

# Important Disclosures

Large Group Plan  
**EPO Disclosure Form (101+)**  
Provider Network: Full PPO

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## Notice

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

The Evidence of Coverage (EOC) and the Group Health Service Contract (Contract) disclose the terms and conditions of your coverage. You should read this disclosure form and the EOC 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 EOC prior to enrollment. Applicants may contact Blue Shield for additional information about this plan's Benefits. Call Customer Service at (888) 256-1915.

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

## General disclosures

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### **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 EOC.

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 EOC to understand the specifics and costs associated with your principal Benefits and coverages.



### Principal Benefits and Coverages




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Acupuncture services

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Allergy testing and immunotherapy Benefits

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Ambulance services

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Bariatric surgery Benefits

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Chiropractic services

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

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Diabetes care services

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

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Dialysis Benefits

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Durable medical equipment

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Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Customer Service at (888) 256-1915.



## Principal Benefits and Coverages

Emergency Benefits

Family planning and Infertility Benefits

Home health services

Hospice program services

Hospital services

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

Mental Health or Substance Use Disorder Benefits

Physician and other professional services

PKU formulas and special food products

Podiatric services

Pregnancy and maternity care

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 EOC to learn more about this plan's general exclusions and limitations.

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

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

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Customer Service at (888) 256-1915.

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

	<h2 style="text-align: center;">General exclusions and limitations</h2>	
1	<p>Clinical Trials.</p> <p>This Plan does not cover clinical trials, except Approved Clinical Trials as described in the EOC in the <i>Clinical trials for treatment of cancer or Life-Threatening diseases or conditions</i> Benefits section or as required by law.</p> <p>Coverage of Approved Clinical Trials does not include the following:</p> <ul style="list-style-type: none"> <li>• The investigational drug, item, or service itself.</li> <li>• Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.</li> <li>• Drugs, items, devices, and services specifically excluded from coverage in the EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.</li> <li>• Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.</li> </ul> <p>This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental or Investigational services independent review process as described in the EOC in the <i>Independent Medical Review</i> section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in the EOC in the <i>California Department of Managed Health Care</i> review section.</p>	
2	<p>Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the EOC in the <i>Reconstructive Surgery Benefits</i> section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the EOC in the <i>Reconstructive Surgery Benefits</i> section, or as required by law.</p> <p>This exclusion does not apply to the following:</p> <ul style="list-style-type: none"> <li>• Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.</li> <li>• Reconstructive surgery as described in the EOC in the <i>Reconstructive Surgery Benefits</i> section.</li> <li>• For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians</li> </ul>	



## General exclusions and limitations



	specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC in the <i>Reconstructive Surgery Benefits</i> section.
3	<p>Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.</p> <p>This exclusion does not apply to the following:</p> <ul style="list-style-type: none"> <li>• Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.</li> <li>• Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.</li> <li>• Custodial care provided in a healthcare facility.</li> </ul>
4	<p>Dental Services. This Plan does not cover dental services or supplies, except as described in the EOC in the <i>Medical treatment of the teeth, gums, or jaw joints and jaw bones</i> and <i>Hospital services</i> sections or as required by law.</p>
5	<p>Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in the EOC in the <i>PKU formulas and special food products</i> section or as required by law.</p>
6	<p>Disposable Supplies for Home Use. This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in the EOC in the <i>Durable medical equipment, Home health services, Hospice program services</i>, sections, or as required by law.</p>
7	<p>Experimental or Investigational services.</p> <p>This Plan does not cover Experimental Services or Investigational Services, except as required by law.</p> <p>Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.</p> <p>Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:</p> <ul style="list-style-type: none"> <li>• Testing is not complete; and</li> <li>• The efficacy and safety of such services in human subjects are not yet established; and</li> <li>• The service is not in wide usage.</li> </ul>



## General exclusions and limitations



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

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

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

### Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

### External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a



## General exclusions and limitations



	<p>decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.</p> <p>DMHC's Independent Medical Review (IMR)</p> <p>This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in the EOC in the Independent Medical Review section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the California Department of Managed Health Care review section.</p>
8	Vision Care. This Plan does not cover Vision Services, except as described in the EOC in the <i>Prosthetic equipment and devices</i> section or as required by law.
9	Hearing Aids. This Plan does not cover hearing aids, except as described in the Hearing aid services rider if selected by your Employer as an optional Benefit, or as required by law.
10	Immunizations. This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.
11	Non-licensed or Non-certified Providers. This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in the EOC in the <i>Mental Health or Substance Use Disorder Benefits</i> section or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
12	Private Duty Nursing. This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in the EOC in the <i>Hospice program services</i> section or as required by law.
13	Personal or Comfort Items. This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
14	Reversal of Voluntary Sterilization. This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.



## General exclusions and limitations



15	Surrogate Pregnancy. This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.
16	<p>Therapies. This Plan does not cover the following physical and occupational therapies, except as described in the EOC in the <i>Rehabilitative and habilitative services</i> section or as required by law:</p> <ul style="list-style-type: none"> <li>• Massage therapy, unless it is a component of a treatment plan;</li> <li>• Training or therapy for the treatment of learning disabilities or behavioral problems;</li> <li>• Social skills training or therapy; and</li> <li>• Vocational, educational, recreational, art, dance, music, or reading therapy.</li> </ul>
17	Routine Physical Examination. The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.
18	Travel and Lodging. This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in the EOC in the <i>Ambulance services</i> section, as otherwise described in the EOC in the <i>Bariatric surgery Benefits</i> and <i>Transplant services</i> sections, or as required by law.
19	Weight Control Programs and Exercise Programs. This Plan does not cover weight control programs and exercise programs, except as described in the EOC in the <i>Diabetes care services</i> section or as required by law.

## **Prepayments fees**

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

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

## **Other charges**

Your Cost Share is the amount you pay for Covered Benefits. 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 Benefits, or the provider's billed charge for those Covered Benefits, 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 Benefits, except as stated in the *Exception for other coverage and Reductions – third party liability* sections of the EOC. 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 Benefits you receive, the Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the 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 Benefits. When you see a Non-Participating Provider, you are responsible for:

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

## Calendar Year Deductible

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

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

Amounts you pay over the Allowable Amount do not count toward your Deductible.

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

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

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

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

### Prior carrier Deductible credit

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

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

## Copayment and Coinsurance

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

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

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

## **Calendar Year Out-of-Pocket Maximum**

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

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

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

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

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

- Charges for services that are not covered; 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 EOC 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. 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 Benefits.

With an EPO plan, there is generally no coverage for services from Non-Participating Providers.

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 Benefits. You may be responsible for the total amount billed by a Non-Participating Provider. All Covered Benefits must be received from a Participating Provider in the Blue Shield PPO network, except:

- For Emergency or Urgent Services;
- When you receive care at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings), some Covered Benefits may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances;
- Inter-Plan Arrangements, including the BlueCard® and Blue Shield Global® Core programs described in the *Out-of-area services* section of the EOC;
- Services provided by a 988 center, Mobile Crisis Team, or other provider of Behavioral Health Crisis Services; and
- When prior authorized by Blue Shield.

### Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Benefits may be provided by a Non-Participating Provider. 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.

### If you cannot find a Participating Provider

Call Customer Service if you need help finding a Participating Provider who can provide the care you need close to home. If a Participating Provider is not available, you can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be

obtained from a Participating Provider, we will approve your request and you will only be responsible for 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 Primary Care Physician for a second medical opinion.

## **Continuity of care**



Continuity of care may be available if:

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

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

If your Former Participating Provider is no longer available to you for one of the reasons noted above, Blue Shield 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:

 <b>Continuity of care with a Former Participating Provider</b> 	
<b>Qualifying conditions</b>	<b>Timeframe</b>
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner

Continuity of care with a Former Participating Provider	
Qualifying conditions	Timeframe
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](https://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 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.

### **Care outside of California**

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



See the *Out-of-area services* section of the EOC for more information about receiving care while outside of California. To find participating providers while outside of California, visit [bcbs.com](https://bcbs.com).

## **Emergency Services**



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

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

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition or a Psychiatric Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the services provided at a Participating Provider facility at the applicable Participating Provider Cost Share. Services provided at a Non-Participating Provider facility will not be covered.

## **Reimbursement provisions**

When you see a Participating Provider, your provider submits the claim to Blue Shield. However, you may need to submit the claim to Blue Shield for the following services when received from a Non-Participating Provider:

- For Emergency or Urgent Services;
- When you receive care at a Participating Provider facility, some Covered Benefits may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances; and
- Inter-Plan Arrangements, including the BlueCard® and Blue Shield Global® Core programs described in the Out-of-area services section.

Claim forms are available at [blueshieldca.com](https://www.blueshieldca.com) or by contacting the Benefit Administrator. Please submit your claim form and medical records within one year of the service date.

## **Facilities**



Visit [blueshieldca.com](https://www.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 prior to obtaining coverage.

For the most up-to-date listings, check our online directories in the Find a Doctor section of [blueshieldca.com](https://www.blueshieldca.com) or by calling Customer Service.

## **Renewal provisions**

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

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

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

## **Individual continuation of Benefits**

If your employment with your current Employer ends, you and any covered Dependents may qualify for continued group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See the Continuation of group coverage section of the EOC for more information on COBRA continuation coverage.

## **Termination of Benefits**

Your coverage will end if:

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

Please refer to the EOC for additional information.

### **If your Employer cancels coverage**

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

### **If the Subscriber cancels coverage**

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

### **Reinstatement**

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

### **If Blue Shield cancels coverage**

Blue Shield can cancel coverage if:

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

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

### **Cancellation for Employer's nonpayment of Premiums**

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

### **Cancellation or rescission for fraud or intentional misrepresentation of material fact**

Blue Shield may cancel or rescind your coverage if you, your Dependent, or your Employer commit fraud or intentional misrepresentation of material fact. It is your Employer's responsibility to notify you if the Contract is rescinded or canceled. Rescission voids the Contract as if it never existed. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. The Employer must provide enrolled Employees with a copy of the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.