Blue Shield of California
Endorsement your On Exchange PPO Plans

This Endorsement should be attached to, and is made part of, your Blue Shield of California Evidence of Coverage (EOC). Please retain it for your records.

Effective **November 1, 2021**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revisions have been made to the **Prior Authorization** table in the **Summary of Benefits**:

    - Outpatient mental health services, except office visits and office-based opioid treatment

2. The following item has been removed from the **Frequently-utilized services that require prior authorization** table:

Benefit	***Services that require prior authorization***
Mental Health and Substance Use Disorder	• Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Behavioral Health Treatment • Electroconvulsive therapy • Psychological testing • Partial Hospitalization Program • Intensive Outpatient Program ~~• Office-based opioid treatment~~ • Transcranial magnetic stimulation

Effective **January 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

3. The following revisions have been made to the **Non-Participating Providers** section:

    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 ~~Hospital~~ 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. 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.

4. The following revisions have been made to the **Continuity of care** section:

Continuity of care may be available if:

- ~~Your Participating Provider becomes a Non-Participating Provider during your care;~~
- ~~Your MHSA Participating Provider becomes an MHSA Non-Participating Provider during your care;~~
- 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 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 MHSA will notify you of the option to continue treatment with your Former Participating Provider.

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

- ~~Ongoing treatment for an acute or serious chronic condition;~~
- ~~Pregnancy care, including care immediately after giving birth;~~
- ~~Treatment for a maternal mental health condition;~~
- ~~Treatment for a terminal illness;~~
- ~~Other services authorized by a now-terminated provider as part of a documented course of treatment; or~~
- ~~Care for a child up to 36 months old.~~

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

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
Authorized procedures and non-elective surgery	Up to 6 months
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, t~~T~~he Former ~~Non-~~Participating Provider must ~~agree to~~ accept Blue Shield's or the MHSA's Allowable Amount as payment in full for the first 90 days of your ongoing care. Once ~~If~~ the provider ~~agrees~~accepts and your request is authorized, you may continue to see the Former ~~Non-~~Participating Provider at the Participating Provider Cost Share. ~~for:~~

- ~~Up to 12 months;~~
- ~~For a maternal mental health condition, 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later; or~~
- ~~If you have a terminal illness, for the duration of the terminal illness.~~

5. The following revisions have been made to the **When coverage ends** section:

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

6. The following revisions have been made to the **Emergency Benefits** section:

Benefits are available for Emergency Services received in the emergency room of a Hospital or other emergency room licensed under state law. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition at any Hospital, even if it is a Non-Participating Hospital.

7. The following revisions have been made to the **Prior authorization/exception request/step therapy process** section of the **Prescription Drug Benefits** section:

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a Drug should be used, nationally recognized treatment guidelines, medical studies, information from the Drug manufacturer, and the relative cost of treatment for a condition. If your Physician or Health Care Provider believes that step therapy coverage requirements ~~are not met~~ for a prescription need not be met and ~~your Physician or Health Care Provider believes~~ that the Drug is Medically Necessary, the ~~prior authorization~~ step therapy exception process ~~may~~ must be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

8. The following revisions have been made to the **Grievance process** section:

If Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may ~~submit a grievance requesting~~ request an external exception request review. Blue Shield will ensure a decision within 72 hours. Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, or when you are experiencing severe pain~~, or when you are being treated with a non-Formulary Drug~~.

Blue Shield will make a decision within three calendar days for expedited grievance requests related to:

- Medical Benefits;
- Mental Health and Substance Use Disorder services;
- Pediatric dental Benefits; and
- Pediatric vision Benefits.

~~Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug.~~

9. The following revisions have been made to the **Non-participating providers outside of California** section of the **BlueCard® Program** section:

When Covered Services are provided outside of California and within the BlueCard® Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state or federal law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Covered Services as set forth in this paragraph.

10. The following revisions have been made to the **Allowable Amount** definition:

The maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Evidence of Coverage, the Allowable Amount is:

- For a Participating Provider: the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service rendered.
- For a Non-Participating Provider who provides Emergency Services:
  - Physicians and Hospitals: the amount is the Reasonable and Customary amount; or
  - All other providers: (1) the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount, or (2) if applicable, the amount determined under state and federal laws.
- For a Non-Participating Provider in California, who provides services other than Emergency Services:

- The amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area but not exceeding any stated Benefit maximum;
- Non-Participating dialysis center: for services prior authorized by Blue Shield, the amount is the Reasonable and Customary amount.

- For a provider outside of California but inside the BlueCard® Service Area, the lower of:
  - The provider's billed charge, or
  - The local Blue Plan's Participating Provider payment or the pricing arrangement required by applicable state law.
- For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core.
- For a Non-Participating Provider outside of California (within the BlueCard® Service Area) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services other than Emergency Services: the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a Non-Participating Provider performing the same services. Or, if the local Blue Cross and/or Blue Shield plan has no Non-Participating Provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California. Or, if applicable, the amount determined under federal law.
- For Blue Shield's contracted Benefit Administrators (MHSA, DPA, VPA), the Allowable Amount is based on the administrator's contracted rate for its participating providers.

Where required under federal law, the Allowable Amount used to determine your Cost Share may be based on the plan's "qualifying payment amount," which may differ from the amount Blue Shield pays the Non-Participating Provider or facility for Covered Services.

11. The following revisions have been made to the **Emergency Services** definition:

The following services provided for an Emergency Medical Condition:

- Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility;
- Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and
- Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and
- Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

12. The following definition has been added to the **Definitions** section:

Former Participating Provider: A Former Participating Provider is a provider of services to the Member under any of the following conditions:

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

13. The following revisions have been made to the **Reasonable and Customary** definition:

In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider.

Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits or if applicable, the amount determined under state and federal law.

14. The following revisions have been made to the **Notices about your plan** section:

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as specifically provided under the *Extension of Benefits* section and, when applicable, the *Continuity of care* and *Continuation of group coverage* sections.

Effective **August 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

15. The following revisions have been made to the **Claims** section:

Claim forms are available at blueshieldca.com/covered-california-policies or by contacting the Benefit Administrator.