. If discontinuance of coverage occurs prior to the 15th of the month then Dues payment will be waived and refunded to the group.

F. Payment or Refund of Dues Upon Cancellation

In the event of cancellation, the Employer shall promptly pay any earned Dues which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Dues, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for Services incurred during the time coverage was in effect up to and including the effective date of cancellation.

G. Termination of Benefits

No Benefits shall be provided for Services rendered after the effective date of cancellation, except as specifically provided in the *Continuation of group coverage and Extension of Benefits* sections of the EOC.

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Dues, no further Benefits will be provided after cancellation unless the Member is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of Benefits in accordance with the *Extension of Benefits* section of the EOC.

H. Employer to Provide Subscribers with Notice of Cancellation, Rescission or Nonrenewal

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly send a copy of Blue Shield's Notice of Cancellation, Rescission or Nonrenewal to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

PART VIII. GENERAL PROVISIONS

In addition to the provisions contained in the EOC, the following provisions apply to this Group Health Service Contract:

A. Choice of Providers

The Plan has established a network of primary care and specialty Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners to provide Covered Benefits to Members. A Member must obtain or receive approval for all Covered Benefits from his Primary Care Physician. Each Subscriber must select a Primary Care Physician for himself and each of his Dependents from the list of Primary Care Physicians in the Trio HMO Health Plan Physician and Hospital Directory. Members enrolled in this Trio HMO Health Plan may only obtain Covered Benefits from Primary Care Physicians and Medical Group/IPAs designated as Plan Providers in the Blue Shield Trio HMO Health Plan Physician and Hospital Directory, except for Emergency Services or Urgent Services when the Member is out of the Service Area. The Physician and Hospital Directory applicable to this Plan will be given to Members at the time of enrollment. A Member's Primary Care Physician will be accessible to the Member on a 24-hour-a-day, 7-day-a-week basis, or will make appropriate arrangements to assure coverage. Emergency Services will be provided on a 24-hour-a-day, 7-day-a-week basis by a Plan Hospitals.

B. Use of Masculine Pronoun

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

C. Workers' Compensation

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

D. Changes: Entire Contract

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Employer or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract, the Dues payable therefor, and the benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment and annual Out-of-Pocket Maximum amounts, may be changed from time to time. Blue Shield will provide at least 60 days' written notice of any such change, and these changes shall not become effective until at least 60 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield. Benefits for services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

Notice of changes in Benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing Members of the details of their coverage under this Contract, will be distributed by the Employer or his representative as set forth in *Part IX., Contractholder Responsibility for Distribution and Notification Requirements*.

E. Statutory Requirements

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act ("HIPAA") and applicable Centers for Medicare and Medicaid Services ("CMS") requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

PART VIII. GENERAL PROVISIONS

F. Legal Process

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

G. Time of Commencement or Termination

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

H. Records and Information to be Furnished

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Dues and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Employer identification number and Employer size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

I. Inquiries and Complaints

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to the Plan at the address or telephone number indicated on page *GC-1* of this Contract. (See also the *How to contact Customer Service* section of the EOC.)

J. Confidentiality

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Plan to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, the Plan may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

K. Termination of a Plan Provider Contract

1. Blue Shield shall provide written notice to the Employer within a reasonable period of time of any termination or breach of Contract of a Plan Provider if such termination or breach may materially affect the Employer or its Subscribers.

2. Upon termination of a Plan Provider Contract, Blue Shield shall be liable for Benefits rendered by such provider to an eligible Member (other than for Copayments) until the authorized Services being rendered to the Member by the former Plan Provider are completed, unless Blue Shield makes reasonable and medically appropriate provision for the assumption of such Benefits by another Plan Provider.

L. Producer Service Fee

The Contractholder has selected and entered into an agreement with **Alliant Insurance Services, Inc.** ("Producer"), under which the Producer has agreed to provide consulting services to the Contractholder in connection with the Contractholder's Plan(s) (the "Service Agreement"), in return for payment from the Contractholder of compensation negotiated directly between the Contractholder and the Producer (the "Fee"). Blue Shield is not a party to the Service Agreement.

PART VIII. GENERAL PROVISIONS

The Contractholder requests that Blue Shield receive from the Contractholder and pay to the Producer certain amounts comprising payment for the Producer's services under the Service Agreement (the "Pass-Through Arrangement" or "Arrangement").

1. Blue Shield Duties and Responsibilities:

    a. Blue Shield agrees to accept from the Contractholder payment of the monthly Fee amount with the Contractholder's payment of Blue Shield's monthly Premium invoice to the Contractholder.

    b. Blue Shield will forward the Fee to the Producer within 30 days of receipt of the Fee from the Contractholder.

    c. Blue Shield will provide to the Contractholder a summary of the aggregate Fee paid by Blue Shield on behalf of the Contractholder to the Producer for each Calendar Year within 15 business days following the end of such Calendar Year.

    d. Blue Shield is not responsible for determining or confirming the correctness of any information provided by the Contractholder, including the amount of the Fee or the name or other payment information of the Producer to whom the Fee is to be paid; rather, Blue Shield is responsible only for the ministerial functions of receiving payment of the Fee and forwarding such payment to the Producer.

2. The Contractholder Duties and Responsibilities:

    a. The Contractholder acknowledges and agrees that the Fee is not a part of the Premium charged to the Contractholder by Blue Shield, that using the Producer or any other agent or broker is not a requirement for the Contractholder to obtain coverage from Blue Shield and the Contractholder may obtain insurance policies directly from Blue Shield, and that the Contractholder, and not Blue Shield owes and is fully responsible to the Producer for the Fee.

    b. The Contractholder agrees to pay the Fee at the same time payment is made for the Premium for Blue Shield coverages.

    c. The Contractholder will notify Blue Shield immediately if the Service Agreement between the Contractholder and the Producer is terminated.

    d. The Contractholder will be responsible for any and all tax reporting related to the payment of the Fee to the Producer, including Form 1099s, if required.

3. Payments and Adjustments:

    a. The Contractholder and the Producer have agreed that the amount of the Fee initially shall be 2.56% of the monthly Premium amount per month.

    b. The Contractholder will notify Blue Shield of any change to the Fee or the manner in which it is to be paid in writing. For purposes of Blue Shield's duties and responsibilities under this Arrangement, any such change will be effective the first day of the month following Blue Shield's receipt of such written notice of the change.

    c. The Contractholder will notify Blue Shield of a producer of record change in writing. For purposes of Blue Shield's duties and responsibilities under this Arrangement, any such change will be effective the first day of the month following Blue Shield's receipt of such written notice of the change. Following the change, Blue Shield will remit the Fee to the new producer.

    d. The parties acknowledge that any payment received by Blue Shield from the Contractholder will be applied first to Premiums due to Blue Shield, and any amount in addition to such Premiums to payment of the Fee. The Contractholder's failure to pay the Fee through Blue Shield will not subject the Contractholder to termination of any Blue Shield coverages for non-payment of Premium.

e. The Contractholder acknowledges and agrees that Blue Shield may deposit the Fee into a general account that may collect interest. Blue Shield may retain any interest or investment income on funds held in the account.

f. The Contractholder acknowledges and agrees that its Blue Shield coverages may, if otherwise eligible, be taken into account in the calculation of any bonus program offered by Blue Shield to the Producer.

4. Term and Termination:

a. This Pass-Through Arrangement will automatically terminate as of the effective date of the termination of the Contractholder's Blue Shield coverages.

b. The Contractholder may terminate this Arrangement at any time by providing written notice to Blue Shield. Such termination will be effective the first day of the month following Blue Shield's receipt of the notice of termination.

c. Blue Shield may terminate this Arrangement by providing no less than sixty (60) days' prior written notice to the Contractholder.

M. ERISA Plan Administrator

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

N. Continuity of Care

Blue Shield will administer continuity of care benefits as described in the Evidence of Coverage during the term of the Contract. Blue Shield will continue to administer continuity of care benefits for a maximum of 90 days following the date of receipt of notice of the termination of this Contract, as required under 42 USCS § 300gg-113.

O. Prescription Drug and Health Care Spending Report

1. The Contractholder is responsible for any reporting requirements for services not provided by Blue Shield. Blue Shield will annually report on prescription Drug spending, and health care spending, enrollment and Premiums for services provided by Blue Shield, consistent with the requirements of 45 C.F.R. § 149.710 -149.740.
2. Blue Shield will annually report on Premium contributions consistent with these requirements provided that Contractholder provides Blue Shield with consent and complete information on a timely basis to report this information on the Contractholder's behalf. If Contractholder fails to timely provide consent and complete information, Contractholder will be solely responsible for reporting Premium contribution information.

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

The Contractholder has various distribution of notices and Member materials and other notification requirements under this Group Health Service Contract. Some of the major Contractholder distribution and notification requirements are summarized below; however, this is a summary only and is not to be construed as an all-inclusive list.

A. Obtaining Declinations or Waivers of Coverage

All eligible Employees will be offered health benefits coverage during the initial and subsequent enrollment periods. If an Employee elects to decline or waive coverage, the Employer is responsible for obtaining the Employee's signed acknowledgment of receipt of an explicit written notice in bold type specifying that failure to elect coverage during the Open Enrollment Period permits the Plan to impose an exclusion from coverage for a period of 12 months, or at the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria specified in the definition of Late Enrollee as set forth in the EOC.

B. Distribution of Summary of Benefits and Coverage (SBC)

A summary of benefits and coverage (SBC) will be issued by the Plan for all eligible Employees and Dependents. The Employer is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The Employer will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The Employer shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the Employer does not distribute paper SBCs, then the Employer will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the Employer's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the Employer to the Subscriber and any Dependents no later than sixty (60) days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the Employer fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the Employer, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the Employer agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

C. Distribution of Member ID Cards and EOC Booklets

1. Member ID Cards

Membership identification cards will be issued by the Plan for all Subscribers and will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions.

2. EOC Booklets

An EOC which summarizes the Benefits of this Contract and how to obtain Covered Benefits will be issued by the Plan for all Subscribers. The Plan will send the EOC to the Contractholder, and, the Contractholder is responsible for distributing the EOC to Subscribers whether in printed, hardcopy or electronic form.

EOCs will be provided to the Contractholder in electronic form (such as by Compact Disk (CD) or posted on Blue Shield's employer website) or in paper hard copy form. If Contractholder receives the EOC in electronic form, Contractholder is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the EOC after it is provided to Contractholder. If Contractholder receives the EOC in hard copy form, Contractholder will notify Subscribers that printed hard copies of the EOC are available and will promptly distribute to Subscribers.

Contractholder may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Employees of Contractholder; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with Blue Shield's instructions for accessing the EOC from the Blue Shield website.

If Contractholder posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit Employees of Contractholder to download and print a complete and accurate copy of the EOC. Contractholder will notify Employees enrolled with Blue Shield that the EOC for their plan is available to review, download and print from Contractholder's intranet site, and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site.

Contractholder will provide a hard copy of the EOC to an Employee upon request. If Blue Shield receives an inquiry from an Employee of the Contractholder regarding obtaining a copy of the EOC, Blue Shield will refer that individual to Contractholder's human resources benefits staff with instructions that a copy of the EOC is available from Contractholder on request. Contractholder has the option to request a supply of hard copies of the EOC in an amount not to exceed 10% of the total subscriber count at no additional charge.

In the event Blue Shield reasonably concludes that Contractholder is either using the electronic EOC in a matter not permitted by this Agreement or is not providing Subscribers with access to the EOC in accordance herewith, then Blue Shield will print copies of the EOC, and Contractholder will cooperate with Blue Shield to ensure that printed copies of the EOC are timely provided to all Employees of Contractholder enrolled with Blue Shield. Contractholder agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the EOC documents.

D. Notice of Start of Grace Period or Notice of Cancellation, Rescission or Nonrenewal

Upon receipt of a Notice of Start of Grace Period or a Notice of Cancellation, Rescission or Nonrenewal from the Plan, the Employer shall promptly send any such Notice to each subscriber in a manner which complies with applicable law.

E. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). See the *Continuation of group coverage and Extension of Benefits* sections of the EOC for additional information.

1. COBRA

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations

To the extent required by COBRA, and upon timely receipt of Dues and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

The Contractholder is solely responsible for all aspects of the administration of COBRA and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder in the event that federal continuation of coverage requirements of COBRA apply to the Contractholder, include the following:

PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS

a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.

b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.

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

d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.

e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and COBRA.

f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.

g. Contractholder or its COBRA administrator will provide notification of continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.

h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.

i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

2. Cal-COBRA

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber’s termination or reduction in hours of employment within 30 days of the Qualifying Event.

EVIDENCE OF COVERAGE AND DISCLOSURE FORM

An EOC booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this EOC and any applicable Supplements and are included as part of this Contract.

Note: In the EOC, references to "you" or "your" shall mean the eligible Subscriber and/or Dependent of this Plan. References to "we" or "us" shall mean the Plan and/or Blue Shield of California.

Combined Evidence of Coverage and Disclosure Form

Santa Clara Valley Water District Custom Trio HMO 10-0
Admit 2000/4000
Santa Clara Valley Water District
Group Number: W0051426-M0043931
Effective Date: January 1, 2026
Provider Network: Trio

blueshieldca.com

Blue Shield of California is an independent member of the Blue Shield Association

blue california

Table of contents

Table of contents **2**
Summary of Benefits **5**
Introduction **11**
About this Evidence of Coverage 11
About this plan 12
How to contact customer service 12
Your bill of rights **14**
Your responsibilities **17**
How to access care **18**
Health care professionals and facilities 18
Your Primary Care Physician 19
Your Medical Group 20
Self-referral for obstetrical/gynecological (OB/GYN) services 21
Specialist referrals 21
ID cards 23
Canceling appointments 24
Continuity of care 24
Second medical opinion 25
Care outside of California 26
Emergency Services 26
If you cannot find a Participating Provider 27
Other ways to access care 27
Timely access to care 29
Health advice and education 30
Medical management **32**
Prior authorization and PCP referrals 32
While you are in the Hospital (inpatient utilization review) 33
After you leave the Hospital (discharge planning) 33
Using your Benefits effectively (care management) 34
Your payment information **35**
Paying for coverage 35
Paying for Covered Benefits 35
Claims for Emergency or Urgent Services 38
Your coverage **40**
Eligibility for this plan 40
Enrollment and effective dates of coverage 40
Plan changes 42
Coordination of benefits 42
When coverage ends 43
Extension of Benefits 44
Continuation of group coverage 44
Your Benefits **49**
Allergy testing and immunotherapy Benefits 49
Ambulance services and Emergency Medical Services programs 49

Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits 50
Diabetes care services 51
Diagnostic X-ray, imaging, pathology, laboratory, and other testing services 51
Dialysis Benefits 52
Durable medical equipment 52
Emergency Benefits 54
Family planning and Infertility Benefits 56
Fertility preservation services 57
Home health services 57
Hospice program services 59
Hospital services 60
Medical treatment of the teeth, gums, jaw joints, and jaw bones 61
Mental Health or Substance Use Disorder Benefits 62
Physician and other professional services 64
PKU formulas and special food products 65
Podiatric services 65
Pregnancy and maternity care 65
Preventive Health Services 66
Reconstructive Surgery Benefits 67
Rehabilitative and habilitative services 67
Skilled Nursing Facility (SNF) services 69
Transplant services 69
Urgent care services 71
Exclusions and limitations 72
Grievance process 77
Submitting a grievance 77
California Department of Managed Health Care review 78
Independent Medical Review 78
ERISA review 79
Other important information about your plan 80
Your coverage, continued 80
Special enrollment period 80
Out-of-area services 81
Limitation for duplicate coverage 84
Exception for other coverage 85
Reductions – third-party liability 85
Coordination of benefits, continued 86
Services not charged 87
General provisions 87
Definitions 90
Notices about your plan 104
Outpatient Prescription Drug Rider 109
Acupuncture and Chiropractic Services Rider 122
Notice informing individuals about nondiscrimination and accessibility requirements 126
Language access services 127
Trio ACO HMO Plan Service Area 129

blue of california

Summary of Benefits

Santa Clara Valley Water District
Effective January 1, 2026
HMO Plan

Santa Clara Valley Water District Custom Trio HMO 10-0 Admit 2000/4000

This Summary of Benefits shows the amount you will pay for Covered Benefits under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Trio ACO HMO Network**

This Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Benefits under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Benefits each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$2,000
Family coverage	$2,000: individual
	$4,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Benefits.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Trio+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$10/visit	
Teladoc Health consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Medical nutrition therapy, not related to diabetes	$0	
Infertility Services		
Physician or surgeon services in an Outpatient Facility	$0	
Artificial Inseminations limited to 6 per lifetime	$0	
Oocyte (egg) retrieval limited to 3 per lifetime		
• Ambulatory Surgery Center	$0	
• Outpatient Department of a Hospital	$0	
In vitro fertilization (IVF)	$0	
Embryo transfer		
• Ambulatory Surgery Center	$0	
• Outpatient Department of a Hospital	$0	
Cryopreservation limited to 1 year of storage per lifetime for each of the following: sperm, reproductive tissue, oocytes (eggs), and embryos	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Abortion and abortion-related services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Emergency Services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$100/visit	
Emergency room Physician services	$0	
Urgent care center services	$10/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$100/transport	
Outpatient Facility services		
Ambulatory Surgery Center	$0	
Outpatient Department of a Hospital: surgery	$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$0	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	$0	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$0	
• Outpatient Department of a Hospital	$0	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*		
Office location	$10/visit	
Outpatient Department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$10/visit	
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0	
Hemophilia home infusion services *Includes blood factor products.*	$0	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*		
Freestanding SNF	$0	
Hospital-based SNF	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$10/visit	
• Medical nutrition therapy	$10/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health or Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$10/visit	
Teladoc Health mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$0	
Residential Care	$0	

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Benefits under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Benefits subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Benefits from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Benefits for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Benefits are Received:

Each time you receive multiple Covered Benefits, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Benefits during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Introduction

Welcome! We are happy to have you as a Member of our Blue Shield of California (Blue Shield) health plan.

At Blue Shield, our mission is to ensure all Californians have access to high-quality health care at an affordable price. To achieve this mission, we pledge to:

- Provide personal service to you that is worthy of our family and friends; and
- Build deep, trusting relationships with providers to improve the quality of health care and lower the cost.

A Blue Shield health plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on your plan.

About this Evidence of Coverage

The Combined Evidence of Coverage and Disclosure Form (Evidence of Coverage) describes the health care coverage that is provided under the Group Health Service Contract (Contract) between Blue Shield and your Employer. The Evidence of Coverage tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your plan;
- Which services are not covered under your plan;
- When and how you must get prior authorization for certain services; and
- Important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Evidence of Coverage includes a *Summary of Benefits* section that lists your Cost Share for Covered Benefits. Use this summary to figure out what your cost will be when you receive care.

Please read this Evidence of Coverage carefully. Some topics in this document are complex. For additional explanation on these topics, you may be directed to a section at the back of the Evidence of Coverage called *Other important information about your plan*. Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Evidence of Coverage in your files for future reference.

Tables and images

In this Evidence of Coverage, you will see the following tables and images to highlight key information:

This table provides easy access to information
Phone numbers and addresses
Answers to commonly-asked questions
Examples to help you better understand important concepts

This box tells you where to find additional information about a specific topic.

This box alerts you to information that may require you to take action.

"You" means the Member

In this Evidence of Coverage, "you" or "your" means any Member enrolled in the plan, including the Subscriber and all Dependents. "Your Employer" means the Subscriber's Employer.

Capitalized words have a special meaning

Some words and phrases in this Evidence of Coverage may be new to you. Key terms with a special meaning within this Evidence of Coverage are capitalized in this document and explained in the *Definitions* section.

About this plan

This is a Health Maintenance Organization (HMO) plan. In an HMO plan, you have access to a network of providers who collaborate to bring you personal, efficient care. You will choose a Primary Care Physician (PCP) who is your first point of contact and manages your care. Your PCP is part of a group of Physicians called a Medical Group. Your PCP can refer you to Participating Providers in your Medical Group for specialized care and assist with other care needs. See the *How to access care* section for information about Participating Providers.

This plan offers a limited choice of Medical Groups and Hospitals. You should review the list of providers in the Trio HMO Physician and Hospital Directory before enrolling in this plan. In some areas, you may need to choose your PCP from within one Medical Group.

How to contact customer service

If you have questions at any time, we're here to help. This plan has a special customer service program called Shield Concierge. A Shield Concierge representative can help you find a doctor, pay a bill, transfer medical records, talk to a registered nurse or

pharmacist, and more. Blue Shield's website and app are also useful resources. Visit blueshieldca.com or use the Blue Shield mobile app to:

- Download forms;
- View or print a temporary ID card;
- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

Blue Shield contact information appears at the bottom of every page.

Contacting Customer Service

If you need information about	*You should contact*
Accolade Care virtual primary care, mental health care, and Specialist care, including scheduling an appointment	Accolade Care Customer Service: (844) 560-6649
Medical Benefits	Shield Concierge: 1-855-829-3566 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Mental Health or Substance Use Disorder services, including prior authorization	Mental Health Customer Service: (877) 263-9952 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540

If you are hearing impaired, you may contact Customer Service through Blue Shield's toll-free TTY number: 711.

Your bill of rights

	As a Blue Shield Member, you have the right to:
1	Receive information about your rights and responsibilities.
2	Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
3	Make recommendations regarding the Plan's member rights and responsibilities policy.
4	Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
5	Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
6	Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
7	Receive timely and geographically accessible health care.
8	Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
9	Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
10	Certain accommodations for your disability, including: • Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility. • Full and equal access, as other members of the public, to medical facilities. • Extra time for visits if you need it. • Taking your service animal into exam rooms with you.
11	Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
12	Receive considerate and courteous care and be treated with respect and dignity.
13	Receive culturally competent care, including but not limited to: • Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions. • To be addressed by your preferred name and pronoun.

	As a Blue Shield Member, you have the right to:
14	Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
15	Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
16	A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
17	Receive health care coverage even if you have a pre-existing condition.
18	Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
19	Receive certain Preventive Health Services, including many without a co-pay, Coinsurance, or Deductible.
20	Have no annual or lifetime dollar limits on basic health care services.
21	Keep eligible Dependent(s) on your Plan.
22	Be notified of an unreasonable rate increase or change, as applicable.
23	Protection from illegal balance billing by a Health Care Provider.
24	Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
25	Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
26	Ask most Health Care Providers for information regarding who has received your personal health information.
27	Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
28	Have your medical information related to sensitive services protected.
29	Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
30	Have an interpreter who speaks your language at all points of contact when you receive health care services.
31	Have an interpreter provided at no cost to you.

	As a Blue Shield Member, you have the right to:
32	Receive written materials in your preferred language where required by law.
33	Have health information provided in a usable format if you are blind, deaf, or have low vision.
34	Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
35	Have an Advanced Health Care Directive.
36	Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
37	File a complaint, grievance, or appeal in your preferred language about: • Your Plan or Health Care Provider. • Any care you receive, or access to care you seek. • Any covered service or benefit decision that your Plan makes. • Any improper charges or bills for care. • Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions. • Not meeting your language needs.
38	Know why your Plan denies a service or treatment.
39	Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
40	Ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

Your responsibilities

	As a Blue Shield Member, you have the responsibility to:
1	Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
2	Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
3	Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
4	To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
5	Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
6	Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
7	Timely pay any premiums, copayments, and charges for non-covered services.
8	Notify your Plan as soon as reasonably possible if you are billed inappropriately.

How to access care

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

Health care professionals and facilities

This plan covers care from Participating Providers within your Medical Group.

If you are assigned to the Accolade Care virtual Medical Group, some services may be provided outside of your Medical Group. Not all medical conditions can be appropriately treated through virtual services. Your Participating Provider will identify any condition that requires treatment by an in-person provider and will refer you to in-person care as appropriate. Your Cost Share for the in-person care will be the same as the amount due to a virtual Participating Provider.

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

Participating Providers

Participating Providers have a contract with a Medical Group in this plan's network. With an HMO plan, there is generally no coverage for services from providers outside of your Medical Group.

If a provider leaves your Medical Group, you will not have coverage for services received from that provider. See the *Continuity of Care* section for more information on how to continue treatment with a Non-Participating Provider.

Visit ***blueshieldca.com*** or use the Blue Shield mobile app and click on ***Find a Doctor*** for a list of your plan's ***Participating Providers***.

Non-Participating Providers

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges as payment in full for Covered Benefits. Except for Emergency Services, Urgent Services, services received at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, and services provided by a 988 center, Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, this plan does not cover services from Non-Participating Providers.

Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Benefits may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above the Allowed Charges, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants
Physician Specialists, such as dermatologists and cardiologists
Physical, occupational, and speech therapists
Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers
Hospitals
Freestanding labs and radiology centers
Ambulatory Surgery Centers

Your Primary Care Physician

In an HMO plan, you are required to have a Primary Care Physician (PCP). Your PCP is your first point of contact for any health concern and for Preventive Health Services. Your PCP will also manage other aspects of your care, including:

- Prior authorization requests;
- Health education;
- Specialist referrals;
- Hospital admissions; and
- Hospice program admissions.

Selecting a PCP

Blue Shield will initially choose a PCP for you, but you can change this selection. You do not need to choose the same PCP for each Member in your family. To change your PCP, visit blueshieldca.com.

PCPs may be virtual or in-person:

- General practitioners;

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

Your PCP must be a Participating Provider. If your PCP leaves this plan's network, Blue Shield will choose a new PCP for you and notify you. Your new PCP will either be virtual or in-person based on your prior PCP. You will be assigned to an Accolade Care virtual PCP if your prior PCP was a virtual Participating Provider or you will be assigned to an in-person PCP if your prior PCP was an in-person Participating Provider.

Your relationship with your PCP

The relationship you have with your PCP is an important element of an HMO plan. Your PCP has a unique holistic view of your medical care. He or she will know your health history, which may help identify problems before they become serious. Your PCP will work with you to ensure you receive Medically Necessary professional services and accommodate your preferences to the extent possible. This relationship also allows for more open communication between you and your PCP. If you are unable to establish a satisfactory relationship with your PCP, you can choose a new one.

Your Medical Group

Some PCPs contract directly with Blue Shield, but most are part of a Medical Group. Medical Groups:

- Share administrative responsibilities with your PCP;
- Work with your PCP to authorize Covered Benefits;
- Ensure that a full panel of Specialists are available to you; and
- Have admission arrangements with Blue Shield's contracted Hospitals within the Medical Group Service Area.

If you are assigned to an Accolade Care virtual PCP, your integrated care team will assist your PCP with administrative responsibilities and coordination of care.

Your PCP and Medical Group are listed on your ID card.

Changing your Medical Group

You can change your Medical Group by visiting blueshieldca.com. If your PCP is not part of your new Medical Group, you will also have to select a new PCP.

Changes to your Medical Group are effective on the first day of the month after Blue Shield approves the change, including changes to the Accolade Care virtual Medical Group through your member portal online. If you are assigned to the Accolade Care virtual Medical Group and you would like to make an immediate change, call Shield Concierge to request the change. Once the change is effective, authorizations for any services by your old Medical Group are no longer valid. If you still need these services, they must be reauthorized by your new Medical Group.

You may not change Medical Groups while you are admitted to the Hospital or in the third trimester of pregnancy. Any requested changes to your Medical Group in these situations will not be effective until the first day of the month after the date of your discharge from the Hospital or completion of postpartum care.

A change in Medical Group during an ongoing course of treatment may interrupt your care. Any requested changes to your Medical Group during an ongoing course of treatment requires an exception. Exceptions must be approved by a Blue Shield Medical Director and will be effective when medically appropriate to transfer care. Call Shield Concierge for more information.

Self-referral for obstetrical/gynecological (OB/GYN) services

You do not need a referral from your PCP for OB/GYN services as long as the obstetrician, gynecologist, or family practice Physician you see is in your Medical Group. Your Cost Share for OB/GYN services with that Physician will be the same as if you received those services from your PCP.

OB/GYN services are female reproductive and sexual health care services. OB/GYN services include Physician services related to:

- Family planning and contraception;
- Treatment during pregnancy;
- Diagnosis and treatment of disorders of the female reproductive system and genitalia;
- Treatment of disorders of the breast; and
- HIV testing.

Specialist referrals

You have two options if you need to see a Specialist.

PCP referrals

This option requires a referral from your PCP to see most types of Specialist. Your PCP will refer you to a Specialist or other appropriate Participating Provider in your Medical Group. If you are assigned to the Accolade Care virtual Medical Group, Specialist services will be provided outside of your Medical Group. Your PCP will refer you to a virtual or in-person Participating Provider as needed. Not all medical conditions can be appropriately treated through virtual services. Your Accolade Care virtual PCP will identify any condition that requires treatment by an in-person provider and will refer you to in-person care as appropriate. Your Cost Share for the in-person care will be the same as the amount due to a virtual Participating Provider.

Self-referral to a Trio+ Specialist

With this option, you do not need a referral from your PCP to visit a Trio+ Specialist in your Medical Group. You can self-refer to a Trio+ Specialist for:

- An examination or other consultation; and
- In-office diagnostic procedures or treatment.

You cannot self-refer to a Trio+ Specialist for:

- Allergy testing;
- Endoscopic procedures;
- Advanced imaging, including CT, MRI, or bone density measurement;
- Injectables, chemotherapy, or other infusion Drugs, other than vaccines and antibiotics;
- Infertility services;
- Inpatient services or any services that result in a facility charge, except for routine X-ray and laboratory services; or
- Services for which the Medical Group routinely allows you to self-refer without authorization from your PCP.

If you are assigned to the Accolade Care virtual Medical Group, Specialist services will be provided outside of your Medical Group. You will need a referral from your PCP to see a Specialist.

Accolade

Blue Shield has contracted with Accolade, a Third Party Corporate Telehealth Provider, to provide telehealth (virtual) services and a telehealth technology platform. These virtual services are available to you if you select or if you are assigned to a virtual PCP in the Accolade Care Medical Group.

Benefits are available for ongoing primary care, mental health care, and Specialist care visits by phone or secure online video. Specialist care visits require a referral from your PCP. Some age restrictions apply. See the table below for age restrictions by service.

Integrated virtual care team

Benefits are provided through an integrated virtual care team that collaborates to manage and deliver health care, assist with some administrative tasks, and answer medical questions. The team includes your Primary Care Physician, mental health care provider, and a health coach.

Primary care

- On-going, routine care.
- Diagnosis and treatment of urgent concerns.
- PCPs can prescribe certain medications.
- Help with referrals to a virtual Specialist or in-person care as appropriate.
- Documentation of all care in the electronic medical record.
- Available to all Members, but a parent or guardian must be present for Members under age 18.

Mental health care

- Mental health visits with a marriage and family therapist (MFT) or a licensed clinical social worker (LCSW).
- Help directing you to a virtual Specialist or in-person care as appropriate in coordination with your PCP.
- Documentation of all care in the electronic medical record.

- Available to Members age 12 and older.

Health coach

- Assistance with scheduling.
- Assistance locating virtual Specialists or in-person care as appropriate in coordination with your PCP.
- Documentation of all care in the electronic medical record.
- Follow up to resolve questions.
- Available to all Members age 12 and older.

Specialist care

- Requires referral from your PCP.
- Diagnosis, treatment, and management of conditions by Specialists with the following specialties: allergy and immunology, cardiology, dermatology, dietary nutrition, endocrinology, gastroenterology, general surgery, HIV medicine, hepatology, infectious disease, nephrology, neurology, orthopedics, otolaryngology, physical medicine and rehabilitation, pulmonology, rheumatology, and urology.
- Specialists can prescribe certain medications.
- Help directing you to another virtual care provider or in-person care as appropriate in coordination with your PCP.
- Available for Members age 18 and older, except dermatologists, allergists, immunologists, and dietary nutritionists are available for Members age 12 and older.
- Documentation of all care in the electronic medical record.
- Members under age 18 require a parent or guardian be present.

Other program services

- Nurse triage with a registered nurse 24 hours a day, seven days a week to help you select appropriate care and to answer general health questions.
- Online tools such as appointment booking, flexible scheduling, prescription renewals, and messaging with your care team.
- Documentation of all care in the electronic medical record.

Not all medical conditions can be appropriately treated through virtual services. Your virtual PCP or Specialist will identify any condition that requires treatment by an in-person provider and will refer you to an in-person network provider as appropriate. Your Cost Share for the in-person care from a network provider will be the same as the amount due to a virtual network provider for the same service.

Call Shield Concierge for questions about virtual services or Participating Providers. You can also visit blueshieldca.com and click on Find a Doctor to access virtual Participating Providers.

ID cards

Blue Shield will provide the Subscriber and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at blueshieldca.com or on the Blue Shield mobile app.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice.

Continuity of care

Continuity of care may be available if:

- Blue Shield or the Medical Group no longer contracts with your Former Participating Provider for the services you are receiving;
- You are a newly-covered Member whose coverage choices do not include out-of-network Benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

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

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

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

Continuity of care with a Former Participating Provider

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

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
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 blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and may review your request for Medical Necessity.

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

See the *Your payment information* section for more information about the Allowed Charges.

Second medical opinion

You can ask your PCP for a referral to another provider for a second medical opinion in situations including but not limited to:

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;
- Your diagnosis is unclear;
- Your condition has not improved after completing the prescribed course of treatment;
- You need additional information before deciding on a treatment plan; or
- You have questions about your diagnosis or treatment plan.

Your Medical Group will work with you to arrange for a second medical opinion. If you are assigned to the Accolade Care virtual Medical Group, your PCP and the integrated care team will work with you to arrange for a second medical opinion from another virtual Participating Provider or from an in-person Participating Provider as necessary.

Who provides your second medical opinion	
If you want a second opinion on	***It will come from***

Who provides your second medical opinion	
A proposed treatment plan from your PCP	Another PCP in your Medical Group
A proposed treatment plan from a Specialist	A Participating Provider in the same or equivalent specialty

Care outside of California

If you need urgent or emergency medical care while traveling outside of California, you're covered. Blue Shield has relationships with health plans in other states, Puerto Rico, and the U.S. Virgin Islands through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care in those geographic areas.

For Members assigned to the Accolade Care virtual Medical Group, you can also access routine care or Urgent Services from your Medical Group while traveling outside of California. The Accolade Care Participating Provider must be licensed in the state you are visiting.

See the ***Out-of-area services*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Away from Home Care

You or your Dependent may be able to enroll in Away from Home Care when you are on an extended stay within the Service Area of another Blue Cross or Blue Shield plan outside of California. Away from Home Care may be available for Dependents who are full-time students, Dependents of Subscribers who are required by court order to provide coverage, and long-term travelers. For more information on the program and which states participate, visit blueshieldca.com or call the Blue Shield of California Away from Home Care coordinators at (800) 622-9402.

Emergency Services

If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition or a Psychiatric Emergency Medical Condition.

Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition or a Psychiatric Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the entire cost of that non-emergency service.

If you cannot find a Participating Provider

Your PCP will refer you to other providers in your Medical Group for the care you need. If these services cannot reasonably be obtained from a Participating Provider, you can ask your Medical Group for authorization to see a Non-Participating Provider. They will review your request for Medical Necessity, and if approved, your Medical Group will pay for Covered Benefits from the Non-Participating Provider. If you are assigned to the Accolade Care virtual Medical Group, you can ask your Accolade Care PCP for approval to see a Non-Participating Provider when services cannot reasonably be obtained from a Participating Provider. The Accolade Care PCP will coordinate with Blue Shield to review your request for Medical Necessity, and if approved, Blue Shield will pay for Covered Benefits from the Non-Participating Provider. You will only be responsible for the Participating Provider Cost Share. If the Medical Group cannot provide the necessary care, you can call Shield Concierge for help finding a Participating Provider who can provide the requested services.

Other ways to access care

For non-emergencies, it may be faster and easier to access care in one of the following ways. For more information, visit blueshieldca.com or use the Blue Shield mobile app.

Teladoc Health

Teladoc Health, a Third-Party Corporate Telehealth Provider, provides consultations by phone or secure online video. Teladoc Health general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc Health mental health consultations are available for Members age 13 and older. Members under age 13 may obtain telebehavioral health services for Mental Health or Substance Use Disorders from a Participating Provider. Teladoc Health is a supplemental service that is not intended to replace care from your PCP, or other Participating Provider, or your relationship with your PCP.

How to access Teladoc Health		
Teladoc Health service	***Ways to access***	***Availability***
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment
Mental health	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	7 a.m. to 9 p.m., 7 days a week by scheduled appointment only Consultations must be scheduled online and cannot be requested by phone

Telebehavioral health services

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

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

If you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your

Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.

Ambulatory Surgery Centers

Many of the more common, uncomplicated, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Evaluations and services under the CARE Act

Blue Shield covers the cost of developing an evaluation and the provision of all health care services for an enrollee when required or recommended pursuant to a CARE (Community Assistance, Recovery, and Empowerment) agreement or CARE plan approved by a court in accordance with the CARE Act. The evaluation and services, other than prescription Drugs, are covered at no charge whether they are provided by a Participating or Non-Participating Provider.

Timely access to care

Participating Providers agree to provide timely access to care. This means that when you call for an appointment, you will see your provider within a reasonable timeframe. Blue Shield's access standards are listed below.

When your appointment will occur	
Urgent appointments	***Appointment will occur***
Services that do not require prior authorization	Within 48 hours
Services that do require prior authorization	Within 96 hours
Non-urgent appointments	***Appointment will occur***
Primary Care Physician office visit	Within 10 business days
Specialist office visit	Within 15 business days
Mental or substance use disorder health provider (who is not a Physician) office visit	Within 10 business days

When your appointment will occur	
Follow-up appointments with a mental or substance use disorder health provider (who is not a Physician)	Within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing Mental Health or Substance Use Disorder condition
Other services to diagnose or treat a health condition	Within 15 business days
Phone inquiries	***Appointment will occur***
Access to a health care professional for phone triage or screening services by calling Shield Concierge	24 hours a day, seven days a week

Call Shield Concierge if you need help finding a Participating Provider or if a Participating Provider is not available. Please see the *If you cannot find a Participating Provider* section for more information.

Contact **Shield Concierge** to schedule ***interpreter services*** for your appointment. For more information about interpreter services, see the ***Language access services*** notice.

Health advice and education

Blue Shield provides several ways for you to get health advice and access to health education and wellness services. These resources are available to you at no extra cost.

NurseHelp 24/7SM

You can contact a registered nurse 24 hours a day, seven days a week through the NurseHelp 24/7SM program. Nurses are available to help you select appropriate care and answer questions about:

- Symptoms you are experiencing;
- Minor illnesses and injuries;
- Medical tests and medications;
- Chronic conditions; and
- Preventive care.

Call (877) 304-0504 or log in to your account at blueshieldca.com and use the chat feature to connect with a nurse. This service is free and confidential.

NurseHelp 24/7 SM is not meant to replace the advice and care you receive from your Physician or other health care professional.

LifeReferrals 24/7℠

The LifeReferrals 24/7 ℠ program offers you access to support services 24 hours a day, seven days a week, including assessments and referrals for consultations for health and psychosocial issues. Professional counselors can provide confidential telephone or in-person support by approved appointment. You are limited to three consultations with a professional counselor every six months.

This bundle of services also includes referrals, resources, and support for additional topics such as:

- Legal services;
- Financial counseling;
- Mediation;
- Child and family care;
- Adult and elder care;
- Chronic conditions and illnesses;
- Income tax preparation; and
- Identity theft assistance.

Call (800) 985-2405 to obtain services or access online tools and resources by visiting lifereferrals.com and using the code: "BSC". These services are free and confidential.

Health and wellness resources

Your Blue Shield coverage gives you access to a variety of health education and wellness services, such as:

- Prenatal and other health education programs;
- Healthy lifestyle programs to help you get more active, quit smoking, lower stress, and much more; and
- A health update newsletter.

Visit blueshieldca.com to explore these resources.

Medical management

Medical management can help you coordinate your care and treatment. It includes utilization management and care management. Blue Shield uses utilization management to help you and your providers identify the most appropriate and cost-effective way to use the Benefits of this plan. Care management and palliative care can help you access the care you need to manage serious health conditions and complex treatment plans.

For written information about ***Blue Shield's Utilization Management Program***, visit blueshieldca.com.

Prior authorization and PCP referrals

Coverage for most Benefits requires pre-approval from the Medical Group. This process is called prior authorization. Prior authorization requests are determined by Blue Shield. The requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. Your PCP will manage your prior authorization requests. If you are assigned to the Accolade Care virtual Medical Group, pre-approval will come from Blue Shield. Your Accolade Care PCP will coordinate with Blue Shield to review prior authorization requests. You do not need prior authorization for services, other than prescription Drugs, provided under a court-approved CARE agreement or CARE plan.

A referral from your PCP is usually required when you want to see a Specialist or other provider, but there are some exceptions. You do not need a referral for:

- Emergency Services;
- Urgent Services;
- Trio+ Specialist visits;
- OB/GYN services by an obstetrician, gynecologist, or family practice Physician within your Medical Group; and
- Office visits with your PCP or for outpatient Mental Health or Substance Use Disorder services with a Participating Provider.

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization from your Medical Group or from Blue Shield. Drugs dispensed by a Physician or Physician's office for outpatient use are not covered.

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

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

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical and Mental Health or Substance Use Disorder requests	Within five business days, but not to exceed seven calendar days
Expedited medical and Mental Health or Substance Use Disorder requests	Within 72 hours

Once a decision is made for routine Mental Health or Substance Use Disorder requests, a written notice will be sent to you and your provider within five calendar days. For urgent Mental Health or Substance Use Disorder requests, a written notice will be sent to you and your provider within 72 hours.

Expedited requests include urgent medical requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

While you are in the Hospital (inpatient utilization review)

When you are admitted to the Hospital, your stay will be monitored for continued Medical Necessity. If it is no longer Medically Necessary for you to receive an inpatient level of care, your Medical Group or Blue Shield will send a written notice to you, your provider, and the Hospital. If you choose to stay in the Hospital past the date indicated in this notice, you will be financially responsible for all inpatient charges after that date. Exceptions to inpatient utilization review include maternity and mastectomy care.

For maternity, the minimum length of an inpatient stay is 48 hours for a normal, vaginal delivery and 96 hours for a C-section. The provider and mother together may decide that a shorter length of stay is adequate.

For mastectomy, you and your provider determine the Medically Necessary length of stay after the surgery.

After you leave the Hospital (discharge planning)

You may still need care at home or in another facility after you are discharged from the Hospital. Your Medical Group will work with you, your provider, and the Hospital's discharge planners to determine the most appropriate and cost-effective way to provide this care.

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. A Blue Shield care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Shield Concierge. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and
- Identify community resources to lend support as you learn to manage a chronic health condition.

Alternative services may be offered when they are medically appropriate and only utilized when you, your provider, and Blue Shield mutually agree. The availability of these services is specific to you for a set period of time based on your health condition. Blue Shield does not give up the right to administer your Benefits according to the terms of this Evidence of Coverage or to discontinue any alternative services when they are no longer medically appropriate. Blue Shield is not obligated to cover the same or similar alternative services for any other Member in any other instance.

Managing a serious illness (palliative care services)

Blue Shield covers palliative care services if you have a serious illness. Palliative care provides relief from the symptoms, pain, and stress of a serious illness to help improve the quality of life for you and your family.

Palliative care services include access to Physicians and case managers who are specially trained to help you:

- Manage your pain and other symptoms;
- Maximize your comfort, safety, autonomy, and well-being;
- Navigate a course of care;
- Make informed decisions about therapy;
- Develop a survivorship plan; and
- Document your quality-of-life choices.

Your payment information

Paying for coverage

Your Employer is responsible for a monthly payment to Blue Shield for health care coverage for the Subscriber and any enrolled Dependents. This monthly payment is a Premium. Any amount the Subscriber must contribute to the Premium is set by your Employer.

The contract states the monthly Premiums for this plan for the Subscriber and any enrolled Dependents.

Paying for Covered Benefits

Your Cost Share is the amount you pay for Covered Benefits. It is your portion of the Blue Shield Allowed Charges.

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Benefits.

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Benefits provided or arranged by Blue Shield, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections. Covered Benefits provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them. If you are assigned to the Accolade Care virtual Medical Group and you are referred to an in-person Participating Provider, Blue Shield will pay the provider directly.

If there is a payment dispute between Blue Shield and a Participating Provider over Covered Benefits you receive, the Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the Allowed Charges. You are only required to pay your Cost Share for those services.

When you see a Participating Provider, you are responsible for your Cost Share.

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Benefits before Blue Shield begins payment. Blue Shield will pay for some Covered Benefits before you meet your Deductible.

Amounts you pay toward your Deductible count toward your Out-of-Pocket Maximum.

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for an individual Member and an entire Family.

If you have a Family plan, there is an individual Deductible within the Family Deductible. This means an individual family member can meet the individual Deductible before the entire Family meets the Family Deductible.

If you have an individual plan and you enroll a Dependent, your plan will become a Family plan. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

See the *Summary of Benefits* section for details on which Covered Benefits are subject to the Deductible and how the Deductible works for your plan.

Prior carrier Deductible credit

If you pay all or part of a Deductible for another Employer-sponsored health plan in the same Calendar Year you enroll in this plan, that amount will be applied to this plan's Deductible if:

- You were enrolled in an Employer-sponsored health plan with another carrier during the same Calendar Year this contract becomes effective and you enroll as of the original effective date of coverage under this contract;
- You were enrolled in another Blue Shield plan sponsored by the same Employer which this plan is replacing; or
- You were enrolled in another Blue Shield plan sponsored by the same Employer and you are transferring to this plan during open enrollment.

Copayment and Coinsurance

A Covered Benefit may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Benefit. A Coinsurance is a percentage of the Allowed Charges you pay for a Covered Benefit.

Your provider will ask you to pay your Copayment or Coinsurance at the time of service. For Covered Benefits that are subject to your plan's Deductible, you are also responsible for all costs up to the Allowed Charges until you reach your Deductible.

You will continue to pay the Copayment or Coinsurance for each Covered Benefit you receive until you reach your Out-of-Pocket Maximum.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Benefits in a Calendar Year. Your Cost Share includes Deductible,

Copayment, and Coinsurance, and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Benefits for the rest of the Calendar Year. If you want information about your Out-of-Pocket Maximum, you can call Shield Concierge.

If you have a Family plan, you will have a separate Out-of-Pocket Maximum for each individual Member and one for the entire Family.

If you have a Family plan, there is an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means an individual family member can meet the individual Out-of-Pocket Maximum before the entire Family meets the Family Out-of-Pocket Maximum.

If you have an individual plan and you enroll a Dependent, your plan will become a Family plan. Any amount you have paid toward the Out-of-Pocket Maximum for your individual plan will be applied to both the individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum for your new plan.

The following do not count toward your Out-of-Pocket Maximum:

- Charges for services that are not covered;
- Charges over the Allowed Charges; and
- Charges for services over any Benefit maximum.

You will continue to be responsible for these costs even after you reach your Out-of-Pocket Maximum.

See the *Summary of Benefits* section for details on how the Out-of-Pocket Maximum works for your plan.

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 Shield Concierge 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 Shield Concierge. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Benefits until you reach your Deductible. Once you reach your Deductible, Blue Shield will pay the Allowed Charges for Covered Benefits, minus your Copayment or Coinsurance amounts, until you reach your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Benefits. Exceptions are described above.

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

Example: You visit the doctor for a sore throat. You have received Covered Benefits throughout the year and have already met your $500 Deductible. However, you have not yet met your $1,000 Out-of-Pocket Maximum.

Deductible: **$500**

Amount paid to date toward Deductible: **$500**

Out-of-Pocket Maximum: **$1,000**

Amount paid to date toward Out-of-Pocket Maximum: **$500**

Participating Provider Copayment: **$30**

Blue Shield Allowed Charges for the doctor's visit: **$100**

	Participating Provider
You pay	**$30** ($30 Copayment)
Blue Shield pays	$70 (Allowed Charges minus your Cost Share)
Total payment to the doctor	$100 (Allowed Charges)

In this example, because you have already met your Deductible, you are only responsible for the Participating Provider Copayment.

Claims for Emergency or Urgent Services

If you receive Emergency or Urgent Services from a Non-Participating Provider, you may be required to pay the charges in full and submit a claim to Blue Shield to request

reimbursement. Blue Shield will process your claim within 30 calendar days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information. Once the missing information is received, Blue Shield will have 30 calendar days to process your claim. Blue Shield may send the payment to the Subscriber or directly to the Non-Participating Provider.

Claim forms are available at blueshieldca.com. Please submit your claim form and medical records within one year of the service date.

See the *Out-of-area services* section in the *Other important information about your plan* section for more information on claims for Emergency or Urgent Services outside of California.

Your coverage

This section explains eligibility and enrollment for this plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this plan

To be eligible for coverage as a Subscriber, you must meet all of your Employer's eligibility requirements and complete any waiting period established by your Employer.

Dependent eligibility

To be eligible for coverage as a Dependent, you must:

- Be listed on the enrollment form completed by the Subscriber; and
- Be the Subscriber's spouse, Domestic Partner, or be under age 26 and the child of the Subscriber, spouse, or Domestic Partner.
    - For the Subscriber's spouse to be eligible for this plan, the Subscriber and spouse must not be legally separated.
    - For the Subscriber's Domestic Partner to be eligible for this plan, the Subscriber and Domestic Partner must have a registered domestic partnership (except as otherwise permitted by your Employer).
    - "Child" includes a stepchild, newborn, child placed for adoption, child placed in foster care, and child for whom the Subscriber, spouse, or Domestic Partner is the legal guardian. It does not include a grandchild unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
    - A child age 26 or older can remain enrolled as a Dependent if the child is disabled, incapable of self-support because of a mental or physical disability, and chiefly dependent on the Subscriber for economic support.
        - The Dependent child's disability must have begun before the period he or she would become ineligible for coverage due to age.
        - Blue Shield will send a notice of termination due to loss of eligibility 90 days before the date coverage will end.
        - The Subscriber must submit proof of continued eligibility for the Dependent at Blue Shield's request. Blue Shield may not request this information again for two years after the initial determination. Blue Shield may request this information no more than once a year after that. The Subscriber's failure to provide this information could result in termination of a Dependent's coverage.

Enrollment and effective dates of coverage

As the Subscriber, you can enroll in coverage for yourself and your Dependents during your initial enrollment period, your Employer's annual open enrollment period, or if you qualify for a special enrollment period.

You are eligible for coverage as a Subscriber on the day following the date you complete any applicable waiting period established by your Employer. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan

are not available before the effective date of coverage. This Contract has a 12-month term that begins on your Employer's effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. You will have an annual open enrollment period set by your Employer. Your Employer will notify its Employees of the open enrollment period each year.

Special enrollment period

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Qualifying Event.

A special enrollment period gives you at least 30 days from a Qualifying Event to apply for or change coverage for yourself or your Dependents. See the *Special enrollment period* section for more information. You should notify your Employer as soon as possible if you experience a Qualifying Event that requires a change in your coverage.

Common Qualifying Events
Change in Dependents
Loss of coverage under another employer health plan or other health insurance
Loss of eligibility in a government program

For a complete list of Qualifying Events, see ***Special enrollment period*** on page 80 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Employee or Dependents qualify for a special enrollment period, coverage will begin no later than the 1st of the month following the date Blue Shield receives the request for special enrollment from your Employer.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

- Newborn;
- Adopted child;
- Child placed for adoption;
- Child placed in foster care; or
- Child for whom the Subscriber, spouse, or Domestic Partner is the court-appointed legal guardian.

For coverage to continue beyond 31 days for a newborn, adopted child, or child placed for adoption, the Subscriber must ***notify the Employer within 31 days*** of birth, adoption, or placement for adoption and request that the child be added as a Dependent.

If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, both are eligible for Dependent Benefits. You may enroll a child as a Dependent of either or of both parents.

A child will be considered adopted for the purpose of Dependent eligibility when one of the following happens:

- The child is legally adopted;
- The child is placed for adoption and there is evidence of the Subscriber, spouse, or Domestic Partner's right to control the child's health care; or
- The Subscriber, spouse, or Domestic Partner is granted legal authority to control the child's health care.

The child's eligibility as a Dependent will continue while waiting for a legal decree of adoption unless the child is removed from the Subscriber, spouse, or Domestic Partner's home before the decree is issued.

Plan changes

Blue Shield has the right to change the Benefits and terms of this plan as the law permits. This includes, but is not limited to, changes to:

Terms and conditions;
Benefits;
Cost Shares;
Premiums; and
Limitations and exclusions.

Blue Shield will give your Employer written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. Your Employer is responsible for letting you know of any changes. Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

Coordination of benefits

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits determines which plan will pay first when both plans have responsibility for paying the

medical claim. For more information, see the *Coordination of benefits, continued* section.

When coverage ends

Your coverage will end if:

- Your Employer cancels or does not renew coverage;
- The Subscriber cancels coverage; or
- Blue Shield cancels or rescinds coverage.

There is no right to receive the Benefits of this plan after coverage ends, except as described in the *Extension of Benefits,* *Continuity of care,* and *Continuation of group coverage* sections.

If your Employer cancels coverage

Your Employer may cancel coverage at any time. To cancel coverage, Your Employer must provide written notice to Blue Shield and its Employees.

If the Subscriber cancels coverage

If the Subscriber decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by your Employer.

Reinstatement

If the Subscriber voluntarily cancels coverage, the Subscriber can contact the Employer for reinstatement options.

If Blue Shield cancels coverage

Blue Shield can cancel coverage if:

- You are no longer eligible for coverage in this plan;
- Your Employer fails to meet Blue Shield's Employer eligibility, participation, and contribution requirements;
- Blue Shield terminates this plan; or
- You or your Employer commit fraud or intentional misrepresentation of material fact.

Blue Shield will provide 30 days' advance written notice of cancellation of coverage to your Employer if your Employer fails to meet Blue Shield's Employer eligibility, participation, and contribution requirements. It is your Employer's responsibility to provide a copy of the notice to its Employees.

Cancellation for Employer's nonpayment of Premiums

Blue Shield can cancel coverage if your Employer does not pay the required Premiums in full and on time. Your Employer is responsible for all Premiums during the term of coverage, including the 30-day grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the date coverage ends.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

Blue Shield may cancel or rescind your coverage if you, your Dependent, or your Employer commit fraud or intentional misrepresentation of material fact. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation, Rescission or Nonrenewal. Rescission voids the Contract as if it never existed. Cancellation is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.

Extension of Benefits

If you become Totally Disabled while covered under this plan and continue to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits directly related to the condition, illness, or injury causing your Total Disability until one of the following occurs:

- 12 months from the effective date of termination;
- The date you are no longer Totally Disabled; or
- The date on which a replacement carrier provides coverage for your Total Disability.

Your extension of Benefits will be subject to all the limitations and restrictions of this plan.

You will not receive an extension of Benefits unless a Physician provides Blue Shield with written certification of your Total Disability within 90 days of the effective date of termination. After that, the Physician must continue to provide written certification of your Total Disability at reasonable intervals Blue Shield determines.

Continuation of group coverage

Please examine your options carefully before declining this coverage.

You can continue coverage under this group plan when your Employer is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, or the California Continuation Benefits Replacement Act (Cal-COBRA).

Your benefits under the group continuation of coverage provisions will be identical to the Benefits you would have received as an active Employee if the qualifying event had not occurred. Any changes in the coverage available to active Employees will also apply to group continuation coverage.

COBRA

You may elect to continue group coverage under this plan if you would otherwise lose coverage because of a COBRA qualifying event. Please contact your Employer for detailed information about COBRA continuation coverage, including eligibility, election of coverage, and Premiums.

Cal-COBRA

If you enroll in COBRA and exhaust the time limit for COBRA group continuation coverage, you may be able to continue your group coverage under Cal-COBRA for a combined total (COBRA plus Cal-COBRA) of 36 months.

You will not be eligible for benefits under Cal-COBRA if, at the time of the Cal-COBRA qualifying event, you are entitled to benefits under Medicare or are covered under another group health plan. Medicare entitlement means that you are eligible for Medicare benefits and enrolled in Part A only.

Cal-COBRA qualifying event

A Cal-COBRA qualifying event is an event that, except for the election of continuation coverage, would result in a loss of coverage for the Subscriber or eligible Dependents:

- The death of the Subscriber;
- Termination of the Subscriber's employment (except termination for gross misconduct which is not a qualifying event);
- Reduction in hours of the Subscriber's employment;
- Divorce or legal separation of the Subscriber from the covered spouse;
- Termination of the Subscriber's domestic partnership with a covered Domestic Partner;
- Loss of Dependent status by a covered Dependent;
- The Subscriber's entitlement to Medicare (This only applies to a covered Dependent); and
- With respect to any of the above, such other qualifying event as may be added to Cal-COBRA.

A child born to or placed for adoption with a covered Subscriber or Domestic Partner during the Cal-COBRA group coverage continuation period may be immediately added as a Dependent provided the Employer is properly notified of the birth or placement for adoption, and the child is enrolled within 31 days of the birth or placement for adoption.

Notification of a qualifying event

You are responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a Dependent's loss of Dependent status under this plan. This notice must be given within 60 days of the date of the qualifying event. Failure to provide such notice within 60 days will disqualify you from receiving continuation coverage under Cal-COBRA.

Your Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the qualifying event.

When Blue Shield is notified that a qualifying event has occurred, Blue Shield will, within 14 days, provide you with written notice of your right to continue group coverage under this plan. You must then give Blue Shield notice in writing of your election of continuation coverage within 60 days of the date of the notice of your right to continue group coverage, or the date coverage terminates due to the qualifying event, whichever is later. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If you do not notify Blue Shield within 60 days, your coverage will terminate on the date you would have lost coverage because of the qualifying event.

If this plan replaces a previous group plan that was in effect with your Employer, and you had elected Cal-COBRA continuation coverage under the previous plan, you may continue coverage under this plan for the balance of your Cal-COBRA eligibility period. To begin Cal-COBRA coverage with Blue Shield, you must notify us within 30 days of the date you were notified of the termination of your previous group plan.

Duration and extension of group continuation coverage

COBRA enrollees who reach the maximum coverage period available under COBRA may elect to continue coverage under Cal-COBRA for a combined maximum period of 36 months from the date continuation of coverage began under COBRA. You must notify Blue Shield of your Cal-COBRA election at least 30 days before COBRA termination. Your Cal-COBRA coverage will begin immediately after the COBRA coverage ends.

You must exhaust all available COBRA coverage before you can become eligible to continue coverage under Cal-COBRA.

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this plan for up to a maximum of 36 months, regardless of the type of qualifying event.

In no event will continuation of group coverage under COBRA, Cal-COBRA, or a combination of COBRA and Cal-COBRA be extended for more than 36 months

from the date of the qualifying event that originally entitled you to continue your group coverage under this plan.

Payment of Premiums

Premiums for continuing coverage will be 110 percent of the applicable group Premium rate, except if you are eligible to continue Cal-COBRA coverage beyond 18 months because of a Social Security disability determination. In that case, the Premiums for months 19 through 36 will be 150 percent of the applicable group Premium rate.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premiums must be paid within 45 days of the date you provided written notification to Blue Shield of your election to continue coverage and must be sent to Blue Shield by first-class mail or other reliable means. You must pay the entire amount due within the 45-day period or you will be disqualified from Cal-COBRA continuation coverage.

Effective date of the continuation of group coverage

If your initial group continuation coverage is Cal-COBRA rather than COBRA, your Cal-COBRA coverage will begin on the date your coverage under this plan would otherwise end due to a qualifying event. Your coverage will continue for up to 36 months unless terminated due to an event described in the *Termination of group continuation coverage* section.

Termination of group continuation coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

- Termination of the Contract (if your Employer continues to provide any group benefit plan for Employees, you may be able to continue coverage with another plan);
- Failure to pay Premiums in full and on time to Blue Shield. Coverage will end as of the end of the period for which Premiums were paid;
- You become covered under another group health plan;
- You become entitled to Medicare; or
- You commit fraud or deception in the use of the services of this Plan.

Continuation of group coverage while on leave

Employers are responsible to ensure compliance with state and federal laws regarding leaves of absence, including the California Family Rights Act, the Family and Medical Leave Act, the Uniformed Services Employment and Re-employment Rights Act, and Labor Code requirements for Medical Disability.

Family leave

The California Family Rights Act of 1991 and the federal Family & Medical Leave Act of 1993 allow you to continue your coverage under this plan while you are

on family leave. Your Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Military leave

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) allows you to continue your coverage under this plan while you are on military leave. If you are planning to enter the Armed Forces, you should contact your Employer for information about your rights under the (USERRA).

Your Benefits

This section describes the Benefits your plan covers. They are listed in alphabetical order so they are easy to find.

Blue Shield provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the medical management section; and
- The terms, conditions, limitations, and exclusions of this Evidence of Coverage.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. Blue Shield's medical management helps your provider ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

See the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Benefits.

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
- Preparation and provision of allergy serum; and
- Allergy serum injections.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services and Emergency Medical Services programs

Benefits are available for ambulance services provided by a licensed ambulance or psychiatric transport van.

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and

- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

Ambulance services are covered at the Participating Provider Cost Share, even if you receive services from a Non-Participating Provider.

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

Benefits do not include:

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

Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits

Benefits are available for routine patient care when you have been accepted into an Approved Clinical Trial for treatment of cancer or a Life-Threatening disease or condition. A Life-Threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

The clinical trial must have therapeutic intent and the treatment must meet one of the following requirements:

- Your Participating Provider determines that your participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by you; or
- You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate.

Coverage for routine patient care received while participating in a clinical trial requires prior authorization. Routine patient care is care that would otherwise be covered by the plan if those services were not provided in connection with an Approved Clinical Trial. The *Summary of Benefits* section lists your Cost Share for Covered Benefits. These Cost Share amounts are the same whether or not you participate in a clinical trial. Routine patient care does not include:

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. 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.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including continuous blood glucose monitors and those designed to help the visually impaired, and all related necessary supplies;
- Insulin pens, syringes, pumps, and all related necessary supplies;
- Blood and urine testing strips and tablets;
- Lancets and lancet puncture devices;
- Podiatric footwear and devices to prevent or treat diabetes-related complications;
- Medically Necessary foot care; and
- Visual aids, excluding eyewear and video-assisted devices, designed to help the visually impaired with proper dosing of insulin.

Your plan also covers the replacement of a covered item after the expiration of its life expectancy.

Benefits do not include:

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

Self-management training and medical nutrition therapy

Benefits are available for outpatient training, education, and medical nutrition therapy when directed or prescribed by your Physician. These services can help you manage your diabetes and properly use the devices, equipment, and supplies available to you. With self-management training, you can learn to monitor your condition and avoid frequent hospitalizations and complications.

Diagnostic X-ray, imaging, pathology, laboratory, and other testing services

Benefits are available for imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury.

Benefits include:

Basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography;

Advanced diagnostic radiological and nuclear imaging, including CT, PET, MRI, and MRA scans;

- COVID-19 diagnostic testing, screening testing, and related healthcare services. Medical Necessity requirements do not apply for COVID-19 screening testing;
- Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month, subject to a maximum reimbursement of $12 per test. See the *Claims* section for information about how to submit a claim for repayment for this Benefit;
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of your disease or condition to guide treatment decisions. Benefits must be prior authorized;
- Clinical pathology services;
- Laboratory services;
- Other areas of non-invasive diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, cardiovascular, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

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

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

Dialysis Benefits

Benefits are available for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting, or in your home.

Benefits include:

- Renal dialysis;
- Hemodialysis;
- Peritoneal dialysis; and
- Self-management training for home dialysis.

Benefits do not include:

- Comfort, convenience, or luxury equipment; or
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

- Mobility devices, such as wheelchairs;
- Peak flow meter for the self-management of asthma;
- Glucose monitor including continuous blood glucose monitor, and all related necessary supplies for the self-management of diabetes;
- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;
- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price;
- Pasteurized donor human milk; and
- Breast pumps.

Benefits do not include:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers;
- Exercise equipment;
- Home testing devices and monitoring equipment except for over-the-counter at-home COVID-19 tests and sexually transmitted disease home testing kits;
- Routine maintenance, repair, or replacement of DME due to loss or misuse, except when authorized;
- Self-help or educational devices;
- Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other speech or language assistance devices, except as specifically listed;
- Wigs;
- Adult eyewear;
- Video-assisted visual aids for diabetics;
- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes. Self-applied continuous blood glucose monitors are also covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

Orthotic equipment and devices

Benefits are available for orthotic equipment and devices you need to perform Activities of Daily Living. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Benefits include:

- Shoes only when permanently attached to orthotic devices;

- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for postoperative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts 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;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities;
- Orthopedic shoes and other supportive devices for the feet, except as listed;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Prosthetic equipment and devices

Benefits are available for prosthetic appliances and devices used to replace a part of your body that is missing or does not function, and related supplies.

Benefits include:

- Tracheoesophageal voice prosthesis (e.g. Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- Supplies necessary for the operation of prostheses;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other speech or language assistance devices, except as listed;
- Dental implants;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Emergency Benefits

Benefits are available for Emergency Services received in the emergency room of a Hospital or other emergency room licensed under state law. The Emergency Benefit

also includes Hospital admission when inpatient treatment of your Emergency Medical Condition or Psychiatric Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition or a Psychiatric Emergency Medical Condition at any Hospital, even if it is a Non-Participating Hospital.

If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

Benefits include:

- Physician services;
- Emergency room facility services; and
- Inpatient Hospital services to stabilize your Emergency Medical Condition or Psychiatric Emergency Medical Condition.

Emergency Services and follow-up health care treatment are provided without a Cost Share for Members treated following a rape or sexual assault for the first nine months after the Member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

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

After your condition stabilizes

Once your Emergency Medical Condition or Psychiatric Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

- Be released from the emergency room if you do not need further treatment;
- Receive additional inpatient treatment at the Participating Hospital; or
- Transfer to a Participating Hospital for additional inpatient treatment if you received treatment of your Emergency Medical Condition or Psychiatric Emergency Medical Condition at a Non-Participating Hospital.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. 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 delivery, including the placenta. Post-stabilization care is Medically Necessary treatment

received after the treating Physician determines the Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized.

If you are admitted to the Hospital for Emergency Services, you should notify your PCP within 24 hours or as soon as possible after your condition has stabilized.

Family planning and Infertility Benefits

Family planning

Benefits are available for family planning services without illness or injury.

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling;
- Follow-up services related to contraceptive Drugs, devices, products, and procedures, including but not limited to management of side effects, counseling for continued adherence, and device removal;
- Voluntary tubal ligation and other similar sterilization procedures; and
- Vasectomy services and procedures.

Family planning services may also be covered under the Preventive Health Services Benefit and the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

Infertility Benefits

Benefits are provided for the diagnosis and treatment of Infertility, including professional, Hospital, Ambulatory Surgery Center, and related services to diagnose and treat Infertility.

Benefits include:

- Artificial insemination, including intrauterine insemination (IUI);
- Oocyte (egg) retrievals;
- In vitro fertilization (IVF);
- Unlimited embryo transfers;
- Cryopreservation storage of sperm, reproductive tissue, oocytes, embryos;
- Intracytoplasmic sperm injection (ICSI) for male factor Infertility;
- Preimplantation genetic testing; and
- Treatment of low sperm count.

Self-administered Drugs prescribed to induce fertilization are covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit

Benefits do not include:

- Gamete intrafallopian Transfer (GIFT) procedure;
- Zygote intrafallopian Transfer (ZIFT);

- Services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
- Services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure; and
- Microsurgical Epididymal Sperm Aspiration (MESA), Percutaneous Epididymal Sperm Aspiration (PESA), and Testicular Sperm Aspiration (TESA), except for the treatment of low sperm count.

Fertility preservation services

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

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

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

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

Benefits are available from a Participating home health care agency for diagnostic and treatment services received in your home under a written treatment plan approved by your Physician.

Benefits include:

- Intermittent home care for skilled services from:
  - Registered nurses;
  - Licensed vocational nurses;
  - Physical therapists;
  - Occupational therapists;
  - Speech and language pathologists;
  - Licensed clinical social workers; and
  - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

- Fewer than seven days per week; or
- Daily, for fewer than eight hours per day, up to 21 days.

Benefits are limited to a visit maximum as shown in the *Summary of Benefits* section for home health agency visits. For this Benefit, coverage includes:

- Up to four visits per day, two hours maximum per visit, with a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or licensed clinical social worker. A visit of two hours or less is considered one visit. Nursing visits cannot be combined to provide Continuous Nursing Services.
- Up to four hours maximum per visit with a Home Health Aide. A visit of four hours or less is considered one visit.

Benefits do not include:

- Continuous Nursing Services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These services may also be described as "shift care" or "private duty nursing."

Home infusion and injectable medication services

Benefits are available through a Participating home infusion agency for home infusion, enteral, and injectable medication therapy.

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Administration of parenteral nutrition formulations and solutions;
- Administration of enteral nutrition formulas and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

See the *PKU formulas and special food products* section for more information.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include:

- Insulin;
- Insulin syringes; and
- Services related to hemophilia, which are described below.

Hemophilia home infusion services

Benefits are available for hemophilia home infusion products and services for the treatment of hemophilia and other bleeding disorders. Benefits must be prior authorized and provided in the home or in an infusion suite managed by a Participating Hemophilia Home Infusion Provider.

Benefits include:

- 24-hour service;
- Home delivery of hemophilia infusion products;
- Blood factor product;
- Supplies for the administration of blood factor product; and
- Nursing visits for training or administration of blood factor products.

There is no Calendar Year visit maximum for hemophilia home infusion agency services.

Benefits do not include:

- In-home services to treat complications of hemophilia replacement therapy; or
- Self-infusion training programs, other than nursing visits to assist in administration of the product.

Most Participating home health care and home infusion agencies are not Participating Hemophilia Home Infusion Providers. A list of Participating Hemophilia Home Infusion Providers is available at blueshieldca.com.

Hospice program services

Benefits are available through a Participating Hospice Agency for specialized care if you have been diagnosed with a terminal illness with a life expectancy of one year or less. When you enroll in a Hospice program, you agree to receive all care for your terminal illness through the Hospice Agency. Hospice program enrollment is prior authorized for a specified period of care based on your Physician's certification of eligibility. The period of care begins the first day you receive Hospice services and ends when the specified timeframe is over or you choose to receive care for your terminal illness outside of the Hospice program.

The authorized period of care is for two 90-day periods followed by unlimited 60-day periods, depending on your diagnosis. Your Hospice care continues through to the next period of care when your Physician recertifies that you have a terminal illness. The Hospice Agency works with your Physician to ensure that your Hospice enrollment continues without interruption. You can change your Participating Hospice Agency only once during each period of care.

A Hospice program provides interdisciplinary care designed to ease your physical, emotional, social, and spiritual discomfort during the last phases of life, and support your primary caregiver and your family. Hospice services are available 24 hours a day through the Hospice Agency.

While enrolled in a Hospice program, you may continue to receive Covered Benefits that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;

- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

- Services provided by a Non-Participating Hospice Agency, except in certain circumstances where there are no Participating Hospice Agencies in your area and services are prior authorized.
- Domiciliary care, which is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
- Custodial care, which is assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

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

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
    - Semiprivate Hospital room, or private room if Medically Necessary;
    - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
    - General and specialized nursing care; and
    - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
    - Operating, recovery, labor and delivery, and other specialized treatment rooms;
    - Anesthesia, oxygen, medicines, and IV solutions;
    - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;

  - Dialysis services and supplies;
  - Blood and blood products;
  - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
  - Radiation therapy, chemotherapy, and associated supplies;
  - Therapy services, including physical, occupational, respiratory, and speech therapy;
  - Acute detoxification;
  - Acute inpatient rehabilitative services; and
  - Emergency room services resulting in admission.

Benefits do not include:

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

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

Medical treatment of the teeth, gums, jaw joints, and jaw bones

Benefits are available for outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues.

Benefits include:

- Treatment of odontogenic and non-odontogenic oral tumors (benign or malignant);
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;
- Surgical treatment of temporomandibular joint syndrome (TMJ);
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:
  - The Member is younger than seven years old; or
  - The Member is developmentally disabled; or

- The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

- Diagnostic dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ;
- Preventive dental services such as cleanings, space maintainers, and habit control devices except as covered under the Preventive Health Services Benefit;
- Periodontal care such as hard and soft tissue biopsies and routine oral surgery including removal of teeth;
- Reconstructive or restorative dental services such as crowns, fillings, and root canals;
- Orthodontia for any reason other than cleft palate repair;
- Dental implants for any reason other than cleft palate repair;
- Any procedure to prepare the mouth for dentures or for the more comfortable use of dentures;
- 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; or
- Fluoride treatments for any reason other than preparation of the oral cavity for radiation therapy or for Benefits covered under Preventive Health Services.

Mental Health or Substance Use Disorder Benefits

Blue Shield administers Mental Health or Substance Use Disorder services for Members in California. See the *Out-of-area services* section for an explanation of how Benefits are administered for out-of-state services.

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

A Participating Provider must get prior authorization from Blue Shield for all non-emergency Hospital admissions for Mental Health or Substance Use Disorder services, and for certain outpatient Mental Health or Substance Use Disorder Services. See the *Medical management* section for more information about prior authorization.

To find a Participating Provider, visit blueshieldca.com and click on Find a Doctor.

If you are unable to schedule an appointment with a Participating Provider for Mental Health or Substance Use Disorder services, contact Mental Health Customer Service. They will help you either schedule an appointment with a Participating Provider, or select a Non-Participating Provider in your area within five calendar days and contact you regarding available appointment times. For any Covered Benefits, you will be responsible for no more than the Cost Share for using a Participating Provider. Mental Health Customer Service may work with you to transition to a Participating Provider when one becomes available.

Upon request to Mental Health Customer Service, and at no cost to you, Mental Health Customer Service will provide the clinical review criteria and any training material or

resources used to conduct utilization reviews for Mental Health or Substance Use Disorder benefits and services.

Office visits

Benefits are available for professional office visits, including Physician office visits, for the diagnosis and treatment of Mental Health or Substance Use Disorders in an individual, Family, or group setting.

Benefits are also available for telebehavioral health online counseling services, psychotherapy, and medication management with a Mental Health or Substance Use Disorder provider.

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health or Substance Use Disorders. You can receive these other outpatient services in a facility, office, home, or other non-institutional setting.

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

Other Outpatient Mental Health and Substance Use Disorder Services include, but are not limited to:

- Behavioral Health Treatment – 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 Blue Shield to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Behavioral Health Crisis Services and other services provided by a 988 center, a Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, regardless of whether the service is rendered by a Participating or Non-Participating Provider;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression;
- Intensive Outpatient Program – outpatient care for Mental Health or Substance Use Disorders when your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services that are at a minimum 20 hours per week;
- Psychological Testing – testing to diagnose a mental health condition; and
- Transcranial magnetic stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Benefits do not include:

- Treatment for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health or Substance Use Disorders in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when you do not require acute inpatient care.

Medically Necessary inpatient substance use disorder detoxification is covered under the Hospital services Benefit.

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

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

Physician and other professional services

Benefits are available for services performed by a Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition.

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications that must be administered by a Health Care Provider;
- Administration of radiopharmaceutical medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person; and

- Teladoc Health general medical consultations.

See the *Mental Health or Substance Use Disorder Benefits* section for information on Mental Health or Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for conditions other than diabetes. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to receive medical nutrition therapy as long as your treatment is Medically Necessary. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

Benefits are available for formulas and special food products if you are diagnosed with phenylketonuria (PKU). The items must be part of a diet prescribed and managed by a Physician or appropriately-licensed Health Care Provider.

Benefits include:

- Enteral formulas;
- Parenteral nutrition formulations; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods or pre-packaged foods including shakes, snack bars, used by the general population;
- Additives such as thickeners, enzyme products; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

Benefits are available for the diagnosis and treatment of conditions of the foot, ankle, and related structures. These services, including surgery, are generally provided by a licensed doctor of podiatric medicine.

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;
- Elective newborn circumcision within 18 months of birth; and
- Abortion and abortion-related services, including preabortion and followup services.

See the *Diagnostic X-ray, imaging, pathology, and laboratory services* and *Preventive Health Services* sections for information about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
    - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
    - Screening for HPV;
    - Screening for osteoporosis; and
    - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit. A Physician or other Health Care Provider's order must be provided for coverage;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;

  Adverse Childhood Experiences screenings;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. See the *Family planning Benefits* section for more information.

If there is a new recommendation or guideline in any of the resources described above, Blue Shield will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the plan year that

begins after that year. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

Visit ***blueshieldca.com/preventive*** for more information about ***Preventive Health Services***.

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to:
    - Improve function; or
    - Create a normal appearance to the extent possible;
- Dental and orthodontic surgery services directly related to cleft palate repair; and
- Surgery and surgically-implanted prosthetic devices in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance;
- Reconstructive Surgery when there is a more appropriate procedure that will be approved; or
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

In accordance with the WHCRA, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered for either breast to restore and achieve symmetry following a mastectomy, and for the treatment of the physical complications of a mastectomy, including lymphedemas. For coverage of prosthetic devices following a mastectomy, see the *Durable medical equipment* section. Medically Necessary services will be determined by your attending Physician in consultation with you.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

Rehabilitative and habilitative services

Benefits are available for outpatient rehabilitative and habilitative services. Rehabilitative services help to restore the skills and functional ability you need to perform Activities of Daily Living when you are disabled by injury or illness. Habilitative

services are therapies that help you learn, keep, or improve the skills or functioning you need for Activities of Daily Living.

These services include physical therapy, occupational therapy, and speech therapy. Your Physician or Health Care Provider must prepare a treatment plan. Treatment must be provided by an appropriately-licensed or certified Health Care Provider. You can continue to receive rehabilitative or habilitative services as long as your treatment is Medically Necessary.

Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity.

See the *Hospital services* section for information about inpatient rehabilitative Benefits.

See the *Home health services* and *Hospice program services* sections for information about coverage for rehabilitative and habilitative services provided in the home.

Physical therapy

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

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

Occupational therapy

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

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

Speech therapy

Speech therapy is used to develop, improve, and maintain vocal or swallowing skills that have not developed according to established norms or have been impaired by

a diagnosed illness or injury. Benefits are available for outpatient speech therapy for the treatment of:

- A communication impairment;
- A swallowing disorder;
- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the *Summary of Benefits* section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

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

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

Transplant services

Benefits are available for tissue and kidney transplants and special transplants.

Tissue and kidney transplants

Benefits are available for facility and professional services provided in connection with human tissue and kidney transplants when you are the transplant recipient.

Benefits include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special transplants

Benefits are available for special transplants only if:

- The procedure is performed at a special transplant facility contracting with Blue Shield, or if you access this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield; and
- You are the recipient of the transplant.

Special transplants are:

- Human heart transplants;
- Human lung transplants;
- Human heart and lung transplants in combination;
- Human liver transplants;
- Human kidney and pancreas transplants in combination;
- 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;
- Pediatric human small bowel transplants; and
- Pediatric and adult human small bowel and liver transplants in combination.

Donor services

Transplant Benefits include coverage for donation-related services for a living donor, including a potential donor, or a transplant organ bank. Donor services must be directly related to a covered transplant for a Member of this plan.

Donor services include:

- Donor evaluation;
- Harvesting of the organ, tissue, or bone marrow; and
- Treatment of medical complications for 90 days after the evaluation or harvest procedure.

Travel expense reimbursement for transplant services

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

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

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

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

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

questions about travel expense reimbursements, you should consult with your tax advisor.

You will be assigned a case manager who can help you coordinate your health care services and submit your travel expense reimbursement forms. See the *Using your Benefits effectively (care management)* section for more information on care management. For additional questions, contact Blue Shield Customer Service.

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center, during an after-hours office visit or through Accolade if you are assigned to the Accolade Care virtual Medical Group. You can access urgent care instead of going to the emergency room if you have a medical condition that is not Life-Threatening but prompt care is needed to prevent serious deterioration of your health.

If you need to visit an urgent care center and you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.

See the Out-of-area services section for information on urgent care services outside California.

Exclusions and limitations

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

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

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

	General exclusions and limitations
1	Acupuncture Services. This Plan does not cover acupuncture services, except as described in the Acupuncture and Chiropractic services rider if selected by your Employer as an optional Benefit, or as required by law.
2	Chiropractic Services. This Plan does not cover chiropractic services, except as described in the Acupuncture and Chiropractic services or Chiropractic services rider if selected by your Employer as an optional Benefit, or as required by law.
3	Clinical Trials. This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in the *Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits* section or as required by law. Coverage of Approved Clinical Trials does not include the following: • The investigational drug, item, or service itself. • Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member. • Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law. • Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor. This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental or Investigational services independent review process as described in this EOC in the *Independent Medical Review* section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in the *California Department of Managed Health Care review* section.
4	Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or

General exclusions and limitations

	alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. This exclusion does not apply to the following: • Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages. • Reconstructive surgery as described in this EOC in the *Reconstructive Surgery Benefits* section. • For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the *Reconstructive Surgery Benefits* section.
5	Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law. This exclusion does not apply to the following: • Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals. • Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care. • Custodial care provided in a healthcare facility.
6	Dental Services. This Plan does not cover dental services or supplies, except as described in this EOC in the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections or as required by law.
7	Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in this EOC in the *PKU formulas and special food products* section or as required by law.
8	Disposable Supplies for Home Use. This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections, or as required by law.
9	Experimental or Investigational services.

General exclusions and limitations

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

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

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

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

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

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

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

Qualifications

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

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

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

General exclusions and limitations

	4. You have been denied coverage by the Plan for the recommended or requested service. 5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered. External, Independent Review Process If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. DMHC's Independent Medical Review (IMR) This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in the *Independent Medical Review* section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the *California Department of Managed Health Care review* section.
10	Vision Care. This Plan does not cover Vision Services, except as described in this EOC in the *Prosthetic equipment and devices* section or as required by law.
11	Hearing Aids. This Plan does not cover hearing aids, except as described in the Hearing aid services rider if selected by your Employer as an optional Benefit, or as required by law.
12	Immunizations. This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.
13	Non-licensed or Non-certified Providers. This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in the *Mental Health or Substance Use Disorder Benefits* section or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

General exclusions and limitations	
14	Private Duty Nursing. This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in the *Hospice program services* section or as required by law.
15	Personal or Comfort Items. This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
16	Reversal of Voluntary Sterilization. This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
17	Surrogate Pregnancy. This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.
18	Therapies. This Plan does not cover the following physical and occupational therapies, except as described in this EOC in the *Rehabilitative and habilitative services* section or as required by law: • Massage therapy, unless it is a component of a treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; and • Vocational, educational, recreational, art, dance, music, or reading therapy.
19	Routine Physical Examination. The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.
20	Travel and Lodging. This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in the *Ambulance services* section, as otherwise described in this EOC in the *Transplant services* sections, or as required by law.
21	Weight Control Programs and Exercise Programs. This Plan does not cover weight control programs and exercise programs, except as described in this EOC in the *Diabetes care services* section or as required by law.

Grievance process

Blue Shield has a formal grievance process to address any complaints, disputes, requests for reconsideration of health care coverage decisions made by Blue Shield, or concerns with the quality of care you received from a provider. Blue Shield will receive, review, and resolve your grievance within the required timeframes.

Submitting a grievance

If you have a question about your Benefits or any action taken by Blue Shield, your first step is to make an inquiry through Shield Concierge. If Shield Concierge is not able to fully address your concerns, you can then submit a grievance or ask the Shield Concierge representative to submit one for you. If Blue Shield denies authorization or coverage for health care services, you can appeal the denial and Blue Shield will reconsider your request.

You have 180 days after a denial or other incident to submit your grievance to Blue Shield. Your provider, or someone you choose to represent you, can also submit a grievance on your behalf.

The fastest way to submit a grievance is online at blueshieldca.com. You can also submit the form by mail or begin the grievance process by calling Shield Concierge.

Where to mail grievances

Type of grievance	*Address*
Medical Benefits, Mental Health or Substance Use Disorder services, and prescription Drug Benefits if selected as an optional Benefit by your Employer.	Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762

Once Blue Shield receives your grievance, we will send a written acknowledgment within five calendar days.

Blue Shield will resolve your grievance and provide a written response within 30 calendar days. The response will explain what action you can take if you are not satisfied with how your grievance is resolved.

If your Employer selected the optional Prescription Drug Benefits Rider, and Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may request an external exception request review. Blue Shield will ensure a decision within 72 hours. Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, or when you are experiencing severe pain.

Blue Shield will make a decision within three calendar days for expedited grievance requests related to medical Benefits and Mental Health or Substance Use Disorder services.

Once a decision is made, Blue Shield will notify you and your provider as soon as possible to accommodate your condition.

California Department of Managed Health Care review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-829-3566** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

If you feel Blue Shield improperly cancels, rescinds, or does not renew coverage for you or your Dependents, you can submit a request for review to Blue Shield or to the Director of the California Department of Managed Health Care. Any request for review submitted to Blue Shield will be treated as an expedited grievance request.

Independent Medical Review

You may be eligible for an Independent Medical Review if your grievance involves a claim or service for which coverage was denied on the grounds that the service is:

- Not Medically Necessary; or
- Experimental or Investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996).

You can apply to the Department of Managed Health Care (DMHC) for an Independent Medical Review of the denial. For a Medical Necessity denial, you must first submit a grievance to Blue Shield and wait for at least 30 days before requesting an Independent Medical Review. However, if the request qualifies for an expedited review as described above, or if it involves a determination that the requested service is Experimental or Investigational, you may request an Independent Medical Review as

soon as you receive a notice of denial from Blue Shield. The DMHC's application for Independent Medical Review is included with your appeal outcome letter.

The DMHC will review your application. If the request qualifies for Independent Medical Review, the DMHC will select an independent review organization to conduct a clinical review of your medical records. You can submit additional records for consideration as well. There is no cost to you for this Independent Medical Review. You and your provider will receive copies of the Independent Medical Review determination. The decision of the independent review organization is binding on Blue Shield. If the reviewer determines that the requested service is clinically appropriate, Blue Shield will arrange for the service to be provided or the disputed claim to be paid.

The Independent Medical Review process is in addition to any other procedures or remedies available to you to resolve coverage disputes. It is completely voluntary. You are not required to participate in the Independent Medical Review process, but if you do not, you may lose your statutory right to pursue legal action against Blue Shield regarding the disputed service.

ERISA review

If your Employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your Employer-sponsored plan may have other voluntary alternative dispute resolution options, such as mediation.

Other important information about your plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document and is part of the contractual agreement between the Subscriber and Blue Shield.

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 41 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when an eligible Subscriber or Dependent can enroll in, or change enrollment in, a health plan. The special enrollment period is 30 days following the date of a Qualifying Event except as otherwise specified below. The following are examples of Qualifying Events. For complete details and a determination of eligibility for special enrollment, please consult your Employer.

- Loss of eligibility for coverage, including the following:
    - The eligible Employee or Dependent loses coverage under another Employer health benefit plan or other health insurance and meets all of the following requirements:
        - The Employee or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time the Employee was initially offered enrollment under this Plan;
        - If required by the Employer, the Employee certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that the Employee was given notice that such certification was required and that failure to comply could result in later treatment as a Late Enrollee;
    - The Employee or Dependent was eligible for coverage under the Healthy Families Program or Medi-Cal and such coverage was terminated due to loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage;
    - The eligible Employee or Dependent loses coverage due to legal separation, divorce, loss of dependent status, death of the Employee, termination of employment, or reduction in the number of hours of employment;
    - In the case of coverage offered through an HMO, loss of coverage because the eligible Employee or Dependent no longer resides, lives, or works in the Service Area (whether or not within the choice of the

individual), and if the previous HMO coverage was group coverage, no other benefit package is available to the Employee or Dependent;
    - Termination of the employer health plan or contributions to Employee or Dependent coverage;
    - Exhaustion of COBRA group continuation coverage; or
- The Employee or Dependent is eligible for coverage under the Healthy Families Program or Medi-Cal premium assistance program, provided that enrollment is within 60 days of the notice of eligibility for these premium assistance programs;
- A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit plan. The health plan shall enroll a Dependent child effective the first day of the month following presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party or the Employee, as described in Sections 3751.5 and 3766 of the Family Code; or
- An eligible Employee acquires a Dependent through marriage, establishment of domestic partnership, birth, or placement for adoption. Applies to both the Employee and the Dependent.

Cancellation for Employer's nonpayment of Premiums

Premium grace period

After payment of the first Premium, your Employer has a 30-day grace period from the due date to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. Coverage will continue through the grace period. However, if your Employer does not pay all outstanding Premiums within the grace period, coverage will end the day following the 30-day grace period. Your Employer will be liable for all Premiums owed, even if coverage is canceled. This includes Premiums for coverage during the 30-day grace period. Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the day coverage ends.

Out-of-area services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you access services outside of California, you may obtain care from one of two kinds of providers. Most providers are participating providers and contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Some providers are non-participating providers because they don't contract with the Host Blue. Blue Shield's payment practices in both instances are described in this section.

The Blue Shield Trio HMO plan provides limited coverage for health care services received outside of California. Out-of-Area Covered Health Care Services are

restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Arrangement unless the services and out of state provider are authorized by Blue Shield.

See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Arrangements

Emergency Services

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

BlueCard® Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Evidence of Coverage. 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.

The BlueCard® Program enables you to obtain Out-of-Area Covered Health Care Services outside of California, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance, and Deductible amounts, if any, as stated in the *Summary of Benefits*.

When you receive Out-of-Area Covered Health Care Services outside of California and the claim is processed through the BlueCard® Program, the amount you pay for covered health care services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed charges for your Out-of-Area Covered Health Care Services; or
- The negotiated price that the Host Blue makes available to Blue Shield.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your 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.

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to fully-insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee as part of the claim charges passed on to you. Claims for covered Emergency Services are paid based on the Allowed Charges as defined in this Evidence of Coverage.

Non-participating providers outside of California

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

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

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

Blue Shield Global® Core

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

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider

information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global® Core claim

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

Limitation for duplicate coverage

Medicare

Blue Shield will provide Benefits before Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws); or
- You are eligible for Medicare solely due to end-stage renal disease during the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare.

Blue Shield will provide Benefits after Medicare when:

- You are eligible for Medicare due to age, if the Subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

When Blue Shield provides Benefits after Medicare, your combined Benefits from Medicare and Blue Shield may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You do not have to pay any Blue Shield Deductibles, Copayments, or Coinsurance.

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, Blue Shield will pay the reasonable value or the Allowed Charges for Covered Benefits you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or the Allowed Charges for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and Blue Shield will equal but not be more than what Blue Shield would pay if you were not eligible for Benefits under that coverage. Blue Shield will provide Benefits based on the reasonable value or the Allowed Charges.

Exception for other coverage

A Participating Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this plan.

If you recover from a third party the reasonable value of Covered Benefits received from a Participating Provider, the Participating Provider is not required to accept the fees paid by Blue Shield as payment in full. You may be liable to the Participating Provider for the difference, if any, between the fees paid by Blue Shield and the reasonable value recovered for those services.

Reductions – third-party liability

If you are injured or become ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the plan and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for services provided to you on a fee-for-service basis from any recovery (defined below) obtained by or on your behalf, from or on behalf of the third party responsible for the injury or illness, and you must agree to the provisions below. In addition, if you are injured and no other person is responsible but you receive (or are entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, you must agree to the following provisions. Notwithstanding the foregoing, no coverage is provided under the Plan for services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance, or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for Benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay you or your representatives. For purposes of this provision, your representatives include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is Blue Shield's right of recovery.

- Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery you receive as a result of the injury or illness. This includes any amount awarded to you or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party or third-party insurer, related to the illness or injury (the "Recovery"), whether or not you have been "made whole" by the Recovery. The amount Blue Shield seeks as restitution, reimbursement, or other available remedy will be calculated in accordance with California Civil Code Section 3040.
- Blue Shield will not reduce its share of any Recovery unless, in the exercise of our discretion, Blue Shield agrees in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. You must not take any action that may prejudice Blue Shield's right of recovery.
- You must tell Blue Shield promptly if you have made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for. You must seek recovery of Blue Shield's payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of your claim in order to be reimbursed to the full amount of Benefits Blue Shield has paid or will pay.

Blue Shield may request that you sign a reimbursement agreement consistent with this provision. Your failure to comply with the above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

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

IF THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"), YOU ARE ALSO REQUIRED TO DO THE FOLLOWING:

- Ensure that any recovery is kept separate from and not comingled with any other funds or your general assets;
- Agree in writing that the portion of any recovery required to satisfy the lien or other right of recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield; and
- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

Coordination of benefits, continued

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable

expenses. The coordination of benefits rules also determine which group health plan is primary and prevent delays in benefit payments. Blue Shield follows the rules for coordination of benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group health plans:

- When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering you as an Employee will provide its benefits before the plan covering you as a Dependent.
- Coverage for Dependent children:
    - When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
    - When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:
        - The plan of the custodial parent;
        - The plan of the stepparent; then
        - The plan of the non-custodial parent.
- If the above rules do not apply, the plan which has covered you for the longer period of time is the primary plan. There may be exceptions for laid-off or retired Employees.
- When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.
- Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

These coordination of benefits rules do not apply to the programs included in the *Limitation for Duplicate Coverage* section.

Services not charged

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

General provisions

Independent contractors

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful

acts, or omissions of any person providing services, including any Physician, Hospital, or other Health Care Provider or their employees.

Assignment

The Benefits of this plan may not be assigned without the written consent of Blue Shield. Participating Providers are paid directly by Blue Shield or the Medical Group. When you are authorized to receive Covered Benefits from a Non-Participating Provider, Blue Shield, at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider.

Plan interpretation

Blue Shield shall have the power and authority to construe and interpret the provisions of this plan, to determine the Benefits of this plan, and to determine eligibility to receive Benefits under the Contract. Blue Shield shall exercise this authority for the benefit of all Members entitled to receive Benefits under this plan.

Public policy participation procedure

Blue Shield allows Members to participate in establishing the public policy of Blue Shield. Such participation is not to be used as a substitute for the grievance process.

Recommendations, suggestions or comments should be submitted in writing to:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: (510) 607-2065

Please include your name, address, phone number, Subscriber number, and group number with each communication. Please state the public policy issue clearly. Submit all relevant information and reasons for the policy issue with your letter.

Public policy issues will be heard as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes.

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

Access to information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this plan and the Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary

authorizations) and to cooperate by providing Blue Shield with information in the Member's possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without the Member's consent, except as otherwise permitted or required by law.

Right of recovery

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

Definitions

Advanced Health Care Directive	Means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.
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.
Allowed Charges	• For a Participating Provider: the amounts a Participating Provider agrees to accept as payment from Blue Shield. • For a Non-Participating Provider: (1) the amounts paid by Blue Shield when services from a Non-Participating Provider are covered and are paid as a Reasonable and Customary amount, or (2) if applicable, the amount determined under state and federal law.
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
Appropriately Qualified Health Care Provider	Means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial	Means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life Threatening disease or condition that meets at least one of the following:
	• The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
	  ○ The National Institutes of Health.
	  ○ The federal Centers for Disease Control and Prevention.
	  ○ The Agency for Healthcare Research and Quality.

	○ The federal Centers for Medicare and Medicaid Services. ○ A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs. ○ A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. ○ One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review: ▪ The United States Department of Veteran Affairs. ▪ The United States Department of Defense. ▪ The United States Department of Energy. • The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration. • The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.
ASH Participating Provider	A Physician or Health Care Provider under contract with ASH Plans to provide Covered Benefits to Members.
Behavioral Health Crisis Services	The continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, Mobile Crisis Teams, and crisis receiving and stabilization services.
Behavioral Health Treatment (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or

	autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Benefits)	Means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.
Blue Shield of California	California Physicians' Service, d/b/a Blue Shield of California, is a California not-for-profit corporation, licensed as a health care service plan. It is referred to throughout this Evidence of Coverage as Blue Shield.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.
Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Coinsurance	The percentage amount that a Member is required to pay for Covered Benefits after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Benefits after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Benefits (Benefits)	Means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

Deductible	The Calendar Year amount you must pay for specific Covered Benefits before Blue Shield pays for Covered Benefits pursuant to the Contract.
Dependent	The spouse, Domestic Partner, or child of an eligible Employee, who is determined to be eligible. • A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber. • A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Evidence of Coverage. • A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, 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. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

Domestic Partner	An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements:
	• Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;
	• The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
	• The partners are:
	  ○ not currently married to someone else or a member of another domestic partnership, and
	  ○ not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
	• Both partners are capable of consenting to the domestic partnership; and
	• The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If

	permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however, the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code). The domestic partnership is deemed created on the date when both partners meet the above requirements.
Emergency Medical Condition	Means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: • Placing the patient's health in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.
Emergency Services and Care (Emergency Services)	Means: • medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or • an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.
Employee	An individual who meets the eligibility requirements set forth in the Contract between Blue Shield and the Employer.
Employer (Contractholder)	Any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 101 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Evidence of Coverage	Means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.
Experimental Services (Experimental)	Means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.
Family	The Subscriber and all enrolled Dependents.

Former Participating Provider	A Former Participating Provider is a provider of services to the Member under any of the following conditions:
	• A provider who is no longer available to you as a Participating Provider, but at the time of the provider's contract termination with Blue Shield, you were receiving Covered Benefits from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
	• A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Benefits from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
	• A provider who is a Participating Provider with Blue Shield but no longer available to you as a Participating Provider because:
	  ○ The Employer has terminated its contract with Blue Shield; and
	  ○ The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider in its network; and
	  ○ At the time of the Employer's contract termination you were receiving Covered Benefits from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.

Generally Accepted Standards of Mental Health 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: • Peer-reviewed scientific studies and medical literature; • Clinical practice guidelines and recommendations of nonprofit health care provider professional associations; • Specialty societies and federal government agencies; and • Drug labeling approved by the U.S. Food and Drug Administration.
Group Health Service Contract (Contract)	The contract for health coverage between Blue Shield and the Employer (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.
Health Care Provider	Means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish Covered Benefits.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia. A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria: • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.

Independent Medical Review (IMR)	Means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.
Infertility	• A licensed Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility in paragraph (3); • A person's inability to reproduce either as an individual or with their partner without medical intervention; or • The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.
Intensive Outpatient Program	An outpatient treatment program for Mental Health or Substance Use Disorders that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.
Inter-Plan Arrangements	Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Investigational Services (Investigational)	Means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but: • Testing is not complete; and • The efficacy and safety of such services in human subjects are not yet established; and • The service is not in wide usage.

Late Enrollee	An eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the date a written request for coverage is made or at the Employer's next open enrollment period.
Life-Threatening	Means either or both of the following: • Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted. • Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
Medical Group	An organization of Physicians who are generally located in the same facility and provide Benefits to Members, or an independent practice association (a group of Physicians in individual offices who form an organization to contract, manage, and share financial responsibilities for providing Benefits to Members).
Medical Group Service Area	The geographic area served by the Medical Group.
Medically Necessary (Medical Necessity)	Means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following: • In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care. • Clinically appropriate in terms of type, frequency, extent, site, and duration. • Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.
Member	Means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.
Mental Health or Substance Use Disorder(s)	Means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases

	or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
Mobile Crisis Team	A multidisciplinary team of trained behavioral health professionals who provide Behavioral Health Crisis Services in the least restrictive setting 24 hours a day, 7 days a week, 365 days per year.
Non-Participating (Non-Participating Provider)	Any provider who does not participate in this plan's network and does not contract with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Benefits. Also referred to as an out-of-network provider.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health or Substance Use Disorders, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Service Area.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Benefits each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services that are at a minimum 20 hours per week.
Participating Hospice or Participating Hospice Agency	An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits.
Participating (Participating Provider)	A provider who participates in this plan's network and has an agreement to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Benefits. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician. Your PCP will provide your primary care and refer, authorize, supervise, and coordinate the provision of your Benefits. If your PCP is an Accolade Care virtual PCP, your PCP will coordinate with Blue Shield to review prior authorization requests.
Psychiatric Emergency Medical Condition	Means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
Psychological Testing	Testing to diagnose a mental health condition when referred by a Participating Provider providing Mental Health or Substance Use Disorder Benefits.
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
Reasonable and Customary	In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable

	state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider. Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits or if applicable, the amount determined under state and federal law.
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: • Improve function; or • Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.
Seriously Debilitating	Means diseases or conditions that cause major irreversible morbidity.
Service Area	Means the geographic area designated by the plan within which a plan shall provide health care services.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and

	• Other designated as appropriate.
Standard Fertility Preservation Services	Means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
Subacute Care	Skilled Nursing or skilled 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 that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Subscriber	An eligible Employee who is enrolled and maintains coverage under the Contract.
Third-Party Corporate Telehealth Provider	A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.
Total Disability (Totally Disabled)	In the case of an Employee, or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity. In the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.
Trans-Inclusive Health Care	Means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Vision Services	Services or materials related to orthoptics, vision training, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
Urgent Services	Those Covered Benefits rendered outside of the Medical Group Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Medical Group Service Area.

Notices about your plan

This Evidence of Coverage constitutes only a summary of the health plan. The health plan Contract must be consulted to determine the exact terms and conditions of coverage.

Notice about this group health plan: Blue Shield makes this health plan available to Employees through a contract with the Employer. The Contract includes the terms in this Evidence of Coverage, as well as other terms. A copy of the Contract is available upon request. A Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage. The *Summary of Benefits* sets forth your Cost Share for Covered Benefits under this plan.

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as specifically provided under the *Extension of Benefits* section and, when applicable, the *Continuity of care* and *Continuation of group coverage* sections. Blue Shield may change Benefits during the term of coverage as specifically stated in this Evidence of Coverage. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

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

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

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

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

www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

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

Notice about Mental Health or Substance Use Disorder services: You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

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

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

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

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your plan and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or contact Shield Concierge to ensure that you can obtain the health care services you need.

Notice about Participating Providers: Blue Shield contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual agreement may include incentives to manage all services for Members in an appropriate manner consistent with the Contract. To learn more about this payment system, contact Shield Concierge.

The Trio HMO plan offers a limited selection of Medical Groups from which Members must choose, and a limited network of Hospitals. Except for Emergency Services, Urgent Services when the Member is out of the Medical Group Service Area, or when prior authorized, all services must be obtained through the Member's Primary Care Physician.

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

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

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

Please see the Health care professionals and facilities section for additional information.

Notice about Manifest MedEx participation: Blue Shield participates in the Manifest MedEx health information exchange (HIE). Blue Shield makes its Members' health information available to Manifest MedEx for access by their authorized Health Care Providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized Health Care Providers may securely access their patients' health information through the Manifest MedEx HIE to support the provision of care.

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

You have the right to direct Manifest MedEx not to share your health information with your Health Care Providers. Although opting out of Manifest MedEx may limit your Health Care Provider's ability to quickly access important health care information about you, your Blue Shield coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or Hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

If you do not wish to have your health care information displayed in Manifest MedEx, you should fill out the online form at manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142.

Notice about organ and tissue donation: Thousands of people in the United States need an organ or tissue transplant. Each person on the transplant waiting list faces death while waiting for an available organ or tissue.

Many Californians are eligible to become organ and tissue donors. To learn more about organ and tissue donation, or to register as a donor, visit Donor Network West (donornetworkwest.org) or Donate Life California (donatelifecalifornia.org). You may also call the nearest city's regional organ procurement agency for additional information.

Notice about confidentiality of personal and health information: Blue Shield protects the privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. Blue Shield will not disclose this information without authorization, except as permitted or required by state or federal law.

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Shield Concierge or by visiting blueshieldca.com.

Members who are concerned that Blue Shield may have violated their privacy rights, or who disagree with a decision Blue Shield made about access to their individually-identifiable personal information, may contact Blue Shield at:

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

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

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

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

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

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

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

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing

medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

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

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

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

Outpatient Prescription Drug Rider

Santa Clara Valley Water District
Effective January 1, 2026
HMO/POS

Santa Clara Valley Water District HMO Rx Plan Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$0

Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$10/prescription	
Tier 2 Drugs	$15/prescription	
Tier 3 Drugs	$30/prescription	
Tier 4 Drugs	20% up to $200/prescription	
Retail pharmacy prescription Drugs		
Per prescription, for a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$30/prescription	
Tier 2 Drugs	$45/prescription	
Tier 3 Drugs	$90/prescription	
Tier 4 Drugs	20% up to $600/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, for a 31-90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$20/prescription	
Tier 2 Drugs	$30/prescription	
Tier 3 Drugs	$60/prescription	

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Prescription Drug Benefits[3,4]	Your payment	
	When using a Participating Pharmacy[2]	CYPD[1] applies
Tier 4 Drugs	20% up to $400/prescription	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting https://www.blueshieldca.com/wellness/drugs/formulary#heading2.

Non-Participating Pharmacies. Drugs from Non-Participating Pharmacies are not covered except in emergency situations.

3 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

4 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic or Biosimilar Drug is available. If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

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

Notes

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

Retail pharmacy. You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

Prescription Drug Benefits

Benefits are available for outpatient prescription Drugs as described in this supplement. This Prescription Drug Benefit is separate from the medical Plan coverage. The Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Rider. However, the Calendar Year Out-of-Pocket Maximum, general provisions and exclusions of the Group Health Service Contract apply. Outpatient Prescription Drugs do not include Drugs used for hemophilia, blood or blood products and any Drugs which are not considered to be safe for self-administration. These products and Drugs may be covered under the Home health services, Home infusion and injectable medication services, Hospice program services, or Family Planning sections.

Outpatient prescription Drugs are self-administered Drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies that are prescribed and are not provided for use on an inpatient basis. Drugs also include diabetic testing supplies, self-applied continuous blood glucose monitors, and all related necessary supplies. Glucose monitors are also covered under the Durable medical equipment section of your Evidence of Coverage.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from a Participating Pharmacy, except as noted below. Drugs, items, and services that are not covered under this Benefit are listed in the *Exclusions and limitations* section.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization to be covered. The prior authorization process is described in the *Prior authorization/exception request process/step therapy* section. You or your Physician may request prior authorization from Blue Shield.

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

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

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

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

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

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of FDA-approved preferred Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs.

Blue Shield's Formulary is established and maintained by Blue Shield's Pharmacy and Therapeutics (P&T) Committee. This committee consists of Physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year.

Your Physician or Health Care Provider might prescribe a Drug even though it is not included in the Blue Shield Formulary.

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

Formulary Drug tiers	
Drug Tier	***Description***
Tier 1	• Most Generic Drugs or low cost preferred Brand Drugs
Tier 2	• Non-preferred Generic Drugs • Preferred Brand Drugs • Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
Tier 3	• Non-preferred Brand Drugs • Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost • Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	• Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than $600 (net of rebates) for a one-month supply

Visit ***blueshieldca.com/pharmacy***, use the Blue Shield mobile app, or contact Customer Service for more information on the ***Drug Formulary*** or to request a printed copy of the Formulary.

Obtaining outpatient prescription Drugs at a Participating Pharmacy

You must present a Blue Shield ID Card at a Participating Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. See the *Obtaining Specialty Drugs from a Network Specialty Pharmacy* section for more information. If you obtain Drugs at a Non-Participating Pharmacy, Blue Shield will deny the claim and will not pay anything toward the cost of the Drugs, unless they are for a covered emergency.

Visit **blueshieldca.com/pharmacy** or use the Blue Shield mobile app to locate a *retail Participating Pharmacy*.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

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

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

If you, your Physician, or your Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you must pay the difference in cost, plus the applicable tier Copayment or Coinsurance of the Brand Drug. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent or Biosimilar Drug, plus the applicable tier Copayment or Coinsurance of the Brand Drug. For example, you select Brand Drug A when there is an equivalent Generic Drug A or Biosimilar Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300, and the contracted rate for Generic Drug A or Biosimilar Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the applicable tier Copayment or Coinsurance. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility.

If you, your Physician, or your Health Care Provider believes the Brand Drug is Medically Necessary, you can request an exception to the difference in cost between the Brand Drug and Generic Drug equivalent or Biosimilar Drug through the Blue Shield prior authorization process. The request will be reviewed for Medical Necessity. If the request is approved, you pay only the applicable tier Copayment or Coinsurance.

Blue Shield created a Patient Review and Coordination (PRC) program to help reduce harmful prescription drug misuse and the potential for abuse. Examples of harmful misuse include obtaining an excessive number of prescription medications or obtaining very high doses of prescription opioids from multiple providers or pharmacies within a 90-day period. If Blue Shield

determines a Member is using prescription drugs in a potentially harmful, abusive manner, Blue Shield may, subject to certain exemptions and upon 90 days' advance notice, restrict a Member to obtaining all non-emergent outpatient prescriptions drugs at a single pharmacy home. This restriction applies for a 12-month period and may be renewed. The pharmacy home, a single Participating Pharmacy, will be assigned by Blue Shield or a Member may request to select a pharmacy home. Blue Shield may also require prior authorization for all opioid medications if sufficient medical justification for their use has not been provided. Members that disagree with their enrollment in the PRC program can file an appeal or submit a grievance to Blue Shield as described in the *Grievance process* section of your Evidence of Coverage. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Customer Service at the number listed on their Identification Card.

Obtaining extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy

You also have an option to receive up to a 90-day supply of prescription Drugs at a Participating Pharmacy when you take maintenance Drugs on a regular basis to treat an ongoing chronic condition. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed.

You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

Obtaining outpatient prescription Drugs at a Non-Participating Pharmacy in an emergency

When you receive Drugs from a Non-Participating Pharmacy for a covered emergency, you must pay for the prescription in full and then submit a claim form for reimbursement to:

Blue Shield of California
1606 Ave. Ponce de Leon
San Juan, PR 00909-4830

Blue Shield will reimburse you as shown on the Summary of Benefits, based on the price you paid for the Drugs.

Claim forms may be obtained by calling Customer Service or visiting blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining outpatient prescription Drugs from the mail service pharmacy

You have an option to receive prescription Drugs from the mail service pharmacy when you take maintenance Drugs on a regular basis to treat an ongoing chronic condition. This allows you to receive up to a 90-day supply of the Drug, which may save you money. You may enroll in this program online, by phone, or by mail. Once enrolled, please allow up to 14 days to receive the Drug. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the mail service pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the mail service pharmacy.

You must pay the applicable Copayment or Coinsurance listed in the *Summary of Benefits* for each prescription Drug.

Visit blueshieldca.com or use the Blue Shield mobile app for additional information about how to get prescription Drugs from the mail service pharmacy.

Obtaining Specialty Drugs from a Network Specialty Pharmacy

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

Specialty Drugs are only available from a Network Specialty Pharmacy. If you obtain a Specialty Drug anywhere other than at a Network Specialty Pharmacy, you may be responsible for the entire cost of the Drug. A Network Specialty Pharmacy provides Specialty Drugs by mail or, at your request, will transfer the Specialty Drug to an associated retail store for pickup.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA.

To be covered, most Specialty Drugs require prior authorization by Blue Shield, as described in the *Prior authorization/exception request/step therapy process* section.

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

Visit blueshieldca.com for a complete list of Specialty Drugs or to select a Network Specialty Pharmacy.

Prior authorization/exception request/step therapy process

Some Drugs and Drug quantities require approval based on Medical Necessity before they are eligible for coverage under this Benefit. This process is prior authorization.

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs;
- Drugs for the Medically Necessary treatment of Class III obesity when prior authorized. You are required to enroll in a comprehensive weight loss program that includes a reduced calorie diet, physical activity, and behavior therapy. You will need to be in this type of program for a reasonable period of time, prior to and while on the weight loss Drug;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.

You pay the Tier 3 Copayment or Coinsurance for covered compounded medications.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours

in routine circumstances or within 24 hours in exigent circumstances. Once Blue Shield receives all required supporting information, Blue Shield 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. Approvals for prior authorizations can be granted for up to one year, however, the timeframe may be greater or less, depending on the medication.

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. You can submit an exception request by calling Customer Service. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. See the *Obtaining outpatient prescription Drugs at a Participating Pharmacy* section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a Drug should be used, nationally recognized treatment guidelines, medical studies, information from the Drug manufacturer, and the relative cost of treatment for a condition. If 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, the step 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 denies a request for prior authorization or an exception request, you, your representative, your Physician, or your Health Care Provider can file a grievance with Blue Shield. See the *Grievance process* section of your Evidence of Coverage for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Limitation on quantity of Drugs that may be obtained per prescription or refill

Except as otherwise stated in this section, you may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

If you, your Physician, or your Health Care Provider request 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.

Blue Shield has a short cycle Specialty Drug program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for the initial prescription. This program allows you to receive a 15-day supply of the Specialty Drug to help determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save money if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program,

which you can elect at that time. You, your Physician, or your Health Care Provider may choose a full 30-day supply for the first fill.

If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug.

Visit ***blueshieldca.com/pharmacy*** for a list of *Specialty Drugs* in the *short cycle Specialty Drug program*.

You may receive up to a 90-day supply of Drugs at a Participating Pharmacy or from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will dispense that amount and you are responsible for the applicable Copayment or Coinsurance listed in the *Summary of Benefits* section. Refill authorizations cannot be combined to reach a 90-day supply.

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

You may receive up to a 12-month supply of hormonal contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

Special programs

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

Exclusions and limitations

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

	Outpatient prescription Drug exclusions and limitations
1	When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
2	When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
3	When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
4	When prescribed solely for the purpose of shortening the duration of the common cold. Non-formulary Drugs, unless an exception request is approved.
5	Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to: • Insulin, • Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs), • Over-the-counter drugs for reversal of an opioid overdose, or • An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
6	Replacement of lost or stolen drugs.
7	Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
8	Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met. Prescription Drugs that are repackaged by an entity other than the original manufacturer.

Definitions

Anticancer Medications	Drugs used to kill or slow the growth of cancerous cells.
Biosimilar Drugs	Drugs that are FDA-approved that are highly similar to an FDA-approved biologic (reference product) with no clinically meaningful differences in terms of safety, purity, strength and effectiveness.
Brand Drugs	Drugs that are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer.
Calendar Year Pharmacy Deductible	The amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit.
Formulary	A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.
Generic Drugs	Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs.
Network Specialty Pharmacy	Select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.
Non-Participating Pharmacy	A pharmacy that does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.
Outpatient Prescription Drug	Means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.
Participating Pharmacy	A pharmacy that has contracted with Blue Shield to provide covered Drugs at certain rates. A Participating Pharmacy participates in the Blue Shield Pharmacy Network.
Prescription Drug (Drug)	Means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes:

	• disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; • syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; • drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and • at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.
Schedule II Controlled Substance	Prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.
Specialty Drugs	Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available exclusively at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high-cost.

Please be sure to retain this document. It is not a Contract but is a part of your Evidence of Coverage.

Acupuncture and Chiropractic Services Rider

Group Rider
Effective January 1, 2026
HMO/POS

Santa Clara Valley Water District Chiropractic and Acupuncture Benefits Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Benefits under this acupuncture and chiropractic services Benefit.

Benefits	Your Payment	
Covered Benefits must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
Acupuncture Services		
Office visit	$10/visit	Not covered
Chiropractic Services		
Office visit	$10/visit	Not covered
Chiropractic Appliances	All charges above $50	Not covered

Benefit Plans may be modified to ensure compliance with State and Federal Requirements.

Blue Shield of California is an independent member of the Blue Shield Association

Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Benefits, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Benefits received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Benefits from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your

Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

Note: You should exhaust the Benefits covered under this rider before accessing the same services through the "Alternative Care Discount Program," which is a wellness discount program. For more information about the Alternative Care Discount Program, visit www.blueshieldca.com.

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

Member Services

For all acupuncture and chiropractic services, Blue Shield of California has contracted with ASH Plans to act as the Plan's acupuncture and chiropractic services administrator. Contact ASH Plans with questions about acupuncture and chiropractic services, ASH Participating Providers, or acupuncture and chiropractic Benefits.

Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Exclusions

Acupuncture services do not include:

- treatment of asthma;
- treatment of addiction (including without limitation smoking cessation); or
- vitamins, minerals, nutritional supplements (including herbal supplements), or other similar products.

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

Definitions

American Specialty Health Plans of California, Inc. (ASH Plans)	ASH Plans is a licensed, specialized health care service plan that has entered into an agreement with Blue Shield of California to arrange for the delivery of acupuncture and chiropractic services.
ASH Participating Provider	An acupuncturist or a chiropractor under contract with ASH Plans to provide Covered Benefits to Members.
Musculoskeletal and Related Disorders	Musculoskeletal and Related Disorders are conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as: structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions. Musculoskeletal and Related Disorders include Myofascial/Musculoskeletal Disorders, Musculoskeletal Functional Disorders and subluxation.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

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

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

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
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.

Language access services

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում է՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទស្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Trio ACO HMO Plan Service Area

The Trio ACO HMO Plan Service Area consists of the counties, and ZIP codes listed within those counties, on the charts below. You must reside or work within one of these ZIP codes to be eligible for a Trio HMO plan. The Trio ACO HMO Plan Service Area may change. Visit blueshieldca.com, use the Blue Shield mobile app, or call Shield Concierge for more information.

Alameda County			
94501	94502	94505	94514
94536	94537	94538	94539
94540	94541	94542	94543
94544	94545	94546	94550
94551	94552	94555	94557
94560	94566	94568	94577
94578	94579	94580	94586
94587	94588	94601	94602
94603	94604	94605	94606
94607	94608	94609	94610
94611	94612	94613	94614
94615	94617	94618	94619
94620	94621	94622	94623
94624	94649	94659	94660
94661	94662	94666	94701
94702	94703	94704	94705
94706	94707	94708	94709
94710	94712	94720	95377
95391			

Contra Costa County			
94505	94506	94507	94509
94511	94513	94514	94516
94517	94518	94519	94520

Contra Costa County			
94521	94522	94523	94524
94525	94526	94527	94528
94529	94530	94531	94547
94548	94549	94551	94553
94556	94561	94563	94564
94565	94569	94570	94572
94575	94582	94583	94595
94596	94597	94598	94706
94707	94708	94801	94802
94803	94804	94805	94806
94807	94808	94820	94850

El Dorado County			
95664	95672	95682	95762

Kern County			
93203	93205	93206	93215
93216	93220	93224	93225
93226	93240	93241	93250
93251	93252	93255	93263
93268	93276	93280	93283
93285	93287	93301	93302
93303	93304	93305	93306
93307	93308	93309	93311
93312	93313	93314	93380
93383	93384	93385	93386
93387	93388	93389	93390
93501	93502	93504	93505
93516	93518	93531	93560
93561	93596		

Los Angeles County			
90001	90002	90003	90004
90005	90006	90007	90008
90009	90010	90011	90012
90013	90014	90015	90016
90017	90018	90019	90020
90021	90022	90023	90024
90025	90026	90027	90028
90029	90030	90031	90032
90033	90034	90035	90036
90037	90038	90039	90040
90041	90042	90043	90044
90045	90046	90047	90048
90049	90050	90051	90052
90053	90054	90055	90056
90057	90058	90059	90060
90061	90062	90063	90064
90065	90066	90067	90068
90069	90070	90071	90072
90073	90074	90075	90076
90077	90078	90079	90080
90081	90082	90083	90084
90086	90087	90088	90089
90090	90091	90093	90094
90095	90096	90099	90189
90201	90202	90209	90210
90211	90212	90213	90220
90221	90222	90223	90224
90230	90231	90232	90233
90239	90240	90241	90242
90245	90247	90248	90249

Los Angeles County			
90250	90251	90254	90255
90260	90261	90262	90263
90264	90265	90266	90267
90270	90272	90274	90275
90277	90278	90280	90290
90291	90292	90293	90294
90295	90296	90301	90302
90303	90304	90305	90306
90307	90308	90309	90310
90311	90312	90401	90402
90403	90404	90405	90406
90407	90408	90409	90410
90411	90501	90502	90503
90504	90505	90506	90507
90508	90509	90510	90601
90602	90603	90604	90605
90606	90607	90608	90609
90610	90637	90638	90639
90640	90650	90651	90652
90660	90661	90662	90670
90671	90701	90702	90703
90706	90707	90710	90711
90712	90713	90714	90715
90716	90717	90723	90731
90732	90733	90734	90744
90745	90746	90747	90748
90749	90755	90801	90802
90803	90804	90805	90806
90807	90808	90809	90810
90813	90814	90815	90822
90831	90832	90833	90834

Los Angeles County			
90835	90840	90842	90844
90846	90847	90848	90853
90895	90899	91001	91003
91006	91007	91008	91009
91010	91011	91012	91016
91017	91020	91021	91023
91024	91025	91030	91031
91040	91041	91042	91043
91046	91066	91077	91101
91102	91103	91104	91105
91106	91107	91108	91109
91110	91114	91115	91116
91117	91118	91121	91123
91124	91125	91126	91129
91182	91184	91185	91188
91189	91199	91201	91202
91203	91204	91205	91206
91207	91208	91209	91210
91214	91221	91222	91224
91225	91226	91301	91302
91303	91304	91305	91306
91307	91308	91309	91310
91311	91313	91316	91321
91322	91324	91325	91326
91327	91328	91329	91330
91331	91333	91334	91335
91337	91340	91341	91342
91343	91344	91345	91346
91350	91351	91352	91353
91354	91355	91356	91357
91364	91365	91367	91371

Los Angeles County			
91372	91376	91380	91381
91382	91383	91384	91385
91386	91387	91390	91392
91393	91394	91395	91396
91401	91402	91403	91404
91405	91406	91407	91408
91409	91410	91411	91412
91413	91416	91423	91426
91436	91470	91482	91495
91496	91499	91501	91502
91503	91504	91505	91506
91507	91508	91510	91521
91522	91523	91526	91601
91602	91603	91604	91605
91606	91607	91608	91609
91610	91611	91612	91614
91615	91616	91617	91618
91702	91706	91711	91714
91715	91716	91722	91723
91724	91731	91732	91733
91734	91735	91740	91741
91744	91745	91746	91747
91748	91749	91750	91754
91755	91756	91765	91766
91767	91768	91769	91770
91771	91772	91773	91775
91776	91778	91780	91788
91789	91790	91791	91792
91793	91801	91802	91803
91804	91896	91899	93510
93563			

Marin County			
94901	94903	94904	94912
94913	94914	94915	94920
94924	94925	94930	94933
94937	94938	94939	94940
94941	94942	94945	94946
94947	94948	94949	94950
94956	94957	94960	94963
94964	94965	94966	94970
94971	94973	94974	94976
94977	94978	94979	94998

Monterey County			
93901	93902	93905	93906
93907	93908	93912	93915
93920	93921	93922	93923
93924	93925	93926	93933
93940	93942	93943	93944
93950	93953	93955	93960
93962	95012	95039	

Nevada County			
95712	95924	95945	95946
95949	95959	95960	95975
95986			

Orange County			
90620	90621	90622	90623
90624	90630	90631	90632

Orange County			
90633	90638	90680	90720
90721	90740	90742	90743
92602	92603	92604	92605
92606	92607	92609	92610
92612	92614	92615	92616
92617	92618	92619	92620
92623	92624	92625	92626
92627	92628	92629	92630
92637	92646	92647	92648
92649	92650	92651	92652
92653	92654	92655	92656
92657	92658	92659	92660
92661	92662	92663	92672
92673	92674	92675	92676
92677	92678	92679	92683
92684	92685	92688	92690
92691	92692	92693	92694
92697	92698	92701	92702
92703	92704	92705	92706
92707	92708	92711	92712
92728	92735	92780	92781
92782	92799	92801	92802
92803	92804	92805	92806
92807	92808	92809	92811
92812	92814	92815	92816
92817	92821	92822	92823
92825	92831	92832	92833
92834	92835	92836	92837
92838	92840	92841	92842
92843	92844	92845	92846
92850	92856	92857	92859

Orange County			
92861	92862	92863	92864
92865	92866	92867	92868
92869	92870	92871	92885
92886	92887	92899	

Placer County			
95602	95603	95604	95648
95650	95658	95661	95663
95677	95678	95713	95746
95747	95765		

Riverside County			
91752	92220	92223	92230
92320	92501	92502	92503
92504	92505	92506	92507
92508	92509	92513	92514
92515	92516	92517	92518
92519	92521	92522	92530
92531	92532	92543	92544
92545	92546	92548	92551
92552	92553	92554	92555
92556	92557	92562	92563
92564	92567	92570	92571
92572	92581	92582	92583
92584	92585	92586	92587
92589	92590	92591	92592
92593	92595	92596	92599
92860	92877	92878	92879
92880	92881	92882	92883

Sacramento County			
94203	94204	94205	94206
94207	94208	94209	94211
94229	94230	94232	94234
94235	94236	94237	94239
94240	94244	94245	94247
94248	94249	94250	94252
94254	94256	94257	94258
94259	94261	94262	94263
94267	94268	94269	94271
94273	94274	94277	94278
94279	94280	94282	94283
94284	94285	94286	94287
94288	94289	94290	94291
94293	94294	94295	94296
94297	94298	94299	95608
95609	95610	95611	95615
95621	95624	95626	95628
95630	95632	95638	95639
95652	95655	95660	95662
95670	95671	95673	95683
95693	95741	95742	95757
95758	95759	95763	95811
95812	95813	95814	95815
95816	95817	95818	95819
95820	95821	95822	95823
95824	95825	95826	95827
95828	95829	95830	95831
95832	95833	95834	95835
95836	95837	95838	95840
95841	95842	95843	95851
95852	95853	95860	95864

Sacramento County			
95865	95866	95867	95894
95899			

San Bernardino County			
91701	91708	91709	91710
91729	91730	91737	91739
91743	91758	91759	91761
91762	91763	91764	91784
91785	91786	92301	92305
92307	92308	92313	92314
92315	92316	92317	92318
92321	92322	92324	92325
92329	92331	92333	92334
92335	92336	92337	92339
92340	92341	92342	92344
92345	92346	92350	92352
92354	92356	92357	92358
92359	92368	92369	92371
92372	92373	92374	92375
92376	92377	92378	92382
92385	92386	92391	92392
92393	92394	92395	92397
92399	92401	92402	92403
92404	92405	92406	92407
92408	92410	92411	92413
92415	92418	92423	92427

San Diego County			
91901	91902	91903	91905
91906	91908	91909	91910

San Diego County			
91911	91912	91913	91914
91915	91916	91917	91921
91931	91932	91933	91935
91941	91942	91943	91944
91945	91946	91948	91950
91951	91962	91963	91976
91977	91978	91979	91980
91987	92003	92007	92008
92009	92010	92011	92013
92014	92018	92019	92020
92021	92022	92023	92024
92025	92026	92027	92028
92029	92030	92033	92036
92037	92038	92039	92040
92046	92049	92051	92052
92054	92055	92056	92057
92058	92059	92060	92061
92064	92065	92067	92068
92069	92071	92072	92074
92075	92078	92079	92081
92082	92083	92084	92085
92088	92091	92092	92093
92096	92101	92102	92103
92104	92105	92106	92107
92108	92109	92110	92111
92112	92113	92114	92115
92116	92117	92118	92119
92120	92121	92122	92123
92124	92126	92127	92128
92129	92130	92131	92132
92134	92135	92136	92137

San Diego County			
92138	92139	92140	92142
92143	92145	92147	92149
92150	92152	92153	92154
92155	92158	92159	92160
92161	92163	92165	92166
92167	92168	92169	92170
92171	92172	92173	92174
92175	92176	92177	92178
92179	92182	92186	92187
92190	92191	92192	92193
92195	92196	92197	92198
92199			

San Francisco County			
94102	94103	94104	94105
94107	94108	94109	94110
94111	94112	94114	94115
94116	94117	94118	94119
94120	94121	94122	94123
94124	94125	94126	94127
94128	94129	94130	94131
94132	94133	94134	94137
94139	94140	94141	94142
94143	94144	94145	94146
94147	94151	94158	94159
94160	94161	94163	94164
94172	94177	94188	

San Joaquin County			
94514	95201	95202	95203

Questions? Visit blueshieldca.com, use the Blue Shield mobile app, or call Shield Concierge at 1-855-829-3566.

San Joaquin County			
95204	95205	95206	95207
95208	95209	95210	95211
95212	95213	95214	95215
95219	95220	95227	95230
95231	95234	95236	95237
95240	95241	95242	95253
95258	95267	95269	95296
95297	95304	95320	95330
95336	95337	95361	95366
95376	95377	95378	95385
95391	95632	95686	95690

San Luis Obispo County			
93401	93402	93403	93405
93406	93407	93408	93409
93410	93412	93420	93421
93422	93423	93424	93426
93428	93430	93432	93433
93435	93442	93443	93444
93445	93446	93447	93448
93449	93451	93453	93461
93465	93475	93483	

San Mateo County			
94002	94005	94010	94011
94014	94015	94016	94017
94018	94019	94020	94021
94025	94026	94027	94028
94030	94037	94038	94044
94060	94061	94062	94063

San Mateo County			
94064	94065	94066	94070
94074	94080	94083	94128
94303	94401	94402	94403
94404	94497		

Santa Clara County			
94022	94023	94024	94035
94039	94040	94041	94042
94043	94085	94086	94087
94088	94089	94301	94302
94303	94304	94305	94306
94309	94550	95002	95008
95009	95011	95013	95014
95015	95020	95021	95023
95026	95030	95031	95032
95033	95035	95036	95037
95038	95042	95044	95046
95050	95051	95052	95053
95054	95055	95056	95070
95071	95076	95101	95103
95106	95108	95109	95110
95111	95112	95113	95115
95116	95117	95118	95119
95120	95121	95122	95123
95124	95125	95126	95127
95128	95129	95130	95131
95132	95133	95134	95135
95136	95138	95139	95140
95141	95148	95150	95151
95152	95153	95154	95155

Santa Clara County			
95156	95157	95158	95159
95160	95161	95164	95170
95172	95173	95190	95191
95192	95193	95194	95196

Santa Cruz County			
95001	95003	95005	95006
95007	95010	95017	95018
95019	95033	95041	95060
95061	95062	95063	95064
95065	95066	95067	95073
95076	95077		

Solano County			
94503	94510	94589	94592
95620			

Stanislaus County			
95307	95313	95316	95319
95323	95326	95328	95329
95350	95351	95352	95353
95354	95355	95356	95357
95358	95361	95363	95367
95368	95380	95381	95382
95386	95387	95397	

Tulare County			
93219	93256	93260	

Ventura County			
91319	91320	91358	91359
91360	91361	91362	91377
93001	93002	93003	93004
93005	93006	93007	93009
93010	93011	93012	93015
93016	93020	93021	93022
93023	93024	93030	93031
93032	93033	93034	93035
93036	93040	93041	93042
93043	93044	93060	93061
93062	93063	93064	93065
93066	93094	93099	

Yolo County			
95605	95606	95607	95612
95616	95617	95618	95627
95637	95645	95653	95691
95694	95695	95697	95698
95776	95798	95799	95937

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