# Important Disclosures

Small Group Plan

Provider Network: Access+
Local Access+
Trio





blue california

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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 Customer Service at [Customer Service Number].

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

| Principal Benefits and Coverages |
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| 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 and Substance Use Disorder Benefits |
| Pediatric dental Benefits |
| Pediatric vision Benefits |
| Physician and other professional services |
| PKU formulas and special food products |
| Podiatric services |
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| 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.

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

| | General exclusions and limitations |
|---|---|
| 6 | Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency. |
| 7 | Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the *Home infusion and injectable medication services* and *PKU formulas and special food products* sections of the Evidence of Coverage, or as provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder. |
| 8 | Hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments. |
| 9 | For Members 19 years of age and older: eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section of the Evidence of Coverage.<br>For all Members: video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error. |
| 10 | Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section of the Evidence of Coverage. |
| 11 | Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones*, *Pediatric dental Benefits*, and *Hospital services* sections of the Evidence of Coverage. |
| 12 | Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages. |
| 13 | Unless selected as an optional Benefit by your Employer, any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), |

| | General exclusions and limitations |
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| | Intracytoplasmic sperm injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure. |
| 14 | Home testing devices and monitoring equipment. This exclusion does not apply to items specifically described in the *Durable medical equipment* or *Diabetes care services* sections of the Evidence of Coverage. |
| 15 | Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program. |
| 16 | Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program. |
| 17 | Services performed by your spouse, Domestic Partner, child, brother, sister, or parent. |
| 18 | Services provided by an individual or entity that:<br>• Is not appropriately licensed or certified by the state to provide health care services;<br>• Is not operating within the scope of such license or certification; or<br>• Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services.<br>This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law. |

## General exclusions and limitations

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| 19 | Select physical and occupational therapies, such as:<br>• Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan;<br>• Training or therapy for the treatment of learning disabilities or behavioral problems;<br>• Social skills training or therapy;<br>• Vocational, educational, recreational, art, dance, music, or reading therapy; and<br>• Testing for intelligence or learning disabilities.<br>This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder. |
| 20 | Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section of the Evidence of Coverage, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services. |
| 21 | Services or Drugs that are Experimental or Investigational in nature. |
| 22 | Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to:<br>• Drugs;<br>• Medicines;<br>• Supplements;<br>• Tests;<br>• Vaccines;<br>• Devices; and<br>• Radioactive material.<br>However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met. |
| 23 | The following non-prescription (over-the-counter) medical equipment or supplies:<br>• Oxygen saturation monitors;<br>• Prophylactic knee braces; and<br>• Bath chairs. |

## General exclusions and limitations

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| 24 | Member convenience items, such as internet, phones, televisions, guest trays, and personal hygiene items. |
| 25 | Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections of the Evidence of Coverage, or the Prescription Drug Benefit. |
| 26 | Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease. |
| 27 | Chiropractic spinal manipulation and adjustment. |
| 28 | Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van). |
| 29 | Drugs dispensed by a Physician or Physician's office for outpatient use. |

## Outpatient prescription Drug exclusions and limitations

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

| | Outpatient prescription Drug exclusions and limitations |
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| 4 | Non-Formulary Drugs, unless an exception request is approved. See the *Prescription Drug Benefits* section of the Evidence of Coverage for more information. |
| 5 | Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained on an emergency or urgent basis. |
| 6 | Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy, or included on a government exclusion list. |
| 7 | Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician. |
| 8 | Prescription Drugs that are repackaged by an entity other than the original manufacturer. |
| 9 | Replacement of lost, stolen, or destroyed Drugs. |
| 10 | Immunizations and vaccinations solely for the purpose of travel. |
| 11 | Compounded medications unless all of the following requirements are met:<br>• A compounded medication includes at least one Drug;<br>• The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound);<br>• There are no FDA-approved, commercially-available, medically-appropriate alternatives; and<br>• The compounded medication is self-administered. |
| 12 | Appetite suppressants or Drugs for body weight reduction. This exclusion does not apply to Medically Necessary Drugs for the treatment of morbid obesity, when prior authorized. This exclusion does not apply to items or services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder. |

| | Pediatric dental exclusions |
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| 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. |
| 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:<br>• The Member child's primary Dental Provider is a pediatric Dentist; or<br>• The Member child is referred to a pediatric Dentist by the primary Dental Provider. |

| Pediatric dental exclusions | |
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| 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 | |
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| **Preventive (D1000-D1999)** | • Fluoride treatment (D1206 and D1208) is only a Benefit for prescription-strength fluoride products;<br>• Fluoride treatments do not include treatments that use fluoride with prophylaxis paste or the topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and<br>• 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;<br>• Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;<br>• Restorations for primary teeth near exfoliation;<br>• 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;<br>• Prefabricated crowns for primary teeth near exfoliation;<br>• Prefabricated crowns for abutment teeth for cast metal framework partial dentures (D5213 and D5214);<br>• Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes;<br>• Prefabricated crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; |

| Pediatric dental limitations | |
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| | • Prefabricated crowns when a tooth can be restored with an amalgam or resin-based composite restoration;<br>• Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes;<br>• Laboratory crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and<br>• 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;<br>• 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<br>• 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;<br>• Temporary or interim dentures to be used while a permanent denture is being constructed;<br>• Spare or backup dentures;<br>• Evaluation of a denture on a maintenance basis;<br>• Preventative, endodontic, or restorative procedures for teeth to be retained for overdentures. Only extractions for the retained teeth are covered;<br>• Partial dentures to replace missing third molars;<br>• Laboratory relines (D5760 and D5761) for resin-based partial dentures (D5211and D5212);<br>• Laboratory relines (D5750, D5751, D5760, and D5761) within 12 months of chairside relines (D5730, D5731, D5740, and D5741);<br>• Chairside relines (D5730, D5731, D5740, and D5741) within 12 months of laboratory relines (D5750, D5751, D5760, and D5761); |

| Pediatric dental limitations | |
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| | • Tissue conditioning (D5850 and D5851) is only covered to heal unhealthy ridges prior to a definitive prosthodontic treatment; and<br>• Tissue conditioning (D5850 and D5851) is covered the same date of service as an immediate prosthesis that required extractions. |
| **Implant**<br>**(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)**<br>**(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;<br>• Fixed partial dentures when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;<br>• Posterior fixed partial dentures when the number of missing teeth requested to be replaced in the quadrant does not significantly impact masticatory ability;<br>• Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and<br>• Cast resin bonded fixed partial dentures (Maryland Bridges). |
| **Oral and Maxillofacial Surgery**<br>**(D7000-D7999)** | • The prophylactic extraction of third molars;<br>• 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;<br>• TMJ dysfunction procedures solely for the treatment of bruxism; and<br>• 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.<br><br>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 |

## Pediatric dental limitations

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 handicapping malocclusion as determined by our dental consultants;
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite.);
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present, such as stripping of the labial gingival tissue on the lower incisors. Treatment of bi-lateral posterior crossbite is not covered;
- Severe traumatic deviation must be justified by attaching a description of the condition; and
- Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

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

- Coverage for the following conditions is excluded:
  - Crowded dentitions (crooked teeth);
  - Excessive spacing between teeth;
  - Temporomandibular joint (TMJ) conditions and/or horizontal/vertical (overjet/overbite) discrepancies;
  - Treatment in progress prior to the effective date of coverage;
  - Extractions required for orthodontic purposes;
  - Surgical orthodontics or jaw repositioning;
  - Myofunctional therapy;
  - Macroglossia;

| Pediatric dental limitations | |
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| | ○ Hormonal imbalances;<br>○ Orthodontic retreatment when initial treatment was rendered under this plan or changes in orthodontic treatment necessitated by any kind of accident;<br>○ Palatal expansion appliances;<br>○ Services performed by outside laboratories; and<br>○ 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 Services. It is your portion of the Blue Shield Allowed Charges.

Your Cost Share includes any:

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

### Allowed Charges and capitation

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

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

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

## Calendar Year Deductible

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

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

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

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

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

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

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

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

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

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

### Calendar Year Out-of-Pocket Maximum

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

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.

## 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:

- Your provider leaves your Medical Group during your care;
- Your MHSA Participating Provider becomes an MHSA Non-Participating Provider during your care;
- 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.

You can request to continue treatment with your 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 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.

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

The Non-Participating Provider must agree to accept Blue Shield's Allowed Charges as payment in full for your ongoing care. If the provider agrees and your request is authorized, you may continue to see the 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.

## Care outside of California

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

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.

### 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 Services. Except for Emergency Services, Urgent Services, and services received at a Participating Hospital under certain conditions, 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 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.

## Second medical opinion

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

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

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

| Who provides your second medical opinion | |
|---|---|
| ***If you want a second opinion on*** | ***It will come from*** |

| Who provides your second medical opinion | |
|---|---|
| A proposed treatment plan from your PCP | Another PCP in your Medical Group |
| A proposed treatment plan from a Specialist | A Participating Provider in the same or equivalent specialty |

## Emergency Services

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

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

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

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

## Reimbursement provisions

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

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

See the *Out-of-area services* section in the *Other important information about your plan* section of the 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 Customer Service for information on Health Care Providers in your Medical Group Service Area.

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

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**
**Fax: (844) 696-6070**
**Email: BlueShieldCivilRightsCoordinator@blueshieldca.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

# Notice of the Availability of Language Assistance Services
## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

**重要通知：**您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

**QUAN TRỌNG:** Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

**MAHALAGA:** Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

**Baa' ákohwiindzindooígí:** Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

**중요:** 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

**ԿԱՐԵՎՈՐ Է.** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

**ВАЖНО:** Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

**重要：**お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

**مهم:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់ៈ** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

**المهم :**هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

**TSEEM CEEB:** Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

**สำคัญ:** คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

**महत्वपूर्ण:** क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສຳຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)