Important Disclosures

Small Group Plan

HMO for Small Business Plans Disclosure Form

Provider Network: Access+
Local Access+
Trio

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Notice

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

The Evidence of Coverage discloses the terms and conditions of your coverage. You should read this disclosure form and the Evidence of Coverage 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 Evidence of Coverage prior to enrollment. Applicants may contact Blue Shield for additional information about this plan's Benefits. Call Shield Concierge at 1-855-258-3744.

Blue Shield will furnish a copy of the Evidence of Coverage 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 section of the Evidence of Coverage; and
- The terms, conditions, limitations, and exclusions of the Evidence of Coverage.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. Blue Shield's medical management helps your provider 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 Evidence of Coverage 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

Principal Benefits and Coverages
Durable medical equipment
Emergency Benefits
Family planning 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
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 Evidence of Coverage 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.

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.

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

This section has the following tables:

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

	General exclusions and limitations
1	Acupuncture Services. This Plan does not cover acupuncture services, except as described in the EOC in the *Acupuncture services* section or as required by law.
2	Chiropractic Services. This Plan does not cover chiropractic services, except as described in the EOC in the *Chiropractic services* section or as required by law.
3	Clinical Trials. This Plan does not cover clinical trials, except Approved Clinical Trials as described in the EOC in the *Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits* section or as required by law. Coverage of Approved Clinical Trials does not include the following: • The investigational drug, item, or service itself. • Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member. • Drugs, items, devices, and services specifically excluded from coverage in the EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law. • Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

General exclusions and limitations

	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 *Independent Medical Review* section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in the EOC in the *California Department of Managed Health Care review* section.
4	Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the EOC in the *Reconstructive Surgery Benefits* section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the EOC in the *Reconstructive Surgery Benefits* section, or as required by law. This exclusion does not apply to the following: • Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages. • Reconstructive surgery as described in the EOC in the *Reconstructive Surgery Benefits* section. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC in the *Reconstructive Surgery Benefits* section.
5	Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered or domiciliary care, which involves 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 except as described in the EOC or as required by law. This exclusion does not apply to the following: • Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals. • Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care, or

	General exclusions and limitations
	services provided in a healthcare facility, including Mental Health or Substance Use Disorder services.
6	Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in the EOC in the *PKU formulas and special food products* section or as required by law.
7	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 *Durable medical equipment*, *Home health services*, *Hospice program services*, and *Prescription Drug Benefits* sections, or as required by law.
8	Experimental or Investigational services. This Plan does not cover Experimental Services or Investigational Services, except as required by law. Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation. Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but: o Testing is not complete; and o The efficacy and safety of such services in human subjects are not yet established; and o The service is not in wide usage. The determination that a service is an Experimental Service or Investigational Service is based on: • Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration); • Consultation with provider organizations, academic and professional specialists pertinent to the specific service; • Reference to current medical literature. However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an opportunity for you to request an external, independent review. Qualifications 1. You must have a Life-Threatening or Seriously Debilitating condition.

General exclusions and limitations

	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 decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. DMHC's Independent Medical Review (IMR) This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in 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.
9	Hearing Aids. This Plan does not cover hearing aids, except as required by law. The Hearing Aid Coverage for Children Program (HACCP) offers state-funded

General exclusions and limitations

	hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.
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 *Mental Health or Substance Use Disorder Benefits* section or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
12	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.
13	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 *Hospice program services* section or 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.
15	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.
16	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.
17	Therapies. This Plan does not cover the following physical and occupational therapies, except as described in the EOC in the *Rehabilitative and habilitative services* section or as required by law: • Massage therapy, unless it is a component of a treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; and

General exclusions and limitations

	• Vocational, educational, recreational, art, dance, music, or reading therapy.
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 *Ambulance services* section, as otherwise described in the EOC in the *Bariatric surgery Benefits* and *Transplant services* 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 *Diabetes care services* section or as required by law.
20	Adult Vision Services. This Plan does not cover Vision Services for Members age 19 and older, except as described in the EOC in the *Prosthetic equipment and devices* section or as required by law.
21	Pediatric Vision Services. This Plan does not cover the following vision services for Members up to age 19 except as described in the EOC in *Pediatric vision Benefits* section or as required by law. The exclusions and limitations for covered pediatric vision services are provided in the *Pediatric vision Benefits* section.
22	Adult Dental Services. This Plan does not cover dental services or supplies for Members age 19 and older, except as described in the EOC in the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections or as required by law.
23	Pediatric Dental Services. This Plan does not cover dental services or supplies for Members up to age 19, except as described in the EOC in *Pediatric dental Benefits* section or as required by law. The exclusions and limitations for covered pediatric dental services are provided below in the *Pediatric dental exclusion and limitations tables*.

Outpatient prescription Drug exclusions and limitations

1	When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

	Outpatient prescription Drug exclusions and limitations
2	When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
3	When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
4	When prescribed solely for the purpose of shortening the duration of the common cold.
5	Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to: • Insulin, • Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs), • Over-the-counter drugs for reversal of an opioid overdose, or • An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
6	Replacement of lost or stolen drugs.
7	Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
8	Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

	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 Evidence of Coverage 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 Evidence of Coverage 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.
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

Pediatric dental limitations	
	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 • 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

Pediatric dental limitations	
	• 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.
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;

Pediatric dental limitations	
	• 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;
	• 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

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

Prepayment 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.

Other charges

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

Your Cost Share includes any:

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

Allowed Charges and capitation

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

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

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

Calendar Year Deductible

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

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

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

- An individual Member and an entire Family; 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 Benefits are subject to the Deductible and how the Deductible works for your plan.

Prior carrier Deductible credit

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

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

Copayment and Coinsurance

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

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

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

Calendar Year Out-of-Pocket Maximum

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

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

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

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

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

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

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

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

Monthly accrual balance

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

Ratio of health care services

For Blue Shield small group health plans in 2017, the ratio of the value of health services provided to the amount Blue Shield collected in premiums was 77.5%, which means that for each dollar of premiums it collected, Blue Shield paid $0.775 for health care services. This ratio was calculated after provider discounts were applied.

Continuity of care

Continuity of care may be available if:

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

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

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

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

Continuity of care with a Former Participating Provider

Qualifying conditions	***Timeframe***
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	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 Medical Group's Allowed Charges as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may

continue to see the Former Participating Provider at the Participating Provider Cost Share.

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 Inter-Plan Program. The Blue Cross Blue Shield Association can help you access care from providers in those geographic areas.

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



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

Renewal provisions

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

- Non-payment of dues (see the *When coverage ends* section of the Evidence of Coverage);
- Fraud, misrepresentations, or omissions;
- Failure to comply with Blue Shield's applicable eligibility, participation, or contribution rules;
- Termination of plan type by Blue Shield;
- Employer relocates outside of California;
- Employer is an association and association membership ceases; or
- Employer purchases coverage through CCSB and the Employer is no longer eligible to purchase coverage through CCSB.

All group contracts will renew subject to the above.

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 Evidence of Coverage 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 Subscriber's nonpayment of Premiums

Blue Shield can cancel your 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 the Notice of End of Coverage to you and your Employer no later than five calendar days after the date coverage ends.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

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

the Notice of Cancellation, Recission or Nonrenewal and the Notice of End of Coverage.

Choice of Physicians and providers

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

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

Participating Providers

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

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

Non-Participating Providers

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

Non-Participating Providers at a Participating Provider facility

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

If you cannot find a Participating Provider

Call Shield Concierge 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 ask your PCP for a referral to another provider for a second medical opinion in situations including but not limited to:

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

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

Who provides your second medical opinion

If you want a second opinion on	*It will come from*
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 or a Psychiatric Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

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

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

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

See the *Out-of-area services* section in the *Other important information about your plan* section of the Evidence of Coverage 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***.

Each Blue Shield 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 a specific HMO plan is identified in the Summary of Benefits and Evidence of Coverage. Contact Shield Concierge 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 Shield Concierge.

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 Service 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 Servicio 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)**。