

# Access+ HMO<sup>®</sup> 15 - 0 Inpatient

## **Combined Evidence of Coverage and Disclosure Form**

N.E.C.A. West Health & Welfare Trust Fund

Effective Date: April 1, 2008

An Independent Member of the Blue Shield Association



# Combined Evidence of Coverage and Disclosure Form

## N.E.C.A. West Health & Welfare Trust Fund

### Access+ HMO Plan 15 - 0 Inpatient

Effective Date: April 1, 2008

#### NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan.

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

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

#### PLEASE NOTE

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

#### IMPORTANT

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

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

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

**This combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The health Plan Contract must be consulted to determine the exact terms and conditions of coverage.** The Group Health Service Contract is available through your Employer or a copy can be furnished upon request. Your Employer is familiar with this health Plan, and you may also direct questions concerning coverage or specific Plan provisions to the Blue Shield Member Services Department.

# The Blue Shield Access+ HMO Health Plan

## Member Bill of Rights

---

---

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

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

# The Blue Shield Access+ HMO Health Plan

## Member Responsibilities

---

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

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

# Table of Contents

---

<b>Title</b>	<b>Page</b>
Access+ HMO Summary of Benefits.....	5
Your Introduction to the Blue Shield Access+ HMO Health Plan.....	12
Choice of Physicians and Providers.....	12
How to Use Your Health Plan.....	14
Plan Benefits.....	23
Principal Limitations, Exceptions, Exclusions and Reductions .....	34
Termination of Benefits and Cancellation Provisions.....	40
Group Continuation Coverage and Individual Conversion Plan .....	42
Other Provisions .....	46
Member Services .....	48
Grievance Process.....	48
Definitions .....	50
Summary Plan Description .....	56
Statement of ERISA Rights .....	56
Supplement A — Outpatient Prescription Drugs .....	59

## **THE N.E.C.A. WEST HEALTH AND WELFARE TRUST FUND**

Your Health and Welfare Plan has been established as a separate trust.

We will continue to obtain the best coverages and benefits available at the prescribed rates and will arrange for the most efficient and prompt service and claims payment.

Be sure to review this booklet carefully so that you may become familiar with the benefits under this Plan.

The Trustees reserve the right to change the eligibility requirements of the Plan or conditions for continued participation. They reserve the right to charge for and/or increase the charge for this coverage and/or to modify Plan benefits or terminate the Plan.

No Employer, N.E.C.A. Representative, individual Trustee or Trust Employee has the power to represent any guarantee of coverage in contradiction to these provisions.

Very truly yours,

TRUSTEES FOR THE N.E.C.A. WEST HEALTH AND WELFARE TRUST FUND

# **Access+ HMO**

## **Summary of Benefits**

What follows is a summary of your Benefits and the Copayments applicable to the Benefits of your Plan. A more complete description of your Benefits is contained in the Plan Benefits section. Please be sure to read that section and the exclusions and limitations in the Principal Limitations, Exceptions, Exclusions and Reductions section for a complete description of the Benefits of your Plan.

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

Should you have any questions about your Plan, please call the Member Services Department at the number provided on the last page of this booklet.

# Summary of Benefits<sup>1</sup>

Access+ HMO

Services	Member's Copayment
<p><b>Access+ Specialist Services</b></p> <ul style="list-style-type: none"> <li>• An office visit, examination or other consultation with a Plan Specialist in the same Medical Group or IPA as the Personal Physician</li> <li>• Conventional X-rays, lab, diagnostic tests</li> </ul> <p>Note: See the Choice of Physicians and Providers and How to Use Your Health Plan sections for more information and for a list of services which are not covered under this Benefit. Your Medical Group or IPA must be an Access+ Provider in order for you to use this Benefit. Refer to the HMO Physician and Hospital Directory or call Member Services at the number provided on the last page of this booklet to determine whether a Medical Group or IPA is an Access+ Provider.</p>	<p>\$30 per visit</p> <p>You pay nothing</p>
<p><b>Allergy Testing</b></p> <ul style="list-style-type: none"> <li>• Office visits</li> </ul>	<p>\$15 per visit</p>
<p><b>Allergy Treatment</b></p> <ul style="list-style-type: none"> <li>• Office visits (includes visits for allergy serum injections)</li> <li>• Allergy serum purchased separately for treatment</li> </ul>	<p>\$15 per visit</p> <p>50% of Allowed Charges for allergy serum</p>
<p><b>Ambulance Services</b></p> <ul style="list-style-type: none"> <li>• Emergency and non-Emergency Services</li> </ul>	<p>\$50</p>
<p><b>Ambulatory Surgery Center Services</b></p> <ul style="list-style-type: none"> <li>• Ambulatory surgical Services provided on an Outpatient facility basis at an Ambulatory Surgery Center</li> </ul> <p>Note: Outpatient ambulatory surgery Services may also be obtained from a Hospital or an Ambulatory Surgery Center that is affiliated with a Hospital, and will be paid according to the Hospital Services section of this Summary of Benefits.</p>	<p>You pay nothing</p>
<p><b>Diabetes Care</b></p> <ul style="list-style-type: none"> <li>• Diabetic Equipment</li> <li>• Diabetes Self-Management Training and Education</li> </ul>	<p>20% of Allowed Charges</p> <p>\$15 per visit</p>
<p><b>Durable Medical Equipment</b></p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment and oxygen<sup>2</sup></li> </ul>	<p>20% of Allowed Charges<sup>3</sup></p>
<p><b>Emergency Services</b></p> <ul style="list-style-type: none"> <li>• Emergency room Services</li> </ul> <p>Note: For Emergency ambulance Services see the Ambulance Services section of this Summary.</p>	<p>\$50 per visit (waived if Member is admitted directly to the Hospital as an Inpatient)</p>

Services	Member's Copayment
<p><b>Family Planning and Infertility Services</b></p> <ul style="list-style-type: none"> <li>• Family planning counseling</li> <li>• Diagnosis and treatment of cause of Infertility</li> <li>• Tubal ligation</li>   <li>• Elective abortion</li>   <li>• Vasectomy</li>   <li>• Physician office visits for diaphragm fitting</li> <li>• Injectable contraceptives when administered by a Physician</li> </ul>	<p>\$15 per visit 50% of Allowed Charges \$100 (for Professional Services in the office or Outpatient Hospital facility) Facility Services Copayment applies (in a Hospital or Ambulatory Surgery Center facility [in an Inpatient facility, waived if performed in conjunction with delivery or abdominal surgery]) \$100 (for Professional Services in the office or Outpatient Hospital facility) Facility Services Copayment applies (in a Hospital or Ambulatory Surgery Center facility) \$75 (for Professional Services in the office or Outpatient Hospital facility) Facility Services Copayment applies (in a Hospital or Ambulatory Surgery Center facility) Physician Services Copayments apply \$25 per injection plus Physician Services office visit Copayment</p>
<p><b>Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy<sup>2</sup></b></p> <ul style="list-style-type: none"> <li>• Home health care agency Services, including home visits by a nurse, home health aide, physical therapist, speech therapist, or occupational therapist, or care in the home by home health care providers for up to a total of 100 home health care visits per Calendar Year</li> <li>• Medical Social Worker</li> <li>• Medical supplies including parenteral and enteral nutritional Services and supplies and related pharmaceutical and laboratory Services to the extent the Benefits would have been provided had the Member remained in the Hospital</li> <li>• PKU related formulas and Special Food Products</li> <li>• Home infusion IV injectable therapy provided by a Home Infusion Agency<sup>4</sup></li> </ul>	<p>\$15 per visit  You pay nothing You pay nothing  You pay nothing You pay nothing</p>
<p><b>Hospice Program Services when received and authorized by a Participating Hospice Agency</b></p> <ul style="list-style-type: none"> <li>• Continuous Home Care provided during a Period of Crisis</li> <li>• General Inpatient care</li> <li>• Inpatient Respite Care</li> <li>• Routine home care</li> <li>• Pre-Hospice consultative visit</li> </ul>	<p>You pay nothing You pay nothing You pay nothing You pay nothing You pay nothing</p>

Services	Member's Copayment
<p><b>Hospital Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Services, including semi-private room and board, operating room, intensive cardiac care units, general nursing care, Subacute Care, drugs, medications, oxygen, blood and blood plasma<sup>2</sup></li> <li>• Inpatient Hospital Services for acute medical detoxification due to substance abuse</li> <li>• Inpatient Medically Necessary skilled nursing Services including Subacute Care<sup>5</sup></li> <li>• Outpatient Services for surgery and necessary supplies</li> <li>• Outpatient Services for renal dialysis, radiation therapy, chemotherapy, treatment and necessary supplies</li> </ul>	<p>You pay nothing</p> <p>You pay nothing Skilled Nursing Facility Services Copayment applies</p> <p>You pay nothing</p> <p>You pay nothing</p>
<p><b>Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones</b></p> <ul style="list-style-type: none"> <li>• Inpatient or Outpatient treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (be sure to read the Plan Benefits section for a complete description)</li> </ul>	<p>Inpatient- Hospital Services Copayments apply</p> <p>Outpatient- \$15 per visit (in the office)</p> <p>Outpatient facility Services Copayment applies (in an Outpatient facility)</p>
<p><b>Mental Health and Substance Abuse Access+ Specialist Services</b></p> <ul style="list-style-type: none"> <li>• An office visit, examination or other consultation for Mental Health and substance abuse conditions with a MHSA<sup>6</sup> Participating Provider without a referral from the MHSA</li> </ul> <p>Psychological testing and written evaluation are not covered under this Benefit.</p> <p>Note: See the Mental Health and Substance Abuse Services paragraphs in the How to Use Your Health Plan section for more information.</p>	<p>\$30 per visit</p>
<p><b>Mental Health and Substance Abuse Service</b></p> <p><b>All Non-Emergency Services must be arranged through the MHSA<sup>6</sup></b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital and professional Services (Note: Unless selected as an optional Benefit by your Employer, no benefits are provided for Inpatient substance abuse Services except for Inpatient substance abuse detoxification, which is covered as any other medical Benefit shown in this Summary.)</li> <li>• Outpatient psychiatric Partial Hospitalization for the treatment of mental illness</li> <li>• Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and substance abuse counseling up to 20 visits per Calendar Year</li> </ul> <p>The Member Copayment for the initial visit to determine the condition and diagnosis of the Member (except for Mental Health and substance abuse Services Access+ Specialist visits) will be the Physician office visit Copayment amount. Mental Health and substance abuse Services Access+ Specialist visits will accrue toward the 20-visit per Calendar Year maximum. Initial visits which are subsequently diagnosed as being for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for substance abuse care will also accrue toward the 20-visit maximum.</p> <ul style="list-style-type: none"> <li>• Outpatient Psychiatric Care and Intensive Outpatient Care for Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child</li> <li>• Psychological Testing</li> <li>• Psychological Support through Lifepath Advisers</li> </ul> <p>Note: All Mental Health and substance abuse Services Access+ Specialist visits require an Access+ Specialist Copayment per visit. This Copayment is in addition to any Copayments that you may incur for specific Benefits as described in this Summary of Benefits.</p>	<p>You pay nothing</p> <p>You pay nothing<sup>7</sup></p> <p>\$25 per visit</p> <p>\$15 per visit</p> <p>You pay nothing</p> <p>You pay nothing</p>

Services	Member's Copayment
<b>Orthoses</b> <ul style="list-style-type: none"> <li>• Medically Necessary Orthoses for Activities of Daily Living</li> <li>• Office visits</li> </ul>	You pay nothing Physician Services Copayments apply
<b>Pregnancy and Maternity Care</b> <ul style="list-style-type: none"> <li>• Prenatal and postnatal Physician office visits and delivery, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy</li> <li>• All necessary Inpatient Hospital Services for normal delivery, routine newborn circumcision, Cesarean section, and complications of pregnancy</li> <li>• Outpatient routine newborn circumcision</li> </ul>	You pay nothing  Hospital Services Copayments apply \$15 per visit (in the office) Outpatient Services for surgery Copay (in an Outpatient facility)
<b>Preventive Health Services</b> <ul style="list-style-type: none"> <li>• Routine physical exams, including well-baby, well-child, women's gynecological exams and adult exams according to schedule</li> <li>• Medically Necessary immunizations as defined</li> <li>• Vision/hearing screening by Personal Physician for Members through age 18</li> <li>• Health education/health promotion Services</li> <li>• Nurse support through Lifepath Advisers</li> </ul>	You pay nothing  You pay nothing You pay nothing You pay nothing You pay nothing
<b>Professional (Physician) Services</b> <ul style="list-style-type: none"> <li>• Office visits including surgery, chemotherapy, radiation therapy, diabetic counseling, asthma self-management training, audiometry examinations when performed by a Physician or by an audiologist at the request of a Physician, second opinion consultations when authorized or OB/GYN Services from an obstetrician/gynecologist or family practice Physician who is within the same Medical Group/IPA as the Personal Physician</li> <li>• Home visits by Plan Physicians</li> <li>• Inpatient Hospital and Skilled Nursing Facility Services by Physicians, including the Services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist</li> <li>• Lab, X-ray, diagnostic tests</li> <li>• Injectable medications</li> </ul> <p>Note: For information on applicable Copayments for Allergy Testing and Allergy Treatment, see these sections in this Summary.</p> <ul style="list-style-type: none"> <li>• Internet based consultations</li> </ul>	\$15 per visit  \$50 per visit You pay nothing  You pay nothing You pay nothing  \$10 per consultation
<b>Prostheses and Other Services</b> <ul style="list-style-type: none"> <li>• Prostheses (except those provided to restore and achieve symmetry incident to a mastectomy, which are covered under the Reconstructive Surgery Benefit and specified devices following a laryngectomy, which are covered under Physician Services surgical Benefits)<sup>2</sup></li> <li>• Office visits</li> <li>• Surgically implanted devices and supplies</li> </ul>	You pay nothing  Physician Services Copayments apply Physician Services Copayments apply (in the office) Outpatient facility Services Copayment applies (in an Outpatient facility)

Services	Member's Copayment
<p><b>Reconstructive Surgery</b></p> <ul style="list-style-type: none"> <li>Inpatient or Outpatient surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance, Reconstructive Surgery incident to a mastectomy and prosthetic devices provided to restore and achieve symmetry incident to a mastectomy<sup>8</sup></li> </ul>	<p>Facility Services and Physician Services Copayments apply</p>
<p><b>Rehabilitation Services</b></p> <ul style="list-style-type: none"> <li>Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings: <ol style="list-style-type: none"> <li>in the Rehabilitation unit of a Hospital for Medically Necessary days, or</li> <li>in the Skilled Nursing Facility Rehabilitation unit for Medically Necessary days, or</li> <li>in an Outpatient department of a Hospital, or</li> <li>in an office location</li> </ol> </li> </ul>	<p>Hospital Services Copayments apply  Skilled Nursing Facility Services Copayment applies  \$15 per visit  \$15 per visit</p>
<p><b>Skilled Nursing Facility Services</b></p> <ul style="list-style-type: none"> <li>Inpatient Skilled Nursing Facility Services, including Subacute Care and other necessary Services and supplies for up to 100 days per Calendar Year<sup>2,5</sup></li> </ul>	<p>You pay nothing</p>
<p><b>Speech Therapy Services</b></p> <ul style="list-style-type: none"> <li>Speech Therapy Services by a licensed speech pathologist or certified speech therapist in the following settings: <ol style="list-style-type: none"> <li>in the Rehabilitation unit of a Hospital for Medically Necessary days, or</li> <li>in the Skilled Nursing Facility Rehabilitation unit for Medically Necessary days, or</li> <li>in an Outpatient department of a Hospital, or</li> <li>in an office location</li> </ol> </li> </ul>	<p>Hospital Services Copayments apply  Skilled Nursing Facility Services Copayment applies  \$15 per visit  \$15 per visit</p>
<p><b>Transplant Benefits</b></p> <ul style="list-style-type: none"> <li>Organ Transplant Benefits - Inpatient Hospital and professional Services for transplant of a cornea, kidney or skin and Services to obtain the human organ transplant</li> <li>Special Transplant Benefits - Inpatient Hospital and professional Services for transplants of human heart, lung, heart and lung in combination, liver, kidney and pancreas in combination, human bone marrow transplants, pediatric human small bowel transplants, pediatric and adult human small bowel and liver transplants in combination, and Services to obtain the human transplant material with prior written authorization of Blue Shield's Medical Director</li> </ul>	<p>You pay nothing  You pay nothing</p>
<p><b>Urgent Services</b></p> <ul style="list-style-type: none"> <li>Urgent Services outside your Personal Physician Service Area  Medically Necessary Out-of-Area Follow-up Care is covered.</li> </ul> <p>Note: See the How to Use Your Health Plan section for more information.</p>	<p>\$50 per visit</p>
<p><b>Member's Maximum Calendar Year Copayment</b></p> <ul style="list-style-type: none"> <li>Member's maximum Calendar Year Copayment for all Covered Services except for: Outpatient routine newborn circumcision, Durable Medical Equipment, Access+ Specialist office visits including visits for Mental Health and substance abuse Services, Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child and substance abuse Services excluding the initial visit, Internet based consultations and the following optional Benefits: Outpatient prescription drugs, additional Infertility Benefits, chiropractic Services, acupuncture Services, Inpatient substance abuse and vision plan and dental plan Benefits, if covered under this Plan.</li> </ul> <p>Note: Outpatient Partial Hospitalization Psychiatric Care Services do apply to the Member's maximum Calendar Year Copayment.</p>	<p>\$1,000 per Member,  \$2,000 per Family</p>
<p><b>Member's Maximum Lifetime Benefits</b></p> <ul style="list-style-type: none"> <li>There is no maximum lifetime benefit limit under this Plan.</li> </ul>	

# Summary of Benefits<sup>1</sup>

Access+ HMO

## Footnotes

---

- <sup>1</sup> All Benefits must be provided or authorized by your Personal Physician and/or the Medical Group/IPA except in an emergency or as otherwise specified.
- <sup>2</sup> For care received by a Participating Hospice Agency see the Hospice Program Services section.
- <sup>3</sup> These Covered Services, except for oxygen and those Services covered under the Diabetes Care Benefit, have a Benefit maximum of \$2,000 per Member per Calendar Year.
- <sup>4</sup> Home infusion injectable medications require prior authorization by Blue Shield and must be obtained from Home Infusion Agencies. See Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy in the Plan Benefits section for details. See the Outpatient Prescription Drugs Supplement for coverage of home self-administered injectable medication, if the Member's employer provides benefits for prescription drugs through the supplemental benefit for Outpatient Prescription Drugs.
- <sup>5</sup> Skilled nursing Services are limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This 100-day maximum for skilled nursing Services is a combined maximum between Hospital and Skilled Nursing Facilities.
- <sup>6</sup> The MHSA, Mental Health Services Administrator, is a specialized health care service plan contracted by Blue Shield of California to administer all Mental Health and substance abuse Services.
- <sup>7</sup> For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.
- <sup>8</sup> The Reconstructive Surgery Benefit is limited to Medically Necessary surgeries and procedures as described in the Reconstructive Surgery section.

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

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

# The Blue Shield Access+ HMO Health Plan

## Combined Evidence of Coverage and Disclosure Form

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

### YOUR INTRODUCTION TO THE BLUE SHIELD ACCESS+ HMO HEALTH PLAN

Your interest in the Blue Shield Access+ HMO Health Plan is truly appreciated. Blue Shield has served California for over 60 years, and we look forward to serving your health care needs.

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

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

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

To determine whether a provider is a Plan Provider, consult the Blue Shield HMO Physician and Hospital Directory. You may also verify this information by accessing Blue Shield's Internet site located at <http://www.blueshieldca.com>, or by calling Member Services at the telephone number provided on the back page of this booklet. Note: A Plan Provider's status may change. It is your obligation to verify whether the provider you choose is a Plan Provider, in case there have been any changes since your directory was published.

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

- Services received during an Access+ Specialist visit,
- OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Personal Physician,
- Emergency Services, or
- Mental Health and substance abuse Services.\*

\*See the *Mental Health and Substance Abuse Services* paragraphs in the How to Use Your Health Plan section for information.

Note: A decision will be rendered on all requests for prior authorization of services as follows:

- for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
- for other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.

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

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

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

If you have any questions regarding the information, you may contact us through our Member Services Department at the number provided on the last page of this booklet.

## CHOICE OF PHYSICIANS AND PROVIDERS

### SELECTING A PERSONAL PHYSICIAN

A close Physician-patient relationship is an important ingredient that helps to ensure the best medical care. Each Member is therefore required to select a Personal Physician at the time of enrollment. This decision is an important one because your Personal Physician will:

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

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

\*See the *Mental Health and Substance Abuse Services* paragraphs in the How to Use Your Health Plan section for information.

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

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

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption but always within 31 days from the date of birth or placement for adoption. The Personal Physician selected for the month of birth must be in the same Medical Group or IPA as the mother's Personal Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Personal Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If you do not select a Personal Physician within 31 days following the birth or placement for adoption, the Plan will designate a Personal Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Personal Physician for the child after the month of birth or placement for adoption, see the paragraphs below on *Changing Personal Physicians or Designated Medical Group or IPA*. If your child is ill during the first month of coverage, be sure to read the information about changing Personal Physicians during a course of treatment or hospitalization.

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you must submit a written application as explained in the Eligibility section of this Evidence of Coverage and Disclosure Form.

## **ROLE OF THE MEDICAL GROUP OR IPA**

Most Blue Shield Access+ HMO Personal Physicians contract with Medical Groups or IPAs to share administrative and authorization responsibilities with them. (Of note, some Personal Physicians contract directly with Blue Shield.) Your Personal Physician coordinates with your designated Medical Group/IPA to direct all of your medical care needs and refer you to Specialists or Hospitals within your designated Medical

Group/IPA unless because of your health condition, care is unavailable within the Medical Group/IPA.

Your designated Medical Group/IPA (or Blue Shield when noted on your identification card) ensures that a full panel of Specialists is available to provide for your health care needs and helps your Personal Physician manage the utilization of your health Plan Benefits by ensuring that referrals are directed to Providers who are contracted with them. Medical Groups/IPAs also have admitting arrangements with Hospitals contracted with Blue Shield in their area and some have special arrangements that designate a specific Hospital as "in network." Your designated Medical Group/IPA works with your Personal Physician to authorize Services and ensure that that Service is performed by their in network Provider.

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

## **CHANGING PERSONAL PHYSICIANS OR DESIGNATED MEDICAL GROUP OR IPA**

You or your Dependent may change Personal Physicians or designated Medical Group/IPA by calling the Member Services Department at the number provided on the last page of this booklet or submitting a Member Change Request Form to the Member Services Department. Some Personal Physicians are affiliated with more than one Medical Group/IPA. If you change to a Medical Group/IPA with no affiliation to your Personal Physician, you must select a new Personal Physician affiliated with the new Medical Group/IPA and transition any specialty care you are receiving to Specialists affiliated with the new Medical Group/IPA. The change will be effective the first day of the month following notice of approval by Blue Shield.

Once your Personal Physician change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as your Personal Physician and Access+ Specialist visits. Once your Medical Group/IPA change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new Medical Group/IPA, even if you remain with the same Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician or Medical Group/IPA.

Voluntary Medical Group/IPA changes are not permitted during the third trimester of pregnancy or while confined to a Hospital. The effective date of your new Medical Group/IPA will be the first of the month following discharge from the

Hospital, or when pregnant, following the completion of postpartum care.

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

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

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

## **CONTINUITY OF CARE BY A TERMINATED PROVIDER**

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

## **CONTINUITY OF CARE FOR NEW MEMBERS BY NON-CONTRACTING PROVIDERS**

Newly covered Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Member Services to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

## **RELATIONSHIP WITH YOUR PERSONAL PHYSICIAN**

The Physician-patient relationship you and your Personal Physician establish is very important. The best effort of your

Personal Physician will be used to ensure that all Medically Necessary and appropriate professional Services are provided to you in a manner compatible with your wishes.

If your Personal Physician recommends procedures or treatments which you refuse, or you and your Personal Physician fail to establish a satisfactory relationship, you may select a different Personal Physician. Member Services can assist you with this selection.

Your Personal Physician will advise you if he believes that there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, Member Services can assist you in the selection of another Personal Physician.

Repeated failures to establish a satisfactory relationship with a Personal Physician may result in termination of your coverage, but only after you have been given access to other available Personal Physicians and have been unsuccessful in establishing a satisfactory relationship. Any such termination will take place in accordance with written procedures established by Blue Shield and only after written notice to the Member which describes the unacceptable conduct provides the Member with an opportunity to respond and warns the Member of the possibility of termination.

## **HOW TO USE YOUR HEALTH PLAN**

### **USE OF PERSONAL PHYSICIAN**

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

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

If you have not selected a Personal Physician for any reason, you must contact Member Services at the number provided on the last page of this booklet, Monday through Friday, between 8 a.m. and 5 p.m. to select a Personal Physician to obtain Benefits.

## **OBSTETRICAL/GYNECOLOGICAL (OB/GYN) PHYSICIAN SERVICES**

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

Obstetrical and gynecological Services are defined as:

- Physician services related to prenatal, perinatal and post-natal (pregnancy) care,
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia,
- Physician services for treatment of disorders of the breast,
- Routine annual gynecological examinations/annual well-woman examinations.

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

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

## **REFERRAL TO SPECIALTY SERVICES**

Although self-referrals to Plan Specialists are allowed through the Access+ Specialist feature described below, Blue Shield encourages you to receive specialty Services through a referral from your Personal Physician. The Personal Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty Services. Your Personal Physician will generally refer you to a Plan Specialist or Plan Non-Physician Health Care Practitioner in the same Medical Group or IPA as your Personal Physician, but you can be referred outside the Medical Group or IPA if the type of specialist or Non-Physician Health Care Practitioner needed is not available within your Personal Physician's Medical Group or IPA. Your Personal Physician will request any necessary prior authorization from your Medical Group/IPA. For Mental Health care and substance abuse Benefits, see the *Mental Health and Substance Abuse* paragraphs in the How to Use Your Health Plan section for information regarding how to access care. The Plan Specialist

or Plan Non-Physician Health Care Practitioner will provide a complete report to your Personal Physician so that your medical record is complete.

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

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

## **SECOND MEDICAL OPINION**

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, or if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Personal Physician to refer you to another Physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from your Personal Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA as your Personal Physician. If you are requesting a second opinion about care received from a specialist, the second opinion may be provided by any Plan Specialist of the same or equivalent specialty. All second opinion consultations must be authorized. Your Personal Physician may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Member Services Department at the number provided on the last page of this booklet.

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

## **ACCESS+ SPECIALIST**

You may arrange an office visit with a Plan Specialist in the same Medical Group or IPA as your Personal Physician without a referral from your Personal Physician, subject to the limitations described below. Access+ Specialist office visits

are available only to Members whose Personal Physicians belong to a Medical Group or IPA that participates as an Access+ Provider. Refer to the HMO Physician and Hospital Directory or call Blue Shield Member Services at the number provided on the last page of this booklet to determine whether a Medical Group or IPA is an Access+ Provider. You will be responsible for the Copayment listed in the Summary of Benefits for each Access+ Specialist visit. This Copayment is in addition to any Copayments that you may incur for specific Benefits as described in the Summary of Benefits. Each follow-up office visit with the Plan Specialist which is not referred or authorized by your Personal Physician is a separate Access+ Specialist visit and requires a separate Copayment.

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

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

The Access+ Specialist visit includes:

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

An Access+ Specialist visit does not include:

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

10. Inpatient Services, or any Services which result in a facility charge, except for routine X-ray and laboratory Services;
11. Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician;
12. OB/GYN Services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician;
13. Internet based consultations.

## LIFEPATH ADVISERS

Blue Shield of California's Lifepath Advisers provides Members with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these Services by calling 1-866-543-3728, a 24-hour, toll-free telephone number. There is no charge for these Services.

Lifepath Advisers includes a nurse support (see *Preventive Health Services* in the Plan Benefits section) and a psychosocial support feature (see the following section *Mental Health and Substance Abuse Services*).

## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

All Mental Health and substance abuse Services, except for Emergency or Urgent Services, must be provided by an MHSA network Participating Provider. MHSA Providers are indicated in the Blue Shield of California Behavioral Health Provider Directory. Members may contact the MHSA directly for information on, and to select an MHSA Provider by calling 1-877-263-8827. Your Personal Physician may also contact MHSA to obtain information regarding MHSA network Participating Providers for you.

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

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

### 1. Prior Authorization

All Mental Health and substance abuse Services must be prior authorized by the MHSA. For prior authorization of Mental Health and substance abuse Services, the Member should contact the MHSA at 1-877-263-8827.

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

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

- for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
  - for other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.
2. Access+ Specialist visits for Mental Health and substance abuse Services

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

The Member may arrange for an Access+ Specialist office visit for Mental Health and substance abuse Services without a referral from the MHSA, as long as the Provider is an MHSA Participating Provider. Refer to the Blue Shield of California Behavioral Health Provider Directory or call the MHSA Member Services at 1-877-263-9952 to determine the MHSA Participating Providers. Members will be responsible for the Copayment listed in the Summary of Benefits for each Access+ Specialist visit for Mental Health and substance abuse Services. This Copayment is in addition to any Copayments that you may incur for specific Benefits as described in the Summary of Benefits. Each follow-up office visit for Mental Health and substance abuse Services which is not referred or authorized by the MHSA is a separate Access+ Specialist visit and requires a separate Copayment.

Access+ Specialist visits for Mental Health and substance abuse Services are subject to, and accrue toward the Calendar Year Benefit visit maximum as shown in the Summary of Benefits.

### 3. Psychosocial Support

Notwithstanding the Benefits provided under *Mental Health and Substance Abuse Services* in the Plan Benefits section, the Member also may call 1-866-543-3728 on an unlimited, 24-hour basis for confidential psychosocial support Services available through Lifepath Advisers. Professional counselors will provide support through assessment, referrals and counseling.

In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-to-face visits per episode of major life events. An episode shall mean a single event, or multiple events which occur within a 6-month period and are determined by a counselor to be related. Major life events include work related problems, marital and relationship issues, family problems, emotional and personal issues and death and dying issues. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and substance abuse Services.

In the event that the Services required of a Member are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Member will be referred to the MHSA intake line to access their Mental Health and substance abuse Services which are described under *Mental Health and Substance Abuse Services* in the Plan Benefits section.

## EMERGENCY SERVICES

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

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

If you obtain Emergency Services, you should notify your Personal Physician within 24 hours after care is received unless it was not reasonably possible to communicate with the Personal Physician within this time limit. In such case, notice should be given as soon as possible.

An emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

## INPATIENT, HOME HEALTH CARE, HOSPICE PROGRAM AND OTHER SERVICES

The Personal Physician is responsible for obtaining prior authorization before you can be admitted to the Hospital or a Skilled Nursing Facility, including Subacute Care admissions, except for Mental Health and substance abuse Services which are described in the previous *Mental Health and Substance Abuse Services* paragraphs. The Personal Physician is responsible for obtaining prior authorization before you can receive home health care and certain other Services or before you can be admitted into a Hospice Program through a Participating Hospice Agency. If the Personal Physician determines that

you should receive any of these Services, he or she will request authorization. Your Personal Physician will arrange for your admission to the Hospital, Skilled Nursing Facility, or a Hospice Program through a Participating Hospice Agency as well as for the provision of home health care and other Services.

Note: For Hospital admissions for mastectomies or lymph node dissections, the length of Hospital stays will be determined solely by the Member's Physician in consultation with the Member. For information regarding length of stay for maternity or maternity related Services, see *Pregnancy and Maternity Care* in the Plan Benefits section for information relative to the Newborns' and Mothers' Health Protection Act.

## **URGENT SERVICES**

The Blue Shield Access+ HMO provides coverage for you and your family for your urgent service needs when you or your family are temporarily traveling outside of your Personal Physician Service Area.

Urgent Services are defined as those Covered Services rendered outside of the Personal Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment can not reasonably be delayed until the Member returns to the Personal Physician Service Area.

Out-of-Area Follow-up Care is defined as non-emergent Medically Necessary out-of-area services to evaluate the Member's progress after an initial Emergency or Urgent Service.

### **Outside of California**

The Blue Shield Access+ HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

Out-of-Area Follow-up Care is covered and services may be received through the BlueCard® Program participating provider network or from any provider. However, authorization

by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

If services are not received from a BlueCard provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield HMO. Claims for Urgent Services and Out-of-Area Follow-up Care rendered outside of California and not provided by a BlueCard Program participating provider will be reviewed retrospectively for coverage.

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

1. The billed charges for your covered services, or
2. The negotiated price that the local Blue Cross and/or Blue Shield plan passes on to us.

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

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

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

### **Within California**

If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Member Services at the number provided on the last page of this booklet for assistance in receiving Urgent Services through a Blue Shield of California Plan Provider. You may also locate a Plan Provider by visiting our

web site at <http://www.blueshieldca.com>. However, you are not required to use a Blue Shield of California Plan Provider to receive Urgent Services; you may use any provider. Remember that when you are within your Personal Physician Service Area, Urgent Services must be provided or authorized by your Personal Physician just like all other non-emergency services of the Plan. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

If services are not received from a Blue Shield of California Plan Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield HMO. Claims for Urgent Services obtained outside of your Personal Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Personal Physician within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's Allowed Charges.

## **MEMBER MAXIMUM CALENDAR YEAR COPAYMENT**

Your maximum Copayment responsibility each Calendar Year for Covered Services, except those listed below, is shown in the Summary of Benefits.

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

1. Outpatient routine newborn circumcision;
2. Durable Medical Equipment;
3. Access+ Specialist office visits including visits for Mental Health and substance abuse;
4. Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child excluding the initial visit;
5. Substance abuse excluding the initial visit;
6. Internet based consultations;

and the following optional Benefits, if covered under this Plan:

7. Outpatient Prescription Drugs;
8. Additional Infertility Benefits;
9. Chiropractic Services;

10. Acupuncture Services;
11. Vision Plan Benefits;
12. Dental Plan Benefits;
13. Inpatient substance abuse.

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

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

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

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

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

## **MEMBER MAXIMUM LIFETIME BENEFITS**

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

## **LIABILITY OF SUBSCRIBER OR MEMBER FOR PAYMENT**

It is important to note that all Services except for those meeting the Emergency and out-of-Service Area Urgent Services requirements, Access+ Specialist visits, Hospice Program Services received from a Participating Hospice Agency after the Member has been accepted into the Hospice Program, OB/GYN Services by an obstetrician/gynecologist or family practice Physician who is in the same Medical Group/IPA as the Personal Physician, and all Mental Health and substance abuse Services, must have prior authorization by the Personal Physician or Medical Group/IPA. The Member will be responsible for payment of ser-

vices that are not authorized or those that are not an Emergency or covered out-of-Service Area Urgent service procedures. (See the previous *Urgent Services* paragraphs for information on receiving Urgent Services out of the Service Area but within California.) Members must obtain Services from the Plan Providers that are authorized by their Personal Physician or Medical Group/IPA and, for all Mental Health and substance abuse Services, from MHS A Participating Providers. Hospice Services must be received from a Participating Hospice Agency.

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

### **LIMITATION OF LIABILITY**

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

If a Plan Provider ceases to be a Plan Provider, you will be notified if you are affected. The Plan will make every reasonable and medically appropriate provision to have another Plan Provider assume responsibility for Services to you. You will not be responsible for payment (other than Copayments) to a former Plan Provider for any authorized Services you receive. Once provisions have been made for the transfer of your care, services of a former Plan Provider are no longer covered.

### **UTILIZATION REVIEW**

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

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

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

### **PLAN SERVICE AREA**

The Plan Service Area of this Plan is identified in the HMO Physician and Hospital Directory. You and your eligible Dependents must live or work in the Plan Service Area identified in those documents to enroll in this Plan and to maintain eligibility in this Plan.

### **ELIGIBILITY**

If you are an Employee and reside or work in the Plan Service Area, you are eligible for coverage as a Subscriber the day following the date you complete the applicable waiting period established by your Employer.

A new N.E.C.A. Chapter or a new Contractor moving into an approved geographical area under the jurisdiction of the plan shall become an eligible Contractor or Chapter, with respect to its Employees 60 days after moving into the approved area and being designated a Chapter or Contractor by the National Electrical Contractors Association.

Your spouse or Domestic Partner and all your Dependent children who live or work in the Plan Service Area are eligible at the same time. (Special arrangements may be available for Dependents who are full-time students or do not live in the Subscriber's home. Please contact your Member Services Department to request an Away From Home Care<sup>®</sup> Program Brochure which explains these arrangements.)

When you do not enroll yourself or your Dependents during the initial enrollment period and later apply for coverage, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of, 12 months from the date of application for coverage or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under another employer health plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish Blue Shield written proof of the loss of coverage.

Newborn infants of the Subscriber, spouse or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. In order to have coverage continue beyond

the first 31 days without lapse, an application must be submitted to and received by Blue Shield within 31 days of the birth or placement for adoption. Eligibility during the first 31 days includes coverage for treatment of injury or illness only but does not include well-baby care Benefits unless the child is enrolled. Well-baby care Benefits are provided for enrolled children.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;
2. to add a spouse after marriage or add a Domestic Partner after establishing a domestic partnership;
3. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;
4. to add yourself and spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

Coverage is never automatic; an application is always required.

If a husband and wife or both partners in a domestic partnership are both eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification from the Member's Personal Physician of such disabling condition. Blue Shield or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield but not more frequently than 2 years after the initial certification and then annually thereafter.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group Plan. See your Employer for further information.

Subject to the requirements described under the Continuation of Group Coverage provision in this booklet, if applicable, an Employee and his or her Dependents will be eligible to con-

tinue group coverage under this Plan when coverage would otherwise terminate.

## EFFECTIVE DATE OF COVERAGE

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of, 12 months from the date you made a written request for coverage or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

If you declined coverage for yourself and your Dependents during the initial enrollment period because you or your Dependents were covered under another employer health plan, and you or your Dependents subsequently lost coverage under that plan, you will not be considered a Late Enrollee. Coverage for you and your Dependents under this Plan will become effective on the date of loss of coverage, provided you enroll in this Plan within 31 days from the date of loss of coverage. You will be required to furnish Blue Shield written evidence of loss of coverage.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of marriage, establishment of domestic partnership, birth or placement for adoption, you may request enrollment for yourself and your Dependents within 31 days. The effective date of enrollment for both you and your Dependents will depend on how you acquire your Dependent(s):

1. For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment;
2. For birth, the effective date will be the date of birth;
3. For a child placed for adoption, the effective date will be the date the Subscriber, spouse, or Domestic Partner has the right to control the child's health care.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another health plan sponsored by your Employer to the Access+ HMO. A completed enrollment form, which also indicates the choice of Personal Physician, must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the first day of the month following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield within 31 days. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer's next Open Enrollment Period.

If the Member is receiving Inpatient care at a non-Plan facility when coverage becomes effective, the Plan will provide Benefits only for as long as the Member's medical condition prevents transfer to a Plan facility in the Member's Personal Physician Service Area, as approved by the Plan. Unauthorized continuing or follow-up care in a non-Plan facility or by non-Plan Providers is not a Covered Service.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your Employer, you and all your Dependents who were validly covered under the previous group health plan on the date of discontinuance will be eligible under this Plan.

## **RENEWAL OF GROUP HEALTH SERVICE CONTRACT**

Blue Shield of California will offer to renew the Group Health Service Contract except in the following instances:

1. non-payment of Dues (see Termination of Benefits and Cancellation Provisions section);

2. fraud, misrepresentations or omissions;
3. failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4. termination of plan type by Blue Shield;
5. Employer moves out of the Service Area;
6. association membership ceases.

All groups will renew subject to the above.

## **PREPAYMENT FEE**

The monthly Dues for you and your Dependents are indicated in your Employer's group Contract. The initial Dues are payable on the effective date under the group Contract, and subsequent Dues are payable on the same date (called the transmittal date) of each succeeding month. Dues are payable in full on each transmittal date and must be made for all Subscribers and Dependents.

All Dues required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield of California. Payment of Dues will continue the Benefits of this group Contract up to the date immediately preceding the next transmittal date, but not thereafter.

The Dues payable under this Plan may be changed from time to time, for example, to reflect new Benefit levels. Your Employer will receive notice from the Plan of any changes in Dues at least 30 days prior to the change. Your Employer will then notify you immediately.

Note: These paragraphs on *Prepayment Fee* do not apply to a Member who is enrolled under a Contract where monthly Dues automatically increase, without notice, the first day of the month following an age change that moves the Member into the next higher age category.

## **PLAN CHANGES**

No change in the Plan Benefits nor waiver of any of its provisions shall be valid without the approval of Blue Shield.

The Benefits of this Plan are subject to change following at least 30 days' written notice by Blue Shield.

Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change. There is no vested right to obtain Benefits. Benefits for Services or supplies furnished on or after the effective date of any Benefit modification shall be provided based on that modification.

## PLAN BENEFITS

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

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

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

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

You are responsible for paying a minimum charge (Copayment) to the Physician or provider of Services at the time you receive Services. The specific Copayments, as applicable, are listed in the Summary of Benefits.

## AMBULANCE SERVICES

The Plan will pay for ambulance Services as follows:

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

## CLAIMS FOR EMERGENCY AND OUT-OF-AREA URGENT SERVICES

1. Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record for payment to the Plan, within 1 year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. In the event covered medical transportation Services are obtained in such an emergency situation, the Blue Shield Access+ HMO shall pay the medical transportation provider directly.

2. Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating BlueCard Program provider, you must submit a complete claim with the Urgent Service record for payment to the Plan, within 1 year after the first provision of Urgent Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Urgent Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. If the Plan determines that the services would not have been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

## CLINICAL TRIAL FOR CANCER

Benefits are provided for routine patient care for a Member whose Personal Physician has obtained prior authorization and who has been accepted into an approved clinical trial for cancer provided that:

1. the clinical trial has a therapeutic intent and the Member's treating Physician determines that participation in the clinical trial has a meaningful potential to benefit the Member with a therapeutic intent; and
2. the Member's treating Physician recommends participation in the clinical trial; and
3. the Hospital and/or Physician conducting the clinical trial is a Plan Provider, unless the protocol for the trial is not available through a Plan Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits.

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

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

An approved clinical trial is limited to a trial that is:

1. Approved by one of the following:
    - a. one of the National Institutes of Health;
    - b. the federal Food and Drug Administration, in the form of an investigational new drug application;
    - c. the United States Department of Defense;
    - d. the United States Veterans' Administration;
- or
2. Involves a drug that is exempt under federal regulations from a new drug application.

## DIABETES CARE

### 1. Diabetic Equipment

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

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

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

### 2. Diabetes Self-Management Training

Diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the diabetes-related devices and equipment and any additional treatment for these Services if directed or prescribed by the Member's Personal Physician and authorized. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

## DURABLE MEDICAL EQUIPMENT

Medically Necessary Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

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

1. Rental charges for Durable Medical Equipment in excess of purchase price are not covered;
2. Routine maintenance or repairs, even if due to damage, are not covered;

3. Environmental control equipment, generators, and self-help/educational devices are not covered;
4. No benefits are provided for backup or alternate items;
5. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item\*.

\*This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: See the Outpatient Prescription Drugs Supplement for Benefits for asthma inhalers and inhaler spacers.)

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

If you are enrolled in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency. For information see *Hospice Program Services* in the Plan Benefits section.

Note: There is a per Member per Calendar Year Benefit maximum as shown in the Summary of Benefits for all covered Services under the *Durable Medical Equipment* Benefit, except for oxygen and those Services covered under the *Diabetes Care* Benefit.

### EMERGENCY SERVICES

1. Emergency Services. Members who reasonably believe that they have an emergency medical or Mental Health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the Personal Physician or the MHSA by phone within 24 hours of the commencement of the Emergency Services, or as soon as it is medically possible for the Member to provide notice. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition. The Emergency Services Copayment is waived if the Member is admitted directly to the Hospital as an Inpatient from the emergency room.
2. Continuing or Follow-up Treatment. The Plan will provide benefits for care in a non-Plan Hospital only for as long as the Member's medical condition prevents transfer to a Plan Hospital in the Member's Personal Physician Service Area, as approved by the Medical Group/IPA or by Blue Shield. Unauthorized continuing or follow-up care after the initial emergency has been treated in a non-Plan Hospital, or by a non-Plan Provider is not a covered service.

### FAMILY PLANNING AND INFERTILITY SERVICES

1. Family Planning Counseling.
2. Infertility Services. Infertility Services, except as excluded in the Principal Limitations, Exceptions, Exclusions and Reductions section, including professional, Hospital, ambulatory surgery center, and ancillary Services to diagnose and treat the cause of Infertility. Any services related to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service) are not covered.
3. Tubal Ligation.
4. Elective Abortion.
5. Vasectomy.
6. Physician office visits for diaphragm fitting.
7. Injectable contraceptives when administered by a Physician.

### HOME HEALTH CARE SERVICES, PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS, AND HOME INFUSION THERAPY

1. Home Health Care Services

The following home health care Services will be covered when the patient is required to be at home for Medically Necessary purposes at the direction of the Personal Physician, and the Services are Medically Necessary and authorized. Home health Benefits are limited to a combined visit maximum as shown in the Summary of Benefits during any Calendar Year for all providers other than Plan Physicians except when provided through a Hospice Program received from a Participating Hospice.

Note: For information concerning hospice program Services see *Hospice Program Services* in the Plan Benefits section.

- a. Intermittent and part-time home visits by a home health agency to provide Skilled Nursing Services and other skilled Services up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:
  - (1) Registered nurse,
  - (2) Licensed vocational nurse,
  - (3) Physical therapist, occupational therapist, or speech therapist,
  - (4) Certified home health aide in conjunction with the Services of (1), (2) or (3) above;
- b. Medical Social Worker. Medical social Services provided by a licensed medical social worker for consultation and evaluation;
- c. In conjunction with the professional Services rendered by a home health agency, medications, drugs and medical supplies used during a covered visit by

the home health agency necessary for the home health care treatment plan, and related pharmaceutical and laboratory Services to the extent the Benefits would have been provided had the Member remained in the Hospital. This Benefit includes parenteral and enteral nutritional Services and associated supplies and supplements.

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

See the Hospice Program Services section for a specialized description of Skilled Nursing Services for hospice care.

## 2. PKU Related Formulas and Special Food Products

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

## 3. Home Infusion IV Injectable Therapy provided by a Home Infusion Agency

Benefits are provided for home infusion therapy and medical supplies, including the cost of pharmaceuticals administered intravenously; and for Medically Necessary, FDA approved injectable medications, when prescribed by the Personal Physician and prior authorized.

Note: This Benefit does not include Insulin or home self-administered injectables, which are covered under the supplemental Benefit for Outpatient Prescription Drugs, if the Member's Employer provides supplemental benefits for prescription drugs.

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

## **HOSPICE PROGRAM SERVICES**

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

Plan Provider. Member Copayments when applicable are paid to the Participating Hospice Agency.

Note: Hospice services provided by a non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies. If Blue Shield prior authorizes Hospice Program Services from a non-contracted Hospice, the Member's Copayment for these Services will be the same as the Copayments for Hospice Program Services when received and authorized by a Participating Hospice Agency.

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

1. Pre-Hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning (Members do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified Health Aide Services, and Homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical Social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Members to the extent that these needs are not met by the Personal Physician.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical Therapy, Occupational Therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain Activities of Daily Living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24-hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.

12. Respite Care Services are limited to an occasional basis and to no more than 5 consecutive days at a time.

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

## DEFINITIONS

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

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

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

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

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

1. Considers the Member and the Member's family in addition to the Member, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social, and spiritual needs of the Member and the Member's family.

3. Requires the Interdisciplinary Team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of Services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.
8. Is provided through a Participating Hospice.

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

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

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

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

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

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

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

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

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

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

## HOSPITAL SERVICES

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

1. Inpatient Hospital Services include:
  - a. Semi-private room and board, unless a private room is Medically Necessary;
  - b. General nursing care, and special duty nursing when Medically Necessary;
  - c. Meals and special diets when Medically Necessary;
  - d. Intensive care Services and units;
  - e. Operating room, special treatment rooms, delivery room, newborn nursery and related facilities;
  - f. Hospital ancillary Services including diagnostic laboratory, X-ray Services and therapy Services;

- g. Drugs, medications, biologicals, and oxygen administered in the Hospital, and up to 3 days' supply of drugs supplied upon discharge by the Plan Physician for the purpose of transition from the Hospital to home;
- h. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and Prostheses, other medical supplies and medical appliances, and equipment administered in the Hospital;
- i. Administration of blood, blood plasma including the cost of blood, blood plasma, and in-Hospital blood processing;
- j. Radiation therapy, chemotherapy, and renal dialysis;
- k. Subacute Care;
- l. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of 7 or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon;
- m. Medically Necessary Inpatient substance abuse detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room or when Medically Necessary Inpatient substance abuse detoxification is prior authorized;
- n. Medically Necessary Inpatient skilled nursing Services, including Subacute Care. Note: These Services are limited to the day maximum as shown in the Summary of Benefits during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether in a Hospital or a Skilled Nursing Facility;
- o. Rehabilitation when furnished by the Hospital and authorized.

Note: See *Hospice Program Services* in the Plan Benefits section for Inpatient Hospital Services provided under the hospice program Services Benefit.

2. Outpatient Hospital Services:
  - a. Services and supplies for treatment (including dialysis, radiation and chemotherapy) or surgery in an Outpatient Hospital setting.
  - b. Services for general anesthesia and associated facility charges in connection with dental procedures

when performed in a Hospital Outpatient setting or ambulatory surgery center because of an underlying medical condition or clinical status and the Member is under the age of 7 or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

### **MEDICAL TREATMENT OF THE TEETH, GUMS, JAW JOINTS OR JAW BONES**

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

1. The treatment of tumors of the gums;
2. The treatment of damage to natural teeth caused solely by an Accidental Injury is limited to medically necessary Services until the Services result in initial, palliative stabilization of the Member as determined by the Plan;  
  
Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.
3. Medically necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or
6. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct skeletal deformity.

This Benefit does not include:

1. Services performed on the teeth, gums (other than tumors) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ;
3. Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
4. Dental implants (endosteal, subperiosteal or transosteal);

5. Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
6. Fluoride treatments except when used with radiation therapy to the oral cavity.

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

### **MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

Blue Shield of California's MHSA administers and delivers the Plan's Mental Health and substance abuse Benefits. All Non-Emergency Mental Health and substance abuse Services must be arranged through the MHSA. Also, all Non-Emergency Mental Health and substance abuse Services must be prior authorized by the MHSA. For prior authorization for Mental Health and substance abuse Services, Members should contact the MHSA at 1-877-263-8827.

All Mental Health and substance abuse Services must be obtained from MHSA Participating Providers. (See the How to Use Your Health Plan section, the *Mental Health and Substance Abuse Services* paragraphs for more information.)

Benefits are provided for the following Medically Necessary covered Mental Health and substance abuse Services, subject to applicable Copayments and charges in excess of any Benefit maximums. Coverage for these Services is subject to all terms, conditions, limitations and exclusions of the Contract, to any conditions or limitations set forth in the benefit description below, and to the Principal Limitations, Exceptions, Exclusions and Reductions set forth in this booklet.

#### **1. Inpatient Services**

Inpatient Hospital and professional Services in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child) are covered. All Non-Emergency Mental Health and substance abuse Services must be prior authorized by the MHSA and obtained from MHSA Participating Providers. Residential care is not covered.

Note: See *Hospital Services* in the Plan Benefits section for information on Medically Necessary Inpatient substance abuse detoxification.

(If Inpatient substance abuse treatment is selected as an optional benefit by your Employer, refer to the Inpatient Substance Abuse Treatment Supplement for the Benefit description, limitations and Copayments.)

#### **2. Outpatient Services**

- a. Medically necessary Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and substance abuse visits or sessions. This Benefit is limited to a combined visit maximum as shown in the Summary of

Benefits for diagnosis and treatment in any Calendar Year. Intensive Outpatient Care is not covered under this Benefit.

- b. Medically necessary Outpatient Psychiatric Care for the diagnosis and treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child. Intensive Outpatient Care is covered under this Benefit.

### 3. Outpatient Partial Hospitalization Services

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

### 4. Psychological Testing

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

### 5. Psychosocial Support

See the *Mental Health and Substance Abuse Services* paragraphs under the How to Use Your Health Plan section for information on psychosocial support Services available under Lifepath Advisers.

## ORTHOSES

Medically necessary Orthoses for Activities of Daily Living are covered, including the following:

1. Special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, or by accident or developmental disability;
2. Medically Necessary functional foot Orthoses that are custom made rigid inserts for shoes, ordered by a Physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
3. Medically necessary knee braces for post-operative Rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis.

Benefits for Medically Necessary Orthoses are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized appliances equally appropriate for a condition, this Plan will provide Benefits based on the most cost effective appliance. Routine maintenance is not covered. No Benefits are provided for backup or alternate items.

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

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

## OTHER OUTPATIENT SERVICES

1. Laboratory, X-ray, Major Diagnostic Services. All Outpatient diagnostic X-ray and clinical laboratory tests and Services, including diagnostic imaging, electrocardiograms and diagnostic clinical isotope Services.
2. Renal Dialysis. Outpatient renal dialysis unless covered by Medicare.
3. Injectable Medications. Injectable medications approved by the Food and Drug Administration (FDA) are covered for the Medically Necessary treatment of medical conditions when prescribed or authorized by the Personal Physician or as described herein. Insulin and home self-administered injectables will be covered if the Member's Employer provides benefits for prescription drugs through the supplemental Benefit for Outpatient Prescription Drugs.

Note: See *Professional (Physician) Services* in the Plan Benefits section for information on separate coverage for allergy injectable medications, subject to the applicable Copayments.

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

Note: See *Pregnancy and Maternity Care* in the Plan Benefits section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

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

## OUTPATIENT REHABILITATION SERVICES

Rehabilitation Services include Physical Therapy, Occupational Therapy, and/or Respiratory Therapy pursuant to a written treatment plan for as long as continued treatment is Medically Necessary, and when rendered in the Provider's office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in *Speech Therapy* in the Plan Benefits section. Medically Necessary Services will be authorized for

an initial treatment period and any additional subsequent Medically Necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is Medically Necessary and is provided with the expectation that the patient has restorative potential.

Note: See *Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy* in the Plan Benefits section for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

## **PREGNANCY AND MATERNITY CARE**

The following pregnancy and maternity care is covered subject to the exclusions listed in the Principal Limitations, Exceptions, Exclusions and Reductions section:

1. Prenatal and postnatal Physician office visits and delivery, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.

Note: See *Other Outpatient Services* in the Plan Benefits section for information on coverage of other genetic testing and diagnostic procedures.

2. Inpatient Hospital Services. Hospital Services for the purposes of a normal delivery, routine newborn circumcision,\* Cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth.
3. Outpatient routine newborn circumcision.\*

\*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized.

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

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

## **PREVENTIVE HEALTH SERVICES**

Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of

disease when no symptoms are present and for those items specifically listed below.

1. Scheduled routine physical examinations as follows:
  - a. Well-baby care through age 2 years;
  - b. Exams every year, age 3-19 years;
  - c. Exams every 5 years, age 20-40 years;
  - d. Exams every 2 years, age 41-50 years;
  - e. Exams every year over age 50 years;
  - f. Routine breast and pelvic exams and Pap tests or other FDA (Food and Drug Administration) approved cervical cancer and human papillomavirus virus (HPV) screening tests every year. A woman may self-refer to an OB/GYN or family practice Physician who is in the same Medical Group/IPA as her Personal Physician for a routine annual gynecological exam;
  - g. Mammography for screening purposes recommended by Member's Personal Physician.
2. Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), except for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.
3. Hearing screening by the Personal Physician for Members through the age of 18 to determine the need for an audiogram or for hearing correction, as well as newborn hearing screening Services.
4. Vision screening by the Personal Physician for Members through the age of 18 to determine the need for a refraction for vision correction.
5. Health education and health promotion Services provided by Blue Shield's Center for Health Improvement offer a variety of wellness resources including, but not limited to, a Member newsletter and a prenatal health education program.
6. Blue Shield's Internet site is located at <http://www.blueshieldca.com>. Members with Internet access and a Web browser may view and download health-care information.
7. Nurse support: As part of Lifepath Advisers, Members may call a registered nurse via 1-866-543-3728, a 24-hour, toll-free number to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

Note: See *Family Planning and Infertility Services, Other Outpatient Services, Pregnancy and Maternity Care, and Professional (Physician) Services* in the Plan Benefits section for information on other preventive health and diagnostic screening services, including genetic testing and diagnostic procedures, family planning, and prenatal care.

**PROFESSIONAL (PHYSICIAN) SERVICES  
(OTHER THAN FOR MENTAL HEALTH AND SUBSTANCE  
ABUSE SERVICES)**

1. **Physician Office Visits.** Office visits for examination, diagnosis, and treatment of a medical condition, disease or injury, including Specialist office visits, second opinion or other consultations, office surgery, Outpatient chemotherapy and radiation therapy, diabetic counseling, audiometry examinations when performed by a Physician or by an audiologist at the request of a Physician, and OB/GYN Services from an obstetrician/gynecologist or family practice Physician who is within the same Medical Group/IPA as the Personal Physician. Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
2. **Home Visits.** Medically Necessary home visits by Plan Physician.
3. **Allergy Testing and Treatment.** Office visits for the purpose of allergy testing and treatment, including injectables and serum.
4. **Inpatient Medical and Surgical Physician Services.** Physicians' Services in a Hospital or Skilled Nursing Facility for examination, diagnosis, treatment and consultation including the Services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist. Inpatient professional Services are covered only when Hospital and Skilled Nursing Facility Services are also covered.
5. **Treatment of physical complications of a mastectomy,** including lymphedemas.
6. **Internet Based Consultation.** Medically Necessary consultations with Internet Ready Physicians via the Blue Shield approved Internet portal. Internet based consultations are available only to Members whose Personal Physicians (or other Physicians to whom you have been referred for care within your Personal Physician's Medical Group/IPA) have agreed to provide Internet based consultations via the Blue Shield approved Internet portal ("Internet Ready"). Internet based consultations for Mental Health and substance abuse care are not covered. Refer to the On-Line Physician Directory to determine whether your Physician is Internet Ready and how to initiate an Internet based consultation. This information can be accessed at <http://www.blueshieldca.com>.

**PROSTHESES AND OTHER SERVICES**

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are 2 or more professionally recognized items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

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

1. Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

Routine maintenance is not covered. Benefits do not include wigs for any reason or any type of speech or language assistance devices except as specifically provided above. See the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices. No benefits are provided for backup or alternate items.

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

Note: For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see *Reconstructive Surgery* in the Plan Benefits section. Blom-Singer and artificial larynx Prostheses for speech following a laryngectomy are covered as a surgical professional Benefit.

**RECONSTRUCTIVE SURGERY**

Medically Necessary Services in connection with Reconstructive Surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health and Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy are covered. Surgery must be authorized as described herein. Any such Services must be received while the Plan is in force with respect to the Member. Benefits will be provided in accordance with guide-

lines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

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

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

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

#### **SKILLED NURSING FACILITY SERVICES**

Subject to all of the Inpatient Hospital Services provisions, Medically Necessary skilled nursing Services, including Subacute Care, will be covered when provided in a Skilled Nursing Facility and authorized. This Benefit is limited to a combined day maximum as shown in the Summary of Benefits during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing Services whether in a Hospital or a Skilled Nursing Facility. Custodial care is not covered.

Note: For information concerning hospice program Services see *Hospice Program Services* in the Plan Benefits section.

#### **SPEECH THERAPY**

Initial Outpatient Benefits for Speech Therapy Services when diagnosed and ordered by a Physician and provided by an appropriately licensed speech therapist, pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, or (2) evaluate the effectiveness of treatment, and when rendered in the Provider's office or Outpatient department of a Hospital.

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

Continued Outpatient Benefits will be provided for Medically Necessary Services as long as continued treatment is Medically Necessary, pursuant to the treatment plan, and likely to

result in clinically significant progress as measured by objective and standardized tests. The Provider's treatment plan and records will be reviewed periodically. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Member will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under the Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy Benefit, no Outpatient Benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See *Home Health Care Services*, *PKU Related Formulas and Special Food Products*, and *Home Infusion Therapy* in the Plan Benefits section for information on coverage for Speech Therapy Services rendered in the home, including visit limits. See *Hospital Services* in the Plan Benefits section for information on Inpatient Benefits and *Hospice Program Services* in the Plan Benefits section for hospice program Services.

#### **TRANSPLANT BENEFITS**

##### **Organ Transplant Benefits**

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

1. Provided in connection with the transplant of a cornea, kidney, or skin, when the recipient of such transplant is a Member;
2. Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

##### **Special Transplant Benefits**

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

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

- a. Human heart transplants;
  - b. Human lung transplants;
  - c. Human heart and lung transplants in combination;
  - d. Human kidney and pancreas transplants in combination;
  - e. Human liver transplants;
  - f. Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
  - g. Pediatric human small bowel transplants;
  - h. Pediatric and adult human small bowel and liver transplants in combination.
3. Services incident to obtaining the transplant material from a living donor or an organ transplant bank will be covered.

### **URGENT SERVICES**

Urgent Services required when the Member is within his or her Personal Physician Service Area must be obtained in accordance with the How to Use Your Health Plan section.

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

#### **Inside California**

For Urgent Services within California but outside the Member's Personal Physician Service Area, the Member should, if possible, contact Blue Shield Member Services at the number provided on the last page of this booklet in accordance with the How to Use Your Health Plan section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California Plan Provider. Members may also locate a Plan Provider by visiting Blue Shield's internet site at <http://www.blueshieldca.com>. You are not required to use a Blue Shield of California Plan Provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

#### **Outside California or the United States**

When temporarily traveling outside California or the United States, if possible, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard Program participating provider. When a BlueCard Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-BlueCard participating provider. If you received services

from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. See *Claims for Emergency and Out-of-Area Urgent Services* in the Plan Benefits section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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

Outside the United States, Urgent Services are available through the BlueCard Worldwide Network, but may be received from any provider.

Members before traveling abroad should call their local Member Services office for the most current listing of participating providers worldwide or they can go on line at <http://www.bcbs.com> and select the "Find a Doctor or Hospital" tab. However, a Member is not required to receive Urgent Services outside of the United States from the BlueCard Worldwide Network. If the Member does not use the BlueCard Worldwide Network, a claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the Plan Benefits section.

## **PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS**

### **GENERAL EXCLUSIONS AND LIMITATIONS**

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

1. Experimental or Investigational in Nature except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under *Clinical Trial for Cancer* in the Plan Benefits section;
2. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for Custodial, Maintenance, or Domiciliary Care except as provided under *Hospice Program Services* in the Plan Benefits section; or rest;
3. for substance abuse treatment or rehabilitation on an Inpatient, Partial Hospitalization or Outpatient basis, except as specifically provided

under *Mental Health and Substance Abuse Services* in the Plan Benefits section;

4. performed in a Hospital by Hospital officers, residents, interns and others in training;
5. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
6. for Cosmetic Surgery or any resulting complications, except that Medically Necessary Services to treat complications of Cosmetic Surgery (e.g., infections or hemorrhages) will be a Benefit, but only upon review and approval by a Blue Shield Physician consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
  - Lower eyelid blepharoplasty;
  - Spider veins;
  - Procedures to smooth the skin (i.e., chemical face peels, laser resurfacing, and abrasive procedures);
  - Hair removal by electrolysis or other means; and
  - Reimplantation of breast implants originally provided for cosmetic augmentation;
7. incident to an organ transplant; except as provided under *Transplant Benefits* in the Plan Benefits section;
8. for convenience items such as telephones, TVs, guest trays, and personal hygiene items;
9. for transgender or gender dysphoria conditions, including but not limited to intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
10. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.) procedure, artificial insemination, including related medications, laboratory, and radiology services, services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for Covered Services for Pregnancy and Maternity Care under a Blue Shield of California health plan;
11. for or incident to the treatment of Infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation, or any resulting complications, except for medically necessary treatment of medical complications;
12. for or incident to Speech Therapy, speech correction, or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically provided under *Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy; Speech Therapy; and Hospice Program Services* in the Plan Benefits section;
13. for routine foot care including callus, corn paring or excision and toenail trimming (except as may be provided through a Participating Hospice Agency); treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot; for special footwear (e.g., non-custom made or over-the-counter shoe inserts or arch supports) except as specifically provided under *Orthoses and Diabetes Care* in the Plan Benefits section;
14. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided under *Prostheses and Other Services* in the Plan Benefits section, and video-assisted visual aids or video magnification equipment for any purpose);
15. for hearing aids;

16. for Dental Care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones* in the Plan Benefits section;
17. for or incident to services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under *Hospital Services* and *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones* in the Plan Benefits section;
18. for or incident to reading, vocational, educational, recreational, art, dance or music therapy; weight control or exercise programs;
19. for learning disabilities, or behavioral problems;
20. for or incident to acupuncture, except as specifically provided;
21. for spinal manipulation and adjustment, except as specifically provided under *Professional (Physician) Services* (other than for Mental Health and Substance Abuse Services) in the Plan Benefits section;
22. for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of Benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges;
23. in connection with private duty nursing, except as provided under *Hospital Services, Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy*, and *Hospice Program Services* in the Plan Benefits section;
24. for testing for intelligence or learning disabilities;
25. for rehabilitation services except as specifically provided under *Hospital Services, Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy*, and *Outpatient Rehabilitation Services* in the Plan Benefits section;
26. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drugs Supplement or *Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy* in the Plan Benefits section;
27. for contraceptives and contraceptive devices, except as specifically included under *Family Planning and Infertility Services* in the Plan Benefits section and under the Outpatient Prescription Drugs Supplement; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drugs Supplement; no benefits are provided for contraceptive implants;
28. for transportation services other than provided under *Ambulance Services* in the Plan Benefits section;
29. for unauthorized non-Emergency Services;
30. not provided by, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN Services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician, Emer-

- gency Services or Urgent Services as provided under *Emergency Services* and *Urgent Services* in the Plan Benefits section, when specific authorization has been obtained in writing for such Services as described herein, for Mental Health and substance abuse Services which must be arranged through the MHSA or for Hospice Services received by a Participating Hospice Agency;
31. performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;
  32. for orthopedic shoes, except as provided under *Diabetes Care* in the Plan Benefits section, home testing devices, environmental control equipment, generators, exercise equipment, self help/educational devices, or for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistance devices, except as provided under *Prostheses and Other Services* in the Plan Benefits section, vitamins, and comfort items;
  33. for physical exams required for licensure, employment, or insurance unless the examination corresponds to the schedule of routine physical examinations provided under *Preventive Health Services* in the Plan Benefits section, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;
  34. for penile implant devices and surgery, and any related services except for any resulting complications and Medically Necessary Services as provided under *Reconstructive Surgery* in the Plan Benefits section;
  35. for home testing devices and monitoring equipment except for use of the peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes and the apnea monitor for management of newborn apnea when authorized as Durable Medical Equipment;
  36. for or incident to sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
  37. for non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under *Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy, Hospice Program Services and Diabetes Care* in the Plan Benefits section;
  38. for Reconstructive Surgery and procedures: 1) where there is another more appropriate surgical procedure that is approved by a Blue Shield Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited under *Reconstructive Surgery* in the Plan Benefits section;
  39. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health and Safety Code, Section 1367.21 have been met;
  40. for prescription or non-prescription food and nutritional supplements, except as provided for PKU related formulas as described under *Home Health Care Services, PKU Related Formulas and Special Food Products and Home Infusion Therapy* in the Plan Benefits section;
  41. for genetic testing except as described under *Other Outpatient Services, and Pregnancy and Maternity Care* in the Plan Benefits section;
  42. not specifically listed as a benefit.

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

## **MEDICAL NECESSITY EXCLUSION**

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

## **LIMITATIONS FOR DUPLICATE COVERAGE**

### **When you are eligible for Medicare**

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

benefits for end-stage renal disease from Medicare.

- d. When you are retired and age 65 years or older.

When your Blue Shield group plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if you were not eligible to receive benefits from Medicare (based on the lower of Blue Shield's Allowed Charges or the Medicare allowed amount). Your Blue Shield group plan deductible and copayments will be waived.

### **When you are eligible for Medi-Cal**

Medi-Cal always provides benefits last.

### **When you are a qualified veteran**

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

### **When you are covered by another government agency**

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

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

## **EXCEPTION FOR OTHER COVERAGE**

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

## **CLAIMS AND SERVICES REVIEW**

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

## **REDUCTIONS - THIRD PARTY LIABILITY**

If a Member is injured through the act or omission of another person (a "third party"), Blue Shield, the Member's designated Medical Group, and the Independent Practice Association shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution or other available remedy to recover the reasonable costs of Services provided to the Member.

The Member is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Member anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate with Blue Shield and the Member's designated Medical Group, and Independent Practice Association to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and
3. Provide Blue Shield and the Member's designated Medical Group, and Independent Practice Association with a lien, in the amount of the reasonable costs of Benefits provided, calculated in accordance with California Civil Code Section 3040. The lien may be filed with the

third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

A Member's failure to comply with 1. through 3. above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield, the Member's designated Medical Group, or Independent Practice Association.

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

## **COORDINATION OF BENEFITS**

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

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

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

If the covered person is also entitled to benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the Benefits of this Plan.

The following rules determine the order of benefit payments:

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

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the patient as a Dependent of a person whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, shall determine its benefits before a plan which covers that person as a

Dependent of a person whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Notwithstanding (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:
  - a. a plan covering a patient as a laid-off or retired employee, or as a Dependent of such an employee, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such Dependent; and,
  - b. if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (a.) above shall not apply.

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

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

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

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

Blue Shield may release to or obtain from any organization or person any information which Blue Shield considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish Blue Shield with such information as may be necessary to implement these provisions.

## **TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS**

### **TERMINATION OF BENEFITS**

Coverage for you or your Dependents terminates at 12:01 a.m. Pacific Time on the earliest of these dates: (1) the date the Group Health Service Contract is discontinued, (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and your Employer, (3) fifteen (15) days following the date of mailing of the notice to the Employer that Dues are not paid (see *Cancellation for Non-Payment of Dues - Notices*), or (4) on the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment, or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

Except as specifically provided under the *Extension of Benefits* and *Group Continuation Coverage* provisions, there is no right to receive benefits for services provided following termination of this group Contract.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also, see the Group Continuation Coverage and Individual Conversion Plan section for information on continuation of coverage.

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

If application is not made for a newborn or a child placed for adoption within the 31 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 32<sup>nd</sup> day at 12:01 a.m. Pacific Time.

If the Subscriber no longer lives or works in the Plan Service Area, coverage will be terminated for him and all his Dependents. If a Dependent no longer lives or works in the Plan Service Area, then that Dependent's coverage will be terminated. (Special arrangements may be available for Dependents who are full-time students or do not live in the Subscriber's home. Please contact the Member Services Department to request an Away From Home Care<sup>®</sup> Program Brochure which explains these arrangements.)

Additionally, the Plan may terminate coverage of a Member for cause immediately upon written notice for the following:

1. Material information that is false or misrepresented information provided on the enrollment application or given to the group or the Plan; see the Cancellation/Rescission for Fraud, Misrepresentations or Omissions provision;
2. Permitting a non-Member to use a Member identification card to obtain Services and Benefits;
3. Obtaining or attempting to obtain Services or Benefits under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions;
4. Abusive or disruptive behavior which: (1) threatens the life or well-being of the Plan personnel and providers of Services, or, (2) substantially impairs the ability of Blue Shield of California to arrange for Services to the Member, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Member or to other patients.

The Plan may also terminate coverage of a Member for cause upon 31 days written notice for the following:

1. Inability to establish a satisfactory Physician-patient relationship after following the procedures under *Relationship with Your Personal Physician* in the Choice of Physicians and Providers section;
2. Failure to pay any Copayment or supplemental charge.

## **REINSTATEMENT**

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

## **CANCELLATION WITHOUT CAUSE**

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

## **CANCELLATION FOR NON-PAYMENT OF DUES - NOTICES**

Blue Shield may cancel this group Contract for non-payment of Dues. If your Employer fails to pay the required Dues when due, Blue Shield of California will mail your Employer a Prospective Notice of Cancellation at least 15 days before any cancellation of coverage. This notice will provide information to your Employer regarding the consequences of your Employer's failure to pay the Dues due within 15 days of the date the notice was mailed.

If payment is not received from your Employer within 15 days of the date the Prospective Notice of Cancellation is mailed, Blue Shield of California will cancel the Group Health Service Contract at the end of that 15-day period and coverage for you and all your Dependents will end on that date. Blue Shield of California will send your Employer a Notice Confirming Termination of Coverage. Your Employer must provide you with a copy of the Notice Confirming Termination of Coverage.

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

## **CANCELLATION/RESCISSION FOR FRAUD, MISREPRESENTATIONS OR OMISSIONS**

Blue Shield may cancel the group Contract for fraud or misrepresentation by your Employer, or with respect to coverage of Employees or Dependents, for fraud or misrepresentation of the Employee, Dependent, or their representative.

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

Misrepresentations or omissions on an application or a health statement (if a health statement is required by the Employer) may result in the cancellation or rescission of this Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

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

## **RIGHT OF CANCELLATION**

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

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

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

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

See the Cancellation/Rescission for Fraud, Misrepresentations or Omissions provision for termination for misrepresentations or omissions.

## **GROUP CONTINUATION COVERAGE AND INDIVIDUAL CONVERSION PLAN**

### **INDIVIDUAL CONVERSION PLAN**

Regardless of age, physical condition or employment status, you may continue Blue Shield protection when you retire, leave the job or become ineligible for group coverage. If you have held group coverage for 3 or more consecutive months, you and your enrolled Dependents may apply to transfer to an individual conversion health plan then being issued by Blue Shield. Your Employer is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of termination of the Contract's coverage.

An application and first Dues payment for the conversion plan must be received by Blue Shield within 63 days of the date of termination of your group coverage. However, if the group Contract is replaced by your Employer with similar coverage under another contract within 15 days, transfer to the individual conversion health plan will not be permitted. You will not be permitted to transfer to the individual conversion plan and coverage under the individual conversion plan will end, under any of the following circumstances:

1. You failed to pay amounts due the Plan;
2. You were terminated by the Plan for good cause or for fraud or misrepresentation;
3. You knowingly furnished incorrect information or otherwise improperly obtained the Benefits of the Plan;
4. You are covered or eligible for Medicare;
5. You are covered or eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; and,
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in your group Plan.

An individual conversion health Plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for Dependent coverage under the group Plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse or Domestic Partner of a Subscriber, if their marriage or domestic partnership has terminated;
5. Dependents, when continuation of coverage under COBRA and/or Cal-COBRA expires, or is terminated.

When a Dependent reaches the limiting age for coverage as a Dependent, or if a Dependent becomes ineligible for any of the other reasons given above, it is your responsibility to inform Blue Shield. Upon receiving notification, Blue Shield will offer such Dependent an individual conversion health plan for purposes of continuous coverage.

### **GUARANTEED ISSUE INDIVIDUAL COVERAGE**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and under California law, you may be entitled to apply for certain of Blue Shield's individual health plans on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons if you meet the other eligibility requirements, you live or work in Blue Shield's Service Area and you agree to pay all required Dues). You may also be eligible to purchase similar coverage on a guaranteed issue basis from any other health plan that sells individual coverage for hospital, medical or surgical benefits. Not all Blue Shield individual plans are available on a guaranteed issue basis under HIPAA. To be eligible, you must meet the following requirements:

- You must have at least 18 or more months of creditable coverage.
- Your most recent coverage must have been group coverage (COBRA and Cal-COBRA are considered group coverage for these purposes).

- You must have elected and exhausted all COBRA and/or Cal-COBRA coverage that is available to you.
- You must not be eligible for nor have any other health insurance coverage, including a group health plan, Medicare or Medi-Cal.
- You must make application to Blue Shield for guaranteed issue coverage within 63 days of the date of termination from the group plan.

If you elect Conversion Coverage, Continuation of Group Coverage After COBRA and/or Cal-COBRA, or other Blue Shield individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Member Services representative at the telephone number noted on your ID Card.

## EXTENSION OF BENEFITS

If a person becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the group Contract terminates, Blue Shield will extend the Benefits of this Plan, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) the date the covered person is no longer Totally Disabled; (2) 12:00 a.m. Pacific Time on the day following a period of 12 months from the date the group Contract terminated; (3) the date on which the covered person's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the person without limitation as to the Totally Disabling condition.

Written certification of the Member's Total Disability should be submitted to Blue Shield by the Member's Personal Physician as soon as possible after the Group Health Service Contract terminates. Proof of continuing Total Disability must be furnished by the Member's Personal Physician at reasonable intervals determined by Blue Shield.

## GROUP CONTINUATION COVERAGE

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

Applicable to Members when the Subscriber's Employer (Contractholder) 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). The Subscriber's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member will be entitled to elect to continue group coverage under this Plan if the Member would lose coverage otherwise because of

a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The Benefits under the group continuation of coverage will be identical to the Benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

Note: A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare. However, if Medicare entitlement arises after COBRA coverage begins, it will cease.

## Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences:

1. With respect to the Subscriber:
  - a. the termination of employment (other than by reason of gross misconduct); or
  - b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner\* and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
  - a. the death of the Subscriber; or
  - b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
  - c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
  - d. the divorce or legal separation of the Dependent spouse from the Subscriber or termination of the domestic partnership; or

\*Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

- e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
  - f. a Dependent child's loss of Dependent status under this Plan.
3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, when the Employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
  4. Such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

## Notification of a Qualifying Event

1. With respect to COBRA enrollees:

The Member is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

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

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan.

The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees:

The Member is 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 child's loss of Dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The 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 written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If the Member does not notify Blue Shield within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

## Duration and Extension of Continuation of Group Coverage

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.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

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

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

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

## Notification Requirements

The Employer 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. The COBRA enrollee should contact Blue Shield for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield at least 30 days before COBRA termination.

## Payment of Dues

Dues for the Member continuing coverage shall be 102 percent of the applicable group dues rate if the Member is a COBRA enrollee or 110 percent of the applicable group dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, dues for Cal-COBRA coverage shall be 110 percent of the applicable group dues rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all dues contributions to Blue Shield in the manner and for the period established under this Plan.

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

## Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Member's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

## Termination of Continuation of Group 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:

1. discontinuance of this Group Health Service Contract (if the Employer continues to provide any group benefit plan for Employees, the Member may be able to continue coverage with another plan);

2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to Blue Shield of California as applicable. Coverage will end as of the end of the period for which dues were paid;
3. the Member becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the Member;
4. the Member becomes entitled to Medicare;
5. the Member no longer resides in Blue Shield's Service Area;
6. the Member commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

## CONTINUATION OF GROUP COVERAGE AFTER COBRA AND/OR CAL-COBRA

The following section only applies to enrollees who became eligible for Continuation of Group Coverage After COBRA and/or Cal-COBRA prior to January 1, 2005:

Certain former Employees and their Dependent spouses or Dependent Domestic Partners (including a spouse who is divorced from the current Employee/former Employee and/or a spouse who was married to the Employee/former Employee at the time of that Employee/former Employee's death, or a Domestic Partner whose partnership with the current Employee/former Employee has terminated and/or a Domestic Partner who was in a Domestic Partner relationship with the Employee/former Employee at the time of that Employee/former Employee's death) may be eligible to continue group coverage beyond the date their COBRA and/or Cal-COBRA coverage ends. Blue Shield will offer the extended coverage to former Employees of employers that are subject to the existing COBRA or Cal-COBRA, and to the former Employees' Dependent spouses, including divorced or widowed spouses as defined above, or Dependent Domestic Partners, including surviving Domestic Partners or Domestic Partners whose partnership was terminated as defined above. This coverage is subject to the following conditions:

1. The former Employee worked for the Employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended.
2. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA).
3. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent Domestic Partner (a former Domestic Partner, i.e., a sur-

living Domestic Partner or Domestic Partner whose partnership has been terminated as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA).

Items 1., 2. and 3. above are not applicable to a former spouse or former Domestic Partner electing continuation coverage. The former spouse or former Domestic Partner must elect such coverage by notifying the Plan in writing within 30 calendar days prior to the date that the former spouse's or former Domestic Partner's initial COBRA and/or Cal-COBRA benefits are scheduled to end.

If elected, this coverage will begin after the COBRA and/or Cal-COBRA coverage ends and will be administered under the same terms and conditions as if COBRA and/or Cal-COBRA had remained in force.

For Members who transfer to this coverage from COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 102 percent of the applicable age adjusted group dues rate. For Members who transfer to this coverage from Cal-COBRA, dues for this coverage shall be 213 percent of the applicable group dues rate, or 110 percent of the applicable age adjusted group dues rate. Payment is due at the time the Employer's payment is due.

### **Termination of Continuation Coverage After COBRA and/or Cal-COBRA**

This coverage will end automatically on the earliest of the following dates:

1. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner reaches 65;
2. the date the Employer discontinues this Group Health Service Contract and ceases to maintain any group health plan for any active Employees;
3. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner transfers to another health plan, whether or not the benefits of the other health plan are less valuable than those of the health plan maintained by the Employer;
4. the date the former Employee, spouse, or Domestic Partner or former spouse or former Domestic Partner becomes entitled to Medicare;
5. for a spouse or Domestic Partner or former spouse or former Domestic Partner, 5 years from the date the spouse's or Domestic Partner's COBRA or Cal-COBRA coverage would end.

### **AVAILABILITY OF BLUE SHIELD OF CALIFORNIA INDIVIDUAL PLANS**

Blue Shield's Individual Plans described at the beginning of this section may be available to Members whose group coverage, COBRA or Cal-COBRA coverage, or Continuation of

Group Coverage After COBRA and/or Cal-COBRA is terminated or expires while covered under this group Plan. Note: Only Individual Conversion Coverage is available to Members who are terminated from Continuation of Group Coverage After COBRA and/or Cal-COBRA.

## **OTHER PROVISIONS**

### **PUBLIC POLICY PARTICIPATION PROCEDURE**

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

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

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

Sr. Manager, Regulatory Filings  
Blue Shield of California  
50 Beale Street  
San Francisco, CA 94105  
Phone Number: 1-415-229-5065

Please follow the following procedure:

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

### **CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION**

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health

information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

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

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services Department at the number provided on the last page of this booklet, or by accessing Blue Shield of California's Internet site located at <http://www.blueshieldca.com> and printing a copy.

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

### **Correspondence Address:**

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

### **Toll-Free Telephone:**

1-888-266-8080

### **Email Address:**

[blueshieldca\\_privacy@blueshieldca.com](mailto:blueshieldca_privacy@blueshieldca.com)

## **ACCESS TO INFORMATION**

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

## **NON-ASSIGNABILITY**

Benefits of this Plan are not assignable.

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

## **FACILITIES**

The Plan has established a network of Physicians, Hospitals, Participating Hospice Agencies and Non-Physician Health Care Practitioners in your Personal Physician Service Area.

The Personal Physician(s) you and your Dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the Plan network provide access to 24-hour Emergency Services. The list of the Hospitals, Physicians and Participating Hospice Agencies in your Personal Physician Service Area indicates the location and phone numbers of these Providers. Contact Member Services at the number provided on the last page of this booklet for information on Plan Non-Physician Health Care Practitioners in your Personal Physician Service Area.

For Urgent Services when you are within the United States, you simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, 7 days a week. For Urgent Services when you are outside the United States, you can call collect 1-804-673-1177 24 hours a day. We will identify the BlueCard Program provider closest to you. Urgent Services when you are outside the U.S. are available through the BlueCard Worldwide Network. For Urgent Services when you are within California, but outside of your Personal Physician Service Area, you should, if possible, contact your Personal Physician or Blue Shield Member Services at the number listed on the last page of this booklet in accordance with the How to Use Your Health Plan section. For Urgent Services when you are within your Personal Physician Service Area, contact your Personal Physician to obtain Urgent Services which must be provided or authorized by your Personal Physician just like all other non-Emergency Services of the Plan.

## **INDEPENDENT CONTRACTORS**

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

## **PAYMENT OF PROVIDERS**

Blue Shield generally contracts with groups of Physicians to provide Services to Members. A fixed, monthly fee is paid to the groups of Physicians for each Member whose Personal Physician is in the group. This payment system, capitation, includes incentives to the groups of Physicians to manage all Services provided to Members in an appropriate manner consistent with the contract.

If you want to know more about this payment system, contact Member Services at the number listed on the last page of this booklet.

## **PLAN INTERPRETATION**

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

## **ACCESS+ SATISFACTION**

You may provide Blue Shield with feedback regarding the service you receive from Plan Physicians. Return the prepaid postcard available from Member Services to Blue Shield. If you are dissatisfied with the service provided during an office visit with a Plan Physician, you may request a refund of your office visit Copayment, as shown in the Summary of Benefits under Professional (Physician) Services.

## **MEMBER SERVICES**

### **For all Services other than Mental Health and substance abuse**

If you have a question about Services, providers, Benefits, how to use your Plan, or concerns regarding the quality of care or access to care that you have experienced, you may call Blue Shield's Member Services Department at the number listed on the last page of this booklet.

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

You also may write to the Blue Shield Member Services Department as noted on the last page of this booklet.

Member Services can answer many questions over the telephone.

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

### **For all Mental Health and substance abuse Services**

For all Mental Health and substance abuse Services, Blue Shield of California has contracted with the Plan's MHSA. The MHSA should be contacted for questions about Mental Health and substance abuse Services, MHSA Participating Providers, or Mental Health and substance abuse Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

U. S. Behavioral Health Plan, California  
3111 Camino Del Rio North, Suite 600  
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

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

## **GRIEVANCE PROCESS**

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

### **For all Services other than Mental Health and substance abuse**

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

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this form from Member Services. The completed form should be submitted to Member Services Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011.

The Member may also submit the grievance online by visiting <http://www.blueshieldca.com>.

Blue Shield will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

### **For all Mental Health and substance abuse Services**

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

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

1-877-263-9952

U. S. Behavioral Health Plan, California  
Attn: Customer Service  
P. O. Box 880609  
San Diego, CA 92168

The MHSA will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Services section for information on the expedited decision process.

Note: 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 plan may have other voluntary alternative dispute resolution options, such as mediation.

## **EXTERNAL INDEPENDENT MEDICAL REVIEW**

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

## **DEPARTMENT OF MANAGED HEALTH CARE REVIEW**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan **at the number provided on the last page of this booklet** and use your health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If

you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR application forms and instructions online.

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

## DEFINITIONS

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

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

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

**Allowed Charges** — the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan Providers (except that Physicians rendering Emergency Services who are not Plan Providers will be paid based on the lesser of the provider's billed charges or a reasonable and customary amount, as determined by Blue Shield).

**Ambulatory Surgery Center** — an Outpatient surgery facility which:

1. is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,
2. provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital.

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

**Calendar Year** — a period beginning 12:01 a.m., January 1 and ending 12:01 a.m., January 1 of the following year.

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

**Contractholder** — Trustees of N.E.C.A. West Health and Welfare Fund.

**Copayment** — the amount which a Member is required to pay for certain Benefits.

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

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

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

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,
2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

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

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

**Dependent** —

1. a Subscriber's legally married spouse who is:
  - a. not covered for Benefits as a Subscriber; and
  - b. not legally separated from the Subscriber;or,
2. a Subscriber's Domestic Partner, who is not covered for benefits as a Subscriber;
- or,
3. a Subscriber's, spouse's, or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including any stepchild or 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) who is not covered for Benefits as a Subscriber and who is:
  - a. primarily dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance; or

- b. dependent upon the Subscriber, spouse, or Domestic Partner for medical support pursuant to a court order; and is
- c. less than 19 years of age; or
- d. less than 25 years of age if enrolled as a full-time student and if proof of student status is submitted to and received by Blue Shield. (Note: This item d. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19). Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student;

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

- 4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:
  - a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
  - b. the Subscriber, spouse, or Domestic Partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and
  - c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield on the following schedule:
    - (1) within 24 months after the month when the Dependent would otherwise have been terminated; and
    - (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

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

- 1. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
- 2. Both persons have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners

and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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

**Dues** — the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

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

**Emergency Services** — Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1. placing the Member's health in serious jeopardy;
- 2. serious impairment to bodily functions;
- 3. serious dysfunction of any bodily organ or part.

**Employee** —

- 1. an individual who is a N.E.C.A. Chapter Employee, or a N.E.C.A. Contractor, or office or technical employee of such Contractor, who is in regular full-time employment, receiving compensation in the form of salary, wages or commissions, whose regular work week is at least 30 hours, and whose duties in such employment are performed at the employer's usual place of business except salespersons and others whose duties are of a kind and nature that require them to be performed away from such usual place of business; or
- 2. an individual who is retired from such employment in accordance with the rules and regulations of the employer, and who is enrolled under Parts A and B of Medicare.

**Employer (Contractholder)** — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 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.

**Experimental or Investigational in Nature** — any treatment, therapy, procedure, drug or drug usage, facility or facil-

ity usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

**Family** — the Subscriber and all enrolled Dependents.

**Group Health Service Contract (Contract)** — the contract issued by the Plan to the Contractholder that establishes the Services Members are entitled to receive from the Plan.

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

**Hospital** — either (1.), (2.) or (3.) below:

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

**Independent Practice Association (IPA)** — a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members. For all Mental Health and substance abuse Services, this definition includes the MHSA.

**Infertility** — either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Physician as a cause of Infertility, or (2) because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or (3) because of the inability to conceive a pregnancy after six cycles of artificial insemination. The initial six cycles are not a benefit of this Plan.

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

**Intensive Outpatient Care Program** — an Outpatient Mental Health (or substance abuse) treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least 3 hours per day, 3 times per week.

**Late Enrollee** — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent will not be considered a Late Enrollee if any of the conditions listed under (1.), (2.), (3.), (4.), (5.), (6.) or (7.) below is applicable:

1. The eligible Employee or Dependent meets all of the following requirements (a.), (b.), (c.) and (d.):
  - a. The Employee or Dependent was covered under another employer health benefit plan at the time he was offered enrollment under this Plan;
  - b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if he was covered under another employer health plan, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee;
  - c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan’s coverage, exhaustion of COBRA continuation coverage, cessation of an employer’s contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation, divorce, or termination of a domestic partnership; and
  - d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and the eligible Employee elects this Plan during an Open Enrollment Period; or
3. 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 within 31 days of presenta-

tion of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Dependents who have lost or will lose their no share-of-cost Medi-Cal coverage and who request enrollment within 31 days after notification of this loss of coverage; or
6. For eligible Dependents who have lost or will lose their coverage under the Healthy Families Program as a result of exceeding the program's income or age limits and who request enrollment within 31 days after notification of this loss of coverage; or
7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

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

**Medical Necessity (Medically Necessary)** —

1. Benefits are provided only for Services which are Medically Necessary.
2. services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are:
  - a. consistent with Blue Shield medical policy; and,
  - b. consistent with the symptoms or diagnosis; and,
  - c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and,
  - d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

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

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

Inpatient services which are not Medically Necessary include hospitalization:

- a. for diagnostic studies that could have been provided on an Outpatient basis;
  - b. for medical observation or evaluation;
  - c. for personal comfort;
  - d. in a pain management center to treat or cure chronic pain; or
  - e. for Inpatient rehabilitation that can be provided on an Outpatient basis.
5. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

**Member** — either a Subscriber or Dependent.

**Mental Health Services** — see definition for Psychiatric Care.

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

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

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

**Open Enrollment Period** — that period of time set forth in the Contract during which eligible individuals and their Dependents may transfer from another health benefit plan sponsored by the Employer to the Blue Shield Access+ HMO Plan.

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

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

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

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

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

**Participating Hospice or Participating Hospice Agency** — an entity which: 1) provides Hospice Services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice Service Benefits pursuant to the California Health and Safety Code Section 1368.2.

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

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

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

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

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

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

**Plan Non-Physician Health Care Practitioner** — a health care professional who is not a Physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals or Blue Shield to provide

Covered Services to Members when referred by a Personal Physician. For all Mental Health and substance abuse Services, this definition includes MHSA Participating Providers.

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

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

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

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

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

**Reconstructive Surgery** — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible.

**Rehabilitation** — Inpatient or Outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in *Speech Therapy* in the Plan Benefits section. Rehabilitation Services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

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

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

- a. As a result of the mental disorder the child has substantial impairment in at least 2 of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;
- b. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.

**Services** — includes Medically Necessary health care services and Medically Necessary supplies furnished incident to those services.

**Severe Mental Illnesses** — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

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

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

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

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

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

**Subacute Care** — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, Physical, Occupational or Speech Therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility which is primarily a rest home, convalescent facility, or home for the aged is not included.

**Subscriber** — an individual who satisfies the eligibility requirements of the Contract, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this Contract.

**Total Disability** —

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

**Urgent Services** — those Covered Services rendered outside of the Personal Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member’s health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment can not reasonably be delayed until the Member returns to the Personal Physician Service Area.

This combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of the Blue Shield Access + HMO Plan.

Should you have any questions, please call the Blue Shield of California Member Services Department at the number provided on the last page of this booklet.

Blue Shield of California  
50 Beale Street  
San Francisco, CA 94105

## SUMMARY PLAN DESCRIPTION

The following information has been provided to Blue Shield by your employer and is being reprinted in your Evidence of Coverage booklet at the express request of your employer.

Blue Shield makes no representation of any kind that this information is accurate (other than clerical accuracy) or sufficient to meet requirements for disclosure of summary plan information under ERISA.

If you have any questions about this information, they should be directed to your employer.

*Your employer sponsors an Employee benefit plan designed to provide welfare benefits to all participating Employees. The following are some specific features of the plan that you should know.*

### **Name of Plan:**

N.E.C.A. West Health & Welfare Plan  
Group No. H11821

### **Type of Plan:**

This is a group health service plan.

### **Plan Number:**

501

### **Plan Description:**

Group health service plan.

### **Contract Year:**

The plan year ends on December 31st.

### **Type of Administration:**

The Plan is administered by contract.

### **Plan Administrator:**

Board of Trustees of the N.E.C.A. West  
Health & Welfare Plan  
1120 S. Bascom Avenue  
San Jose, CA 95128  
(408) 288-4400

### **Mailing address:**

P.O. Box 5057  
San Jose, CA 95120

Service of legal process should be directed to the Plan Administrator.

### **Trust Identification Number:**

94-2442039

### **Type of Funding:**

Accumulation of dues (rates) for coverage provided in accordance with the Group Health Service Contract issued by California Physicians' Service, 50 Beale Street, San Francisco, California 94105. Amounts paid are held in the N.E.C.A. West Health and Welfare Trust Fund.

### **Sponsoring Organizations:**

The Plan is maintained by dues payments from eligible N.E.C.A. Chapters and eligible N.E.C.A. Contractors for themselves and their eligible Employees. By writing to the Board of Trustees, participants and beneficiaries may determine whether a particular N.E.C.A. Chapter or employer is a sponsor of the Plan, and if so, its address.

### **Contributions:**

Contributions to provide Plan benefits are paid by the sponsoring employers on a monthly basis in accordance with the Trust Agreement and Plan documents. Benefits are not provided in any month until the corresponding dues are received by the Trust's Administrative Office.

### **Plan Year:**

The Plan Year is the 9-month period ending December 31<sup>st</sup> and the Plan's records are maintained on that basis.

### **Eligibility:**

Refer to the Eligibility provision on page 20 of this booklet.

### **Termination of Benefits:**

Refer to page 40 of this booklet for an explanation of Termination of Benefits.

### **Benefits:**

The benefits of the plan are described on pages 23 through 34.

### **To Claim Benefits:**

Refer to the reimbursement provisions on page 39 of this booklet.

## STATEMENT OF ERISA RIGHTS

The following statement of ERISA rights is required by federal law and regulations. As a participant in these plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all plan documents, including insurance contracts and copies of all documents filed by the plan

with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other

plan participants. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

## N.E.C.A. West Health and Welfare Plan Trustees

### **Bart Dickson Jr. (Chairman)**

Los Angeles, NECA  
675 So. Arroyo Park, Ste. 300  
Pasadena, CA. 91105  
(626) 792-6322  
Fax: (626) 792-6372  
bart@la-neca.org

### **Stephen Brown (Co-Chairman)**

Orange County, NECA  
P.O. Box 5210  
Orange, CA. 92863  
(714) 634-8777  
Fax: (714) 634-8582  
steve@ocneca.org

### **Rod Anderson**

Southern Sierra, NECA  
17130 Van Buren Boulevard #715  
Riverside, CA. 92504  
(951) 780-7070  
Fax: (951) 780-7124  
Anupower@aol.com

### **Darlene Besst**

No Cal, NECA  
6300 Village Parkway  
Dublin, CA. 94568  
(925) 828-6322  
Fax: (925) 828-6392  
darleneb@nocalneca.org

### **Peggy Brown**

NECA Orange County Chapter  
P.O. Box 5210  
Orange, CA. 92863  
(714) 634-8777  
Fax: (714) 634-8582  
peggy@ocneca.org

### **Jerri Champlin**

Central Coast, NECA  
530 E. Main Street  
Santa Maria, CA. 93455  
(805) 348-1200  
Fax: (805) 348-1203  
JLChamplin@ccneca.org

### **Patrick D'Antoni**

San Mateo, NECA  
P.O. Box 1282  
Menlo Park, CA. 94026  
(650) 328-3100  
(650) 328-3116  
Neca31545@aol.com

### **Michael Geller**

Contra Costa Chapter, NECA  
1024 Court Street  
Martinez, CA. 94553  
(925) 372-3222  
Fax: (925) 372-0282  
mgneca@sbcglobal.net

### **Ru Jensen**

Electro Construction  
3021 Rowena Avenue  
Los Angeles, CA. 90039-2004  
ru@electroconstruction.com

### **Jason McClean**

SFECA, Inc.  
555 Gough Street  
San Francisco, CA. 94102  
(415) 703-8333  
Fax: (415) 626-0658  
jasonmc@sfeca.org

### **Bernard Poggetti**

Capitol Electric  
480 9th Street  
San Francisco, CA. 94103  
(415) 861-2900

### **David Shankle**

Southern Sierra Chapter, NECA  
1855 Business Center Drive  
San Bernadino, CA. 92408  
(909) 824-7050  
Fax: (909) 796-5270  
necajo@verizon.net

# Supplement A — Outpatient Prescription Drugs

In addition to the benefits found in your Blue Shield Access+ HMO Evidence of Coverage and Disclosure Form, your Plan also provides coverage for Outpatient Prescription Drugs described in this supplement. The following Prescription Drug Benefit is separate from the HMO Health Plan coverage. The Calendar Year Maximum Copayments and the Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Benefit; however, the general provisions and exclusions of the HMO Health Plan contract shall apply.

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

## Outpatient Prescription Drug Benefit

Benefits are provided for Outpatient Prescription Drugs which meet all of the requirements specified in this supplement, are prescribed by the Member's Personal Physician and are obtained from a Participating Pharmacy. Drug coverage is based on the use of the Blue Shield's Outpatient Drug Formulary, which is updated on an ongoing basis by Blue Shield's Pharmacy and Therapeutics Committee. Non-Formulary Drugs may be covered subject to higher Copayments. Selected Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available (the more costly alternative will be authorized when Medically Necessary). Your Physician may request prior authorization from Blue Shield. Coverage for selected Drugs may be limited to a specific quantity as described in "Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

## Outpatient Drug Formulary

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

Members may call Blue Shield Member Services at the number listed on their Blue Shield Identification Card to inquire if a specific drug is included in the Formulary. Member Services can also provide Members with a printed copy of the Formulary. Members may also access the Formulary through

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

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

## Definitions

**Drugs** — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes, (3) pen delivery systems for the administration of Insulin as determined by Blue Shield to be Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (5) oral contraceptives and diaphragms, (6) smoking cessation Drugs which require a prescription – coverage limited to one 12-week course of treatment per lifetime, (7) inhalers and inhaler spacers for the management and treatment of asthma.

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

**Brand Name Drugs** — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

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

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

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

Administered Injectables are listed in the Blue Shield’s Out-patient Drug Formulary.

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

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

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

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

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

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

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

**Obtaining Outpatient Prescription Drugs at a Participating Pharmacy**

1. To obtain Drugs at a Participating Pharmacy, the Member must present his Blue Shield Identification Card. Note: Except for covered emergencies, claims for Drugs obtained without using the Blue Shield Identification Card will be denied.
2. Benefits are provided for Home Self-Administered Injectables only when obtained from a Blue Shield Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered Home Self-Administered Injectables that are needed immediately may be obtained from any Participating Pharmacy, or, if necessary from a Non-Participating Pharmacy.
3. The Member is responsible for paying the applicable Copayment for each new and refill prescription Drug. The pharmacist will collect from the Member the applicable Copayment at the time the Drugs are obtained.

Formulary Generic Drugs	\$10
Formulary Brand Name Drugs*	\$20
Non-Formulary Brand Name Drugs	\$35
Home Self-Administered Injectables, including any combination kit or package containing both oral and Home Self-Administered Injectable Drugs	20% of the Blue Shield negotiated pharmacy contracted rate, up to a maximum of \$100 for each prescription

\*Note: For diabetic supplies (including disposable Insulin needles and syringes), diaphragms, and smoking cessation therapy drugs, the Formulary Brand Name Copayment applies.

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

4. If the Member requests a Brand Name Drug when a Generic Drug equivalent is available, the Member is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment.
5. If the prescription specifies a Brand Name Drug and the prescribing Physician has written “Dispense As Written” or “Do Not Substitute” on the prescription, or if a Generic Drug equivalent is not available, the Member is responsible for paying the applicable Brand Name Drug Copayment.
6. Drugs obtained at a Non-Participating Pharmacy are not covered, unless Medically Necessary for a covered emergency, including Drugs for emergency contraception.

Reimbursement for covered emergency claims will be based upon the purchase price of the covered prescription Drug(s) less any applicable Copayment(s). Claims must be received within 1 year of the date of service to be considered for payment. Claim forms are available upon request from the Blue Shield Service Center. Submit a completed Prescription Drug Claim form noting "Emergency Request" on the form, to Blue Shield Pharmacy Services, P.O. Box 7168, San Francisco, CA 94120.

**Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program**

1. For the Member’s convenience, when Drugs have been prescribed for a chronic condition and the Member's medication dosage has been stabilized, he may obtain the Drug through Blue Shield's Mail Service Prescription Drug Program. Prior to using this Mail Service Program,

the Member must have received the same medication and dosage through the Blue Shield pharmacy network for at least two months. The Member should submit the applicable Mail Service Copayment, an order form and his Blue Shield Member number to the address indicated on the mail order envelope. Members should allow 14 days to receive the Drug. The Member's Physician must indicate a prescription quantity which is equal to the amount to be dispensed. Home Self-Administered Injectables, except for Insulin, are not available through the Mail Service Prescription Drug Program.

2. The Member is responsible for the applicable Mail Service Prescription Drug Copayment for each new or refill prescription Drug.

Mail Service Formulary Generic Drugs	\$20
Mail Service Formulary Brand Name Drugs*	\$40
Mail Service Non-Formulary Brand Name Drugs	\$70

\*Note: For diabetic supplies (including disposable Insulin needles and syringes), the Formulary Brand Name Copayment applies.

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

3. If the Member requests a Mail Service Brand Name Drug when a Mail Service Generic Drug is available, the Member is responsible for the difference between the contracted rate for the Mail Service Brand Name Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment.
4. If the prescription specifies a Mail Service Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Mail Service Generic Drug equivalent is not available, the Member is responsible for paying the applicable Mail Service Brand Name Drug Copayment.

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

1. Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. Mail Service Prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Member's Physician indicates a prescription

quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.

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

### Exclusions

No Benefits are provided under the Outpatient Prescription Drugs Benefit for the following (please note, certain services excluded below may be covered under other benefits/portions of your Evidence of Coverage and Disclosure Form – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage, Drugs for emergency contraception, and Drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible;
2. Any drug provided or administered while the Member is an Inpatient, or in a Physician's office (see the Professional Services and Hospital Services sections of your Evidence of Coverage and Disclosure Form);
3. Take home drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Services and Skilled Nursing Facility Services sections of your Evidence of Coverage and Disclosure Form);
4. Except as specifically listed as covered under this Outpatient Prescription Drugs Supplement, drugs which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;
6. Drugs that are considered to be experimental or investigational;

7. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment section, Orthoses section, and the Prostheses and Other Services section of your Evidence of Coverage and Disclosure Form);
8. Blood or blood products (see the Hospital Services section of your Evidence of Coverage and Disclosure Form);
9. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
10. Dietary or Nutritional Products (see the Home Health Care Services, PKU Related Formulas and Special Food Products, and Home Infusion Therapy section of your Evidence of Coverage and Disclosure Form);
11. Injectable drugs which are not self-administered, and all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the Other Outpatient Services, Hospice Program Services Benefits, and the Family Planning and Infertility Services Benefits of the health plan;
12. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield;
13. Drugs when prescribed for smoking cessation purposes (over the counter or by prescription), except to the extent that smoking cessation prescription Drugs are specifically listed as covered under the “Drug” definition in this benefit description;
14. Contraceptive devices (except diaphragms), injections and implants;
15. Compounded medications if: (1) there is a medically appropriate Formulary alternative, or, (2) there are no FDA-approved indications. Compounded medications that do not include at least one Drug, as defined, are not covered;
16. Replacement of lost, stolen or destroyed prescription Drugs;
17. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to a Member enrolled in a Hospice Program through a Participating Hospice Agency;
18. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.

See the Grievance Process portion of your Evidence of Coverage and Disclosure Form 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.

---

---

# Notes

---

---

---

---

# Notes

---

---

---

---

# Notes

---

---

## Handy Numbers

If your family has more than one Blue Shield HMO Personal Physician, list each family member's name with the name of his or her Physician.

*Family Member* \_\_\_\_\_

*Personal Physician* \_\_\_\_\_

*Phone Number* \_\_\_\_\_

*Family Member* \_\_\_\_\_

*Personal Physician* \_\_\_\_\_

*Phone Number* \_\_\_\_\_

*Family Member* \_\_\_\_\_

*Personal Physician* \_\_\_\_\_

*Phone Number* \_\_\_\_\_

*Important Numbers:*

*Hospital* \_\_\_\_\_

*Pharmacy* \_\_\_\_\_

*Police Department* \_\_\_\_\_

*Ambulance* \_\_\_\_\_

*Poison Control Center* \_\_\_\_\_

*Fire Department* \_\_\_\_\_

*General Emergency* \_\_\_\_\_ **911** \_\_\_\_\_

*Access+ HMO Member Services Department*  
*See last page of this booklet)* \_\_\_\_\_

For information contact Blue Shield of California.

Members may call Blue Shield's Member Services Department toll free: 1-800-424-6521

For Mental Health Services and information, call the MHSA: 1-877-263-8827

The hearing impaired may call Member Services through Blue Shield's toll-free TTY number: 1-800-241-1823

Please direct correspondence to:

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



