Important Disclosures

Individual and Family Plan

IFP Disclosure

Provider Network: Catastrophic, Enhanced, n/a, Native American, Standard, Trio, Trio ACO

blue california

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Notice

This disclosure form is only a summary. Consult the Evidence of Coverage and Health Service Agreement itself to determine the governing contractual provisions.

The Evidence of Coverage and Health Service Agreement (Agreement) discloses the terms and conditions of your coverage. You should read this disclosure form and the Agreement completely and carefully. If you or a covered family member have special health care needs, you should read any relevant sections closely.

Consult the health plan benefits and coverage matrix for additional information.

Applicants for coverage under this plan have a right to view the Agreement prior to enrollment. Applicants may contact Blue Shield for additional information about this plan's Benefits. Call Customer Service at (888) 256-3650. For Covered California plans, call (855) 836-9705.

Blue Shield will furnish a copy of the Agreement upon request.

General disclosures

Principal Benefits and coverages

Your plan includes certain Benefits and coverages, including coverage for acute and subacute care. Blue Shield provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the Medical Management Programs; and
- The terms, conditions, limitations, and exclusions of this Agreement.

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

Review your Summary of Benefits and your Agreement to understand the specifics and costs associated with your principal Benefits and coverages.

Principal Benefits and Coverages
Acupuncture services
Allergy testing and immunotherapy Benefits
Ambulance services
Bariatric surgery Benefits
Chiropractic services (This benefit is only available in select plans)
Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits
Diabetes care services
Diagnostic X-ray, imaging, pathology, laboratory, and other testing services
Dialysis Benefits
Durable medical equipment
Emergency Benefits

Principal Benefits and Coverages
Family planning Benefits
Home health services
Hospice program services
Hospital services
Medical treatment of the teeth, gums, jaw joints, and jaw bones
Mental Health and Substance Use Disorder Benefits
Pediatric dental Benefits
Pediatric vision Benefits
Physician and other professional services
PKU formulas and special food products
Podiatric services
Pregnancy and maternity care
Prescription Drug Benefits
Preventive Health Services
Reconstructive Surgery Benefits
Rehabilitative and habilitative services
Skilled Nursing Facility (SNF) services
Transplant services
Urgent care services

Principal exclusions and limitations on Benefits

Review your Agreement to learn more about this plan's general exclusions and limitations. Prescription Drug, pediatric dental, and pediatric vision Benefits each have additional exclusions and limitations.

This section has the following tables:

- General exclusions and limitations (for all Benefits);
- Outpatient prescription Drug exclusions and limitations;
- Pediatric dental exclusions; and
- Pediatric dental limitations.

General exclusions and limitations

1	This plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.
2	Routine physical examinations solely for: • Immunizations and vaccinations, by any mode of administration, for the purpose of travel; or • Licensure, employment, insurance, court order, parole, or probation. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
3	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	Routine foot care items and services that are not Medically Necessary, including: • Callus treatment; • Corn paring or excision; • Toenail trimming; • Over-the-counter shoe inserts or arch supports; or • Any type of massage procedure on the foot. This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.
5	Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board. Domiciliary care is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.
6	Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.

	General exclusions and limitations
7	Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the *Home infusion and injectable medication services* and *PKU formulas and special food products* sections of the Agreement, or as provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
8	Hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.
9	For Members 19 years of age and older: eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section of the Agreement. For all Members: video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
10	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section of the Agreement.
11	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones, Pediatric dental Benefits*, and *Hospital services* sections of the Agreement.
12	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.
13	Any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.

	General exclusions and limitations
14	Services for anyone in connection with a Surrogacy Arrangement, except for Covered Services provided to a Member who is a surrogate. For more information, see the *Reductions – Surrogacy Arrangement* section of the Agreement.
15	Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits, or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections of the Agreement.
16	Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program.
17	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
18	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
19	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section of the Agreement or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.

General exclusions and limitations

20	Select physical and occupational therapies, such as: • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
21	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section of the Agreement, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.
22	Services or Drugs that are Experimental or Investigational in nature.
23	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that 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 & Safety Code Section 1367.21 have been met.
24	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
25	Member convenience items, such as internet, phones, televisions, guest trays, and personal hygiene items.

General exclusions and limitations

26	Disposable supplies for home use except as provided under the *Durable medical equipment, Home health services*, and *Hospice program services* sections of the Agreement, or the Prescription Drug Benefit.
27	Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.
28	Chiropractic spinal manipulation and adjustment (not applicable to plans that cover chiropractic services).
29	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
30	Drugs dispensed by a Physician or Physician's office for outpatient use.

Outpatient prescription Drug exclusions and limitations

1	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
2	Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, Drugs used to slow or reverse the effects of skin aging or to treat hair loss.
3	Medical devices or supplies, except as listed in the *Durable medical equipment* section of the Agreement. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices.
4	Non-Formulary Drugs, unless an exception request is approved. See the *Prescription Drug Benefits* section of the Agreement for more information.

Outpatient prescription Drug exclusions and limitations	
5	Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained on an emergency or urgent basis.
6	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy, or included on a government exclusion list.
7	Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician.
8	Prescription Drugs that are repackaged by an entity other than the original manufacturer.
9	Replacement of lost, stolen, or destroyed Drugs.
10	Immunizations and vaccinations solely for the purpose of travel.
11	Compounded medications unless all of the following requirements are met: • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially-available, medically-appropriate alternatives; and • The compounded medication is self-administered.

Pediatric dental exclusions	
1	Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member.

	Pediatric dental exclusions
2	General anesthesia or intravenous/conscious sedation unless specifically listed as a Benefit in the *Summary of Benefits* section of the Agreement or on the pediatric dental Benefits table, or administered by a Dentist for a covered oral surgery.
3	Cosmetic dental care.
4	Treatment for which payment is made by any governmental agency, including any foreign government.
5	Services of Dentists or other practitioners of healing arts not associated with the plan, except upon referral arranged by a Dental Provider and authorized by the DPA, or when required in a covered emergency.
6	Hospital charges of any kind.
7	Procedures, appliances, or restorations to correct congenital or developmental malformations, unless specifically listed in the *Summary of Benefits* section of the Agreement or on the pediatric dental Benefits table.
8	Malignancies.
9	Drugs not normally supplied in a dental office.
10	Dental Care Services administered by a pediatric Dentist, except when: • The Member child's primary Dental Provider is a pediatric Dentist; or • The Member child is referred to a pediatric Dentist by the primary Dental Provider.
11	The cost of precious metals used in any form of dental Benefits.
12	Loss or theft of dentures or bridgework.

Pediatric dental exclusions	
13	Charges for second opinions, unless previously authorized by the DPA.

Pediatric dental limitations	
Preventive (D1000-D1999)	• Fluoride treatment (D1206 and D1208) is only a Benefit for prescription-strength fluoride products; • Fluoride treatments do not include treatments that use fluoride with prophylaxis paste or the topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and • The application of fluoride is only a Benefit for caries control and is reimbursed when covered as a full mouth treatment regardless of the number of teeth treated.
Restorative (D2000-D2999)	• Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; • Restorations for primary teeth near exfoliation; • Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations, unless a specific allergy has been documented by a medical specialist (allergist) on his or her professional letterhead or prescription; • Prefabricated crowns for primary teeth near exfoliation; • Prefabricated crowns for abutment teeth for cast metal framework partial dentures (D5213 and D5214); • Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Prefabricated crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; • Prefabricated crowns when a tooth can be restored with an amalgam or resin-based composite restoration; • Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Laboratory crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and

Pediatric dental limitations	
	• Laboratory processed crowns when the tooth can be restored with an amalgam or resin-based composite.
Endodontic (D3000-D3999)	• Endodontic procedures when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; • Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement, or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and • Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
Periodontal (D4000-D4999)	• Tooth-bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth-bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.
Prosthodontic (D5000-D5899)	• Prosthodontic services provided solely for cosmetic purposes; • Temporary or interim dentures to be used while a permanent denture is being constructed; • Spare or backup dentures; • Evaluation of a denture on a maintenance basis; • Preventative, endodontic, or restorative procedures for teeth to be retained for overdentures. Only extractions for the retained teeth are covered; • Partial dentures to replace missing third molars; • Laboratory relines (D5760 and D5761) for resin-based partial dentures (D5211and D5212); • Laboratory relines (D5750, D5751, D5760, and D5761) within 12 months of chairside relines (D5730, D5731, D5740, and D5741); • Chairside relines (D5730, D5731, D5740, and D5741) within 12 months of laboratory relines (D5750, D5751, D5760, and D5761); • Tissue conditioning (D5850 and D5851) is only covered to heal unhealthy ridges prior to a definitive prosthodontic treatment; and • Tissue conditioning (D5850 and D5851) is covered the same date of service as an immediate prosthesis that required extractions.
Implant (D6000-D6199)	• Implant services are covered only when exceptional medical conditions are documented and the services are considered Medically Necessary. Single tooth implants are not a Benefit.

Pediatric dental limitations	
Prosthodontic (Fixed) **(D6200-D6999)**	• Fixed partial dentures (bridgework); however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture; • Fixed partial dentures when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement; • Posterior fixed partial dentures when the number of missing teeth requested to be replaced in the quadrant does not significantly impact masticatory ability; • Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and • Cast resin bonded fixed partial dentures (Maryland Bridges).
Oral and Maxillofacial Surgery **(D7000-D7999)**	• The prophylactic extraction of third molars; • Temporomandibular joint (TMJ) dysfunction procedures are limited to differential diagnosis and symptomatic care. TMJ treatment modalities that involve prosthodontics, orthodontics, and full or partial occlusal rehabilitation are not covered; • TMJ dysfunction procedures solely for the treatment of bruxism; and • Suture procedures (D7910, D7911 and D7912) for the closure of surgical incisions.
Orthodontic	Orthodontic procedures are covered when Medically Necessary to treat handicapping malocclusion, cleft palate, or facial growth management cases for Members under the age of 19, when prior authorization is obtained. Medically Necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. An initial orthodontic exam (D0140), called the Limited Oral Evaluation, must be conducted. This exam includes completion and submission of the completed Handicapping Labio-Lingual Deviation (HLD) Score Sheet with the Specialty Referral Request Form. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for Medically Necessary orthodontic services. Orthodontic procedures are covered only when the diagnostic casts verify a minimum score of 26 points on the HLD Index California Modification Score Sheet Form, DC016 (06/09), one of the six automatic qualifying conditions below exist; or when there is written documentation of a craniofacial anomaly from a credentialed specialist on his or her professional letterhead. The immediate qualifying conditions are: • Cleft lip and or palate deformities;

Pediatric dental limitations

- Craniofacial Anomalies including the following:
  - Crouzon's syndrome;
  - Treacher-Collins syndrome;
  - Pierre-Robin syndrome; and
  - Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities that result in a physically handicapping malocclusion as determined by our dental consultants;
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite.);
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present, such as stripping of the labial gingival tissue on the lower incisors. Treatment of bi-lateral posterior crossbite is not covered;
- Severe traumatic deviation must be justified by attaching a description of the condition; and
- Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

The remaining conditions must score 26 or more to qualify (based on the HDL Index).

- Coverage for the following conditions is excluded:
  - Crowded dentitions (crooked teeth);
  - Excessive spacing between teeth;
  - Temporomandibular joint (TMJ) conditions and/or horizontal/vertical (overjet/overbite) discrepancies;
  - Treatment in progress prior to the effective date of coverage;
  - Extractions required for orthodontic purposes;
  - Surgical orthodontics or jaw repositioning;
  - Myofunctional therapy;
  - Macroglossia;
  - Hormonal imbalances;
  - Orthodontic retreatment when initial treatment was rendered under this plan or changes in orthodontic treatment necessitated by any kind of accident;
  - Palatal expansion appliances;
  - Services performed by outside laboratories; and
  - Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Prepayments fees

The Subscriber is responsible for a monthly payment to Blue Shield for health care coverage. This monthly payment is a Premium. The Premium Appendix is a document the Subscriber receives at the time of enrollment or renewal. It includes the monthly Premium for this plan.

Blue Shield accepts premium payments by mail, phone, internet or Auto-pay. Refer to your Agreement or blueshieldca.com for more information on Premium payment options.

Changes to Premiums

Blue Shield may change your Premium as the law permits. Blue Shield can change your Premium if:

- A federal, state, or other taxing or licensing authority imposes a tax or fee;
- Blue Shield's federal income tax associated with federal excise tax increases;
- Federal or state law requires it; or
- You relocate to a different geographic rating region.

Premiums may vary due to differences in the cost of health care services within each geographic rating region.

Blue Shield will give the Subscriber written notice at least 10 days before the open enrollment period each year, or 60 days prior to renewal, of any Premium change.

Your Premiums may change without written notice when:

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

Calendar Year Deductible

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

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

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for:

- An individual Member and an entire Family;
- Participating Providers and Non-Participating Providers; and
- Medical and pharmacy Benefits.

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

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

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

Copayment and Coinsurance

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

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

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

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Your Cost Share includes Deductible, Copayment, and Coinsurance and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount/Allowed Charges for Covered Services for the rest of the Calendar Year.

Some plans may have a separate Out-of-Pocket Maximum for:

- An individual Member and an entire Family;
- Participating Providers and Non-Participating Providers; and
- Participating Providers and combined Participating and Non-Participating Providers.

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

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

Ratio of health care services

For Blue Shield individual and family health plans in 2017, the ratio of the value of health services provided to the amount Blue Shield and Blue Shield Life collected in dues/premiums was 86.9%, which means that for each dollar of dues/premium it

collected, Blue Shield paid $0.87 for health care services. This ratio was calculated after provider discounts were applied.

Care outside of California

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

This Blue Shield plan provides limited coverage for health care services received outside of the Plan Service Area. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Arrangement unless prior authorized by Blue Shield.

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

Renewal provisions

The Subscriber's option to renew this coverage is guaranteed, except as the law permits. The Subscriber must pay Premiums in full within the required timeframe, and the Subscriber and Dependents must maintain eligibility.

The Subscriber must notify Blue Shield or Covered California within 60 days of any changes that will affect the eligibility of the Subscriber or an enrolled Dependent. Blue Shield is not obligated to pay for Benefits for an ineligible individual, even if the Subscriber continues to pay Premiums for that individual.

Blue Shield has the right to change this plan, as the law permits. This includes changes to:

- Terms and conditions;
- Benefits;
- Premiums; and
- Limitations and exclusions.

Blue Shield will not change terms and conditions, Benefits, or limitations and exclusions on an individual basis. If Blue Shield changes this Agreement, the change will affect everyone covered under this plan. Blue Shield will give the Subscriber written notice of any changes to the Agreement. We will send this notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal.

Your Premiums may change without written notice when you initiate the type of change described in the *Changes to Premiums* section of the Agreement.

Termination of Benefits

Your coverage will end if:

- The Subscriber cancels or does not renew coverage;
- Blue Shield or Covered California cancels or does not renew coverage; or
- Blue Shield or Covered California rescinds coverage.

Please refer to the Agreement for additional information.

If the Subscriber cancels or does not renew coverage

For Covered California plans: The Subscriber can cancel coverage by giving Covered California 14 days' notice. Coverage will end at 11:59 p.m. Pacific Time on the effective date of termination.

If the Subscriber decides to cancel coverage, the actual date coverage ends is based on when the Subscriber gives notice to Covered California. Once the Subscriber's coverage is terminated, coverage under this plan cannot be reinstated. However, you may reapply for coverage during open enrollment, or if you qualify for special enrollment.

For Blue Shield plans: The Subscriber can cancel coverage by giving Blue Shield 30 days' notice. Coverage will end at 11:59 p.m. Pacific Time on the effective date of termination.

If the Subscriber decides to cancel coverage, the actual date coverage ends is based on when the Subscriber gives notice to Blue Shield. Once the Subscriber's coverage is terminated, coverage under this plan cannot be reinstated. However, you may reapply for coverage during open enrollment.

If Blue Shield or Covered California cancels or does not renew coverage

Blue Shield or Covered California can cancel coverage or deny renewal, as the law permits. If this happens, the date coverage ends depends on the reason for cancellation or non-renewal.

Cancellation for Subscriber's nonpayment of Premiums

Blue Shield can cancel your coverage if the Subscriber does not pay the required Premiums in full and on time. The Subscriber is responsible for all Premiums during the term of coverage, including the grace period.

If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send the Notice of Termination or the Notice of End of Coverage to the Subscriber within five business days of the cancellation. This notice will state:

- That the Agreement has been canceled;
- The reasons for cancellation; and
- The specific date and time when your coverage will end.

If Blue Shield or Covered California rescinds coverage

IF THE SUBSCRIBER OR ANY ENROLLED DEPENDENT COMMITS FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT DURING THE APPLICATION

PROCESS, BLUE SHIELD OR COVERED CALIFORNIA CAN RETROACTIVELY CANCEL COVERAGE. THIS INCLUDES FAILURE TO DISCLOSE ANY NEW OR CHANGED FACTS PERTAINING TO THE APPLICATION THAT ARISE AFTER SUBMISSION OF THE APPLICATION BUT BEFORE THE EFFECTIVE DATE OF COVERAGE. THIS RETROACTIVE CANCELLATION IS RESCISSION.

If Blue Shield or Covered California rescinds coverage, Blue Shield will provide the Subscriber with a 30-day notice.

After your contract has been in effect for 24 months, Blue Shield and Covered California cannot rescind coverage for any reason. If Blue Shield or Covered California rescinds coverage, the Subscriber and any enrolled Dependents will lose all coverage dating back to the original effective date of coverage. It will be as if coverage never existed.

HMO-specific disclosures

Other charges

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

Your Cost Share includes any:

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

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Services provided or arranged by Blue Shield, except as stated in the Exception for other coverage and Reductions – third party liability sections of the Agreement. Covered Services provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them.

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

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

Calendar Year Out of Pocket Maximum

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

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

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

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

Accrual balance

Blue Shield provides a summary of your accrual balances toward your Calendar Year Deductible, if any, and Out-of-Pocket Maximum for every month in which your Benefits were used until the full amount has been met. This summary will be mailed to you unless you opt to receive it electronically or have already opted out of paper mailings. You can opt back in to receive paper mailings at any time or elect to receive your balance summary electronically by logging into your member portal online and updating your communication preferences, or by calling Customer

Service at the number on the back of your ID card. You can also check your accrual balances at any time by logging into your member portal online, which is updated daily, or calling Customer Service. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

Choice of Physicians and providers

This plan covers care from Participating Providers.

Participating Providers

Participating Providers have a contract with Blue Shield and agree to accept Blue Shield's Allowed Charges as payment in full for Covered Services.

If a provider leaves this plan's network, the status of the provider will change from Participating to Non-Participating.

Non-Participating Providers at a Participating Provider facility

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

Continuity of care

Continuity of care may be available if:

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

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

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

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

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

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

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

Second medical opinion

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

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;

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

Your Medical Group will work with you to arrange for a second medical opinion.

Who provides your second medical opinion

If you want a second opinion on	*It will come from*
A proposed treatment plan from your PCP	Another PCP in your Medical Group
A proposed treatment plan from a Specialist	A Participating Provider in the same or equivalent specialty

Emergency Services

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

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

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

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

Reimbursement provisions

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

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

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

Facilities

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

The Blue Shield Trio HMO plan has a network of Physicians, Hospitals, Participating Hospice Agencies, and other Health Care Providers in the Member's Medical Group Service Area. The specific network associated with the Trio HMO plan is identified in the health plan Summary of Benefits and EOC. Contact Customer Service for information on Health Care Providers in your Medical Group Service Area.

For the most up-to-date listings, check our online directories in the Find a Doctor section of blueshieldca.com or by calling Blue Shield Customer Service.

PPO-specific disclosures

Other charges

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Blue Shield Allowable Amount.

Your Cost Share includes any:

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

Allowable Amount

The Allowable Amount is the maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Blue Shield's payment to the provider is the difference between the Allowable Amount and your Cost Share.

Participating Providers agree to accept the Allowable Amount as payment in full for Covered Services, except as stated in the Exception for other coverage and Reductions – third party liability sections of the Agreement. When you see a Participating Provider, you are responsible for your Cost Share.

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

Non-Participating Providers do not agree to accept the Allowable Amount as payment in full for Covered Services. When you see a Non-Participating Provider, you are responsible for:

- Your Cost Share; and
- All charges over the Allowable Amount.

Calendar Year Out of Pocket Maximum

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

- Charges for services that are not covered; and
- Charges over the Allowable Amount.

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

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

Accrual balance

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

Choice of Physicians and providers

This plan covers care from Participating Providers and Non-Participating Providers. You do not need a referral. However, some services do require prior authorization.

Participating Providers

Participating Providers have a contract with Blue Shield and agree to accept Blue Shield's Allowable Amount as payment in full for Covered Services. As a result, your Cost Share is less when you receive Covered Services from a Participating Provider.

Some services will not be covered unless you receive them from a Participating Provider. See the Summary of Benefits section of the Agreement to find out which Covered Services must be received from a Participating Provider.

If a provider leaves this plan's network, the status of the provider will change from Participating to Non-Participating.

Non-Participating Providers

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowable Amount as payment in full for Covered Services. Except for Emergency Services and services received at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, you will pay more for Covered Services from a Non-Participating Provider.

Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. If it was not your choice to see a Non-Participating Provider for these services, your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above

the Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

Continuity of care

Continuity of care may be available if:

- Blue Shield or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving; or
- You are a newly-covered Member whose whose previous health plan was withdrawn from the market.

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

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

Continuity of care with a Former Participating Provider

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

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

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

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

Second medical opinion

You can consult a Participating or Non-Participating Provider for a second medical opinion in situations including but not limited to:

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

You do not need prior authorization from Blue Shield or your PCP for a second medical opinion.

Emergency Services

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

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the Participating or Non-Participating Provider Cost Share for that non-emergency Covered Service.

For the lowest out-of-pocket expenses, you can go to a Participating Physician's office for emergency room follow-up services, such as suture removal and wound checks.

Reimbursement provisions

When you receive health care services, a claim must be submitted to request payment for Covered Services. A claim must be submitted even if you have not yet met your Deductible. Blue Shield uses claims information to track dollar amounts that count toward your Deductible.

When you see a Participating Provider, your provider submits the claim to Blue Shield. When you see a Non-Participating Provider, you must submit the claim to Blue Shield or the Benefit Administrator.

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

Blue Shield or the Benefit Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by Blue Shield or the Benefit Administrator to the provider.

When you receive Covered Services from a Non-Participating Provider, Blue Shield or the Benefit Administrator may send the payment to the Subscriber, or directly to the Non-Participating Provider.

The Subscriber must make sure ***the Non-Participating Provider*** receives the ***full billed amount*** for non-emergency services, whether or not Blue Shield makes payment to the Non-Participating Provider.

Facilities

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

We update our provider directories periodically to reflect changes in our provider networks. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHSA Participating Provider prior to obtaining coverage.

For the most up-to-date listings, check our online directories in the Find a Doctor section of blueshieldca.com or by calling Blue Shield Customer Service

Notices available online

Nondiscrimination and Language Assistance Services

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

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

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

Servicios de asistencia en idiomas y avisos de no discriminación

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

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

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

非歧視通知和語言協助服務

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

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

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