Blue Shield of California
Endorsement to your PPO Savings Plan

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.

Coverage for COVID-19 testing (including at-home test kits), and therapeutics will be subject to your deductible in accordance with the updated IRS requirements for Health Savings Account compatible High Deductible Health Plans effective January 1, 2025.

Please note that COVID-19 vaccines, however, are treated differently than COVID-19 testing and treatment, and will continue to be covered as preventive services that are not subject to deductible or cost-sharing.

Effective **January 1, 2025**, your EOC is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revision has been made to the **Prior authorization** section:

   Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Once you reach your Deductible, c~~C~~overage is provided without a Cost Share for services provided by a Participating Provider.

2. The following language has been added to the **Diagnostic X-ray, imaging, pathology, laboratory, and other testing services** section:

   Benefits include: […]

   - Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month, subject to a maximum reimbursement of $12 per test. Prior to being reimbursed by Blue Shield, you must meet your Deductible. See the *Claims* section for information about how to submit a claim for repayment for this Benefit;

3. The following revision has been made to the **Diagnostic X-ray, imaging, pathology, laboratory, and other testing services** section:

   ~~For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services.~~ Once you reach your Deductible, coverage is provided without a Cost Share for services provided by a Participating Provider.

4. The following language has been added to the **Prescription Drug Benefits** section:

   Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Once you reach your Deductible, cCoverage is provided without a Cost Share for services provided by a Participating Provider.

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Effective **January 1, 2024**, your EOC is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revision has been made to the **Ambulance services** section:

   ~~Air a~~Ambulance services are covered at the Participating Provider Cost Share, even if you receive services from a Non-Participating Provider.

2. The following revision has been made to the **Prescription Drug Benefits** section:

Formulary Drug tiers	
Drug Tier	*Description*
Tier 4	• ~~Drugs that are biologics, and~~ Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than $600 (net of rebates) for a one-month supply

Effective **April 1, 2024**, your EOC is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following language has been added to the **Prior Authorization** section:

   Once a decision is made for routine Mental Health and Substance Use Disorder requests, a written notice will be sent to you and your provider within five calendar days. For urgent Mental Health and Substance Use Disorder requests, a written notice will be sent to you and your provider within 72 hours.

2. The following language has been added to the **Mental Health and Substance Use Disorder Benefits** section:

Mental Health and Substance Use Disorder Benefits include Medically Necessary basic health care services and intermediate services, at the full range of levels of care, including but not limited to residential treatment, Partial Hospitalization Program, and Intensive Outpatient Program, and prescription Drugs.

3. The following language has been added to the **Mental Health and Substance Use Disorder Benefits** section:

   If you are unable to schedule an appointment with a Participating Provider for Mental Health and Substance Use Disorder services, contact Mental Health Customer Service. The MHSA will help you either schedule an appointment with a Participating Provider, or select a Non-Participating Provider in your area within five calendar days and contact you regarding available appointment times. For any Covered Services, you will be responsible for no more than the Cost Share for seeing a Non-Participating Provider. The MHSA may work with you to transition to a Participating Provider when one becomes available.

   Upon request to Mental Health Customer Service, and at no cost to you, Mental Health Customer Service will provide the clinical review criteria and any training material or resources used to conduct utilization reviews for Mental Health and Substance Use Disorder benefits and services.

4. The following language has been added to the **Notices about your plan** section:

   Notice about Mental Health and Substance Use Disorder services: You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

   If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

   If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

   If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Effective **July 1, 2024**, your EOC is amended as described below. For ease of review, strikethroughs indicate

deleted text and underlining indicates added text.

1. The following language has been added to the **Diagnostic X-ray, imaging, pathology, laboratory, and other testing services** section:

   Benefits include:
   - Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit. A Physician or other Health Care Provider's order must be provided for coverage;
   - Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of your disease or condition to guide treatment decisions. Benefits must be prior authorized;
   - Clinical pathology services;