Shield Spectrum PPO℠ Savings Plus 1500/3000

Blue Shield of California Life & Health Insurance Company

Certificate of Insurance

County of Sacramento

Effective Date: January 1, 2010

An Independent Licensee of the Blue Shield Association

Blue Shield of California
Life & Health Insurance Company

(Blue Shield Life)

Certificate of Insurance

Shield Spectrum PPO Savings Plus

NOTICE

This Certificate of Insurance describes the terms and conditions of coverage of your Plan. It is your right to view the Certificate of Insurance prior to enrollment in the Plan.

Please read this Certificate of Insurance carefully and completely so that you understand which services are covered health care Services, and the limitations and exclusions that apply to your Plan. If you or your Dependents have special health care needs, you should read carefully those sections of the Certificate that apply to those needs.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Blue Shield Life Customer Service at the address or telephone number provided in this Certificate.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you become a policyholder or select a network provider. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Plan at Blue Shield Life's Customer Service telephone number provided in this Certificate to ensure that you can obtain the health care services that you need.

This Plan is intended to qualify as a “high deductible health plan” for the purposes of qualifying for a health savings account (HSA) within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Although Blue Shield Life believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, Blue Shield Life will make efforts to amend this Plan, if necessary, to meet the requirements of a qualified plan. If Blue Shield Life determines that the amendment necessitates a change in the Plan provisions, Blue Shield Life will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

Important Information Regarding HSAs

The Shield Spectrum PPO Savings Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow you, if you are eligible, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this Plan.

If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

Notice: Blue Shield Life does not provide tax advice. If you intend to purchase this Plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

If you are interested in learning more about Health Savings Accounts, eligibility and the law’s current provisions, ask your benefits administrator and consult with a financial advisor.

The Blue Shield Life PPO Plan

Insured's Bill of Rights

As a Blue Shield Life PPO Plan Insured, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your PPO Plan, the Services we offer you, the Physicians and other practitioners available to care for you.
5. Have reasonable access to appropriate medical services.
6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
7. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive preventive health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
12. Communicate with and receive information from Customer Service in a language you can understand.
13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
14. Be fully informed about the Blue Shield Life grievance procedure and understand how to use it without fear of interruption of health care.
15. Voice complaints or grievances about the PPO Plan or the care provided to you.

The Blue Shield Life PPO Plan

Insured's Responsibilities

As a Blue Shield Life PPO Plan Insured, you have the responsibility to:

1. Carefully read all Blue Shield Life PPO materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield Life PPO membership as explained in the Certificate or Policy.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.
4. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.
8. Offer suggestions to improve the Blue Shield Life PPO Plan.
9. Help Blue Shield Life to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
10. Notify Blue Shield Life as soon as possible if you are billed inappropriately or if you have any complaints.
11. Treat all Plan personnel respectfully and courteously as partners in good health care.
12. Pay your Premiums, Copayments, Coinsurance and charges for non-covered services on time.
13. For all Mental Health and substance abuse Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Non-Emergency Inpatient Mental Health and substance abuse Services.
14. Follow the provisions of the Blue Shield Life Benefits Management Program.

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This Certificate constitutes only a summary of the Plan. The Group Policy must be consulted to determine the exact terms and conditions of coverage.

The Group Policy is on file with your employer and a copy will be furnished upon request.

NOTICE

Please read this Certificate of Insurance carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

Should you have any questions regarding your Plan, see your Employer or contact Blue Shield Life at the address listed on the last page of this Certificate.

IMPORTANT

No Insured has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Continuation of Group Coverage provision in this Certificate.

Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Group Policy.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the Group Policy or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

Note: The following Summary of Benefits contains the Benefits and applicable Copayments/Coinsurance of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, benefits and exclusions of the Plan.

PSP Summary of Benefits

Note that certain services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in no payment by Blue Shield Life for services. Please read this Summary of Benefits and the section entitled Covered Services so you will know from which providers health care may be obtained. The Preferred Provider Directory can be located online at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the last page of this Certificate.

Note: See the end of this Summary of Benefits for important benefit footnotes.

Summary of Benefits

Shield Spectrum PPO Savings Plan

Individual Coverage Calendar Year Deductible[1] (Medical Plan Deductible)	Deductible Responsibility	
	Covered Services by Preferred, Participating, and Other Providers	**Covered Services by Non-Preferred and Non-Participating Providers**
Calendar Year Deductible	$1,500 per Insured	

Family Coverage Calendar Year Deductible[1] (Medical Plan Deductible)	Deductible Responsibility	
	Covered Services by Preferred, Participating, and Other Providers	**Covered Services by Non-Preferred and Non-Participating Providers**
Calendar Year Deductible	$3,000 per Family[2]	

Individual Coverage Insured Maximum per Calendar Year Out-of-Pocket Responsibility[3]	Insured Maximum Calendar Year Out-of-Pocket Responsibility
	Covered Services by any combination of Preferred, Participating, Other Providers, Non-Preferred & Non-Participating Providers
Calendar Year Out-of-Pocket maximum	$4,500 per Insured

Family Coverage Family Maximum per Calendar Year Out-of-Pocket Responsibility[3]	Family Maximum Calendar Year Out-of-Pocket Responsibility
	Covered Services by any combination of Preferred, Participating, Other Providers, Non-Preferred & Non-Participating Providers
Calendar Year Out-of-Pocket maximum	$9,000 per Family

Insured Maximum Lifetime Benefits	Maximum Blue Shield Life Payment	
	Covered Services by Preferred, Participating, and Other Providers	**Covered Services by Non-Preferred and Non-Participating Providers**
Lifetime Maximum	$6,000,000 per Insured[4]	

Reduced Payment(s)
Reduced Payment(s) for Failure to Utilize the Benefits Management Program Refer to the Benefits Management Program section for any Reduced Payments which may apply.

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Acupuncture Benefits	Not covered	Not covered
Allergy Testing and Treatment Benefits Office visits (includes visits for allergy serum injections)	20%	40%
Ambulance Benefits Emergency or authorized transport	20% of billed charges	20% of billed charges
Ambulatory Surgery Center Benefits Outpatient surgery performed in an Ambulatory Surgery Center Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery Services may also be obtained from a Hospital or an ambulatory surgery center that is affiliated with a Hospital. Ambulatory surgery Services obtained from a Hospital or Hospital affiliated ambulatory surgery center will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	20%	40% of up to $350 per day Allowable Amount

Benefit	Insured Copayment/Coinsurance[5]	
	Services by Preferred Bariatric Surgery Services Providers[8]	**Services by Non-Preferred Bariatric Surgery Services Providers[8]**
Bariatric Surgery Benefits for Residents of Designated Counties in California[9]		
Hospital Inpatient Services	20%	Not covered[8]
Hospital Outpatient Services	20%	Not covered[8]
Physician Bariatric Surgery Services	20%	Not covered[8]
Note: Bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this Summary of Benefits. All bariatric surgery Services must be prior authorized, in writing, from the Plan's Medical Director. Prior authorization is required for all Insureds, whether residents of a designated or non-designated county. Covered travel expenses for bariatric surgery For a description of travel expenses which may be covered under this Benefit, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Principal Benefits and Coverages (Covered Services)		

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Chiropractic Benefits		
Chiropractic Services provided by a chiropractor up to a Benefit maximum of 20 visits per Insured per Calendar Year	20%	40%
Clinical Trial for Cancer Benefits		
Covered Services for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized	You pay nothing	You pay nothing
Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in this Summary of Benefits.		
Diabetes Care Benefits		
Devices, equipment and supplies	20% [10]	40%
Diabetes self-management training	20%	40%
Dialysis Center Benefits[11]		
Dialysis Services Note: Dialysis Services may also be obtained from a Hospital. Dialysis Services obtained from a Hospital will be paid at the Preferred or Non-Preferred level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	20%	40% of up to $300 per day
Durable Medical Equipment Benefits		
Durable Medical Equipment Note: There is a combined $2,000 per Insured per Calendar Year maximum on Durable Medical Equipment Benefits. This maximum does not apply to oxygen and those Services covered under Diabetes Care Benefits.	20%	40%
Emergency Room Benefits		
Emergency Room Physician Services	20%	20%
Emergency Room Services not resulting in admission	20%	20%
Emergency Room Services resulting in admission (billed as part of Inpatient Hospital Services)	20%	20% [12]

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Family Planning Benefits[13]		
Counseling and consulting	20%	Not covered
Elective abortion Physician Services Copayment in an office or Outpatient facility only. If procedure is performed in a facility setting, an additional Services Copayment will apply.	20%	Not covered
Injectable contraceptives when administered by a Physician	20% per injection[14]	Not covered
Note: The office visit Copayment shown below also applies.		
Intrauterine device (IUD)	50%	Not covered
Insertion and/or removal of intrauterine device (IUD)	20%	Not covered
Physician office visits for diaphragm fitting or injectable contraceptives	20%	Not covered
Tubal ligation In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services for a delivery/abdominal surgery. Physician Services Copayment in an office or Outpatient facility only. If procedure is performed in a facility setting, an additional Services Copayment will apply.	20%	Not covered
Vasectomy Physician Services Copayment in an office or Outpatient facility only. If procedure is performed in a facility setting, an additional Services Copayment will apply.	20%	Not covered
Home Health Care Benefits		
Home health care agency Services including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist for up to a total of 100 visits by home health care agency providers per Insured per Calendar Year	20%	Not covered[15]
Medical supplies and related laboratory Services to the extent the Benefits would have been provided had the Insured remained in the Hospital or Skilled Nursing Facility	20%	Not covered[15]
Home Infusion/Home Injectable Therapy Benefits		
Home infusion/home injectable therapy and infusion nursing visits provided by a Home Infusion Agency (home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits)	20%	Not covered[15]
Hospice Program Benefits		
Covered Services for Insureds who have been accepted into an approved Hospice Program		
All Hospice Program Benefits must be prior authorized by Blue Shield Life and must be received from a Participating Hospice Agency.		
24-hour Continuous Home Care	20%	Not covered[16]
General Inpatient care	20%	Not covered[16]
Inpatient Respite Care	You pay nothing	Not covered[16]
Pre-hospice consultation	You pay nothing	Not covered[16]
Routine home care	You pay nothing	Not covered[16]

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Hospital Benefits (Facility Services)		
Inpatient Emergency Facility Services	20%	20%[17]
Inpatient Non-Emergency Facility Services	20%	40% of up to $600 per day
All bariatric Surgery Services must be prior authorized in writing.		
For bariatric Surgery Services for residents of designated counties, see the Bariatric Surgery Benefits for Residents of Designated Counties in California section.		
Inpatient Medically Necessary skilled nursing Services including Subacute Care[18]	20%	40% of up to $600 per day
Inpatient Services to treat acute medical complications of detoxification	20%	40% of up to $600 per day
Outpatient dialysis Services[11]	20%	40% of up to $300 per day[17]
Outpatient Services for radiation therapy, chemotherapy, treatment and necessary supplies	20%	40% of up to $350 per day[17]
Outpatient Services for surgery and necessary supplies	20%	40% of up to $350 per day[17]
Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits		
Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (be sure to read the Principal Benefits and Coverages (Covered Services) section for a complete description)		
Inpatient Hospital Services	20%	40% of up to $600 per day[17]
Office location	20%	40%
Outpatient department of a Hospital	20%	40% of up to $350 per day[17]

Benefit	Insured Copayment/Coinsurance[5]	
Mental Health and Substance Abuse Benefits (All Services provided through the Plan's Mental Health Service Administrator [MHSA])	**Covered Services by MHSA Participating Providers**	**Covered Services by MHSA Non-Participating Providers[19]**
Mental Health and Substance Abuse Benefits		
Initial visit For the initial Outpatient visit to determine the condition and diagnosis of the Insured, the Copayments listed for Outpatient Mental Health visits for Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of a Child will apply. Initial visits which are subsequently diagnosed as being for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for substance abuse care will also accrue toward the 20 visit maximum.	20%	40%
Inpatient Hospital and Professional Services[20] Note: Unless selected as an optional Benefit by your Employer, no benefits are provided for Inpatient substance abuse Services, except for Inpatient substance abuse detoxification which is covered as any other medical Benefit shown in this Summary of Benefits.		
Hospital Services	20%	40% of up to $600 per day[21]
]Physician Services	20%	40%
Outpatient Partial Hospitalization[20]	20% per episode[22]	40% of up to $350 per day
Outpatient Psychiatric Care, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT) for Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of a Child	20%[23]	40%[23]
Outpatient Facility & Office Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child and substance abuse	50%	Not covered
Note: Services are limited to a combined Benefit maximum of 20 visits per Insured per Calendar Year. No benefits are provided for Outpatient or out-of-Hospital Mental Health Services & substance abuse care from MHSA Non-Participating Providers, except for the initial visit.[25]		
Psychological testing	20%	40%
Psychosocial support through LifeReferrals 24/7	You pay nothing	You pay nothing

Benefit	Insured Copayment/Coinsurance[45]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Orthotics Benefits		
Office visits	20%	40%
Orthotic equipment and devices	20%	40%

Benefit	Insured Copayment/Coinsurance[5]	
	Participating Pharmacy	Non-Participating Pharmacy[25]
Outpatient Prescription Drug Benefits[24]		
Retail prescriptions		
Formulary Generic Drugs	$10	25% of billed charges plus $10
Formulary Brand Name Drugs[26]	$25	25% of billed charges plus $25
Non-Formulary Brand Name Drugs	$40	25% of billed charges plus $40
Home Self-Administered Injectable Drugs	30% of the Blue Shield negotiated pharmacy contracted rate for each prescription - up to a maximum of $150 per prescription	Not covered
Mail service prescriptions		
Formulary Generic Drugs	$20	Not covered
Formulary Brand Name Drugs[26]	$50	Not covered
Non-Formulary Brand Name Drugs	$80	Not covered
Home Self-Administered Injectable Drugs	Not covered	Not covered

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Outpatient X-ray, Pathology and Laboratory Benefits		
Outpatient X-ray, pathology and laboratory	20%[27]	40%[27]
PKU Related Formulas and Special Food Products Benefits		
PKU related formulas and Special Food Products	20%	20%
The above Services must be prior authorized by the Plan.		
Podiatric Benefits		
Podiatric Services provided by a licensed doctor of podiatric medicine	20%	40%
Pregnancy and Maternity Care Benefits		
All necessary Inpatient Hospital Services for normal delivery, Cesarean section and complications of pregnancy	20%	40% of up to $600 per day[17]
Prenatal and postnatal Physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy	20%	40%[17]
Note: routine newborn circumcision is only covered as described in the Covered Services section. When covered, Services will pay as any other surgery as noted in this Summary.		
Preventive Health Benefits[28, 29]		
Annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus virus (HPV) screening	You pay nothing	Not covered
Annual routine physical examination office visit	You pay nothing[30]	Not covered
Annual Vision and hearing screening	You pay nothing	Not covered
Colorectal cancer screening	You pay nothing	Not covered
Osteoporosis screening	You pay nothing	Not covered
Routine laboratory Services	You pay nothing[27]	Not covered
Well Baby Office visits	You pay nothing[30]	Not covered
Well Baby routine laboratory Services and immunizations	You pay nothing[27]	Not covered
Well Baby Vision and hearing screenings	You pay nothing	Not covered
Professional (Physician) Benefits		
Inpatient Physician Benefits	20%	40%
Internet based consultations	Not covered	Not covered
Mammography and Papanicolaou test	20%	40%
Physician home visits	20%	40%
Physician office visits	20%	40%
Services with the office visit	20%	40%

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Prosthetic Appliances Benefits		
Office visits	20%	40%
Prosthetic equipment and devices	20%	40%
(except those provided to restore and achieve symmetry incident to a mastectomy, which are covered under Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services), and Professional (Physician) Benefits in the Principal Benefits and Coverages (Covered Services) section, and specified devices following a laryngectomy, which are covered under Physician Services surgical Benefits)		
Radiological Procedures Benefits (requiring prior authorization)		
Outpatient, non-emergency radiological procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine	20%[27]	40%[27]
Note: Blue Shield Life requires prior authorization for all these Services.		
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
Rehabilitation Services by a physical, occupational, or respiratory therapist in the following settings:		
Office location	20%[10, 31]	40%
Outpatient department of a Hospital	20%[10, 31]	40% of up to $350 per day
Rehabilitation unit of a Hospital for Medically Necessary days	20%	40% of up to $600 per day
In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services		
Skilled Nursing Facility Rehabilitation unit for Medically Necessary days	20%[32]	20%[32]

Benefit	Insured Copayment/Coinsurance[5]	
	Covered Services by Preferred, Participating, and Other Providers[6]	**Covered Services by Non-Preferred and Non-Participating Providers[7]**
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility[18]	20%[32]	20%[32]
Speech Therapy Benefits		
Note: all Outpatient speech therapy Services must be prior authorized by Blue Shield Life.		
Speech Therapy Services by a licensed speech pathologist or certified speech therapist in the following settings:		
Office location	20%[10, 33]	40%
Outpatient department of a Hospital	20%[10, 33]	40% of to $350 per day
Rehabilitation unit of a Hospital for Medically Necessary days	20%	40% of up to $600 per day
In an Inpatient facility, this Copayment is billed as part of Inpatient Hospital Services		
Skilled Nursing Facility Rehabilitation unit for Medically Necessary days	20%[32]	20%[32]
Transplant Benefits - Cornea, Kidney or Skin		
Organ Transplant for transplant of a cornea, kidney or skin		
Hospital Services	20%	40% of up to $600 per day
Professional (Physician) Services	20%	40%
Transplant Benefits - Special		
Note: The Plan requires prior written authorization for all Special Transplant Services. Also, all Services must be provided at a Special Transplant Facility designated by Blue Shield Life.		
Special Transplant Benefits[34] for transplant of human heart, lung, heart and lung in combination, human bone marrow transplants, pediatric human small bowel transplants, pediatric and adult human small bowel and liver trans-plants in combination, and Services to obtain the human transplant material		
Facility Services in a Special Transplant Facility	20%	Not covered
Professional (Physician) Services	20%	Not covered

Summary of Benefits

Footnotes

[1] The Calendar Year Deductible does not apply to the Services listed below:
Preventive Health Benefits: routine lab and X-ray associated with an Annual Health Appraisal Exam, mammography, Papanicolaou test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer screening tests, colorectal cancer screening, osteoporosis screening, immunizations and vaccinations, vision and hearing screenings, and the Annual Health Appraisal Exam; however, other covered Services received during or in conjunction with an Annual Health Appraisal Exam Participating Physician office visit are subject to the Calendar Year Deductible;
Well Baby Care Benefits: routine lab and X-ray associated with Well Baby Care, office visits, tuberculin tests, vision and hearing screenings, and immunizations and vaccinations; however, other covered Services received during or in conjunction with a Well Baby Care Participating Physician office visit are subject to the Calendar Year Deductible; and,
covered travel expenses for bariatric surgery Services.

Note: Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.

[2] Before benefits will be provided for covered Services to any and all covered Members, the Calendar Year Family Coverage Deductible must be satisfied for those Services to which it applies. This Deductible must be made up of charges covered by the plan and must be satisfied once during each Calendar Year. For those Services to which the Family Coverage Deductible applies, charges Incurred by one or all of the covered Members in combination will be used to calculate the Calendar Year Family Coverage Deductible.

[3] Copayments/Coinsurance for covered travel expenses for bariatric surgery Services do not apply towards the Calendar Year maximum out-of-pocket responsibility.

[4] The Insured maximum lifetime Benefit payment amount is determined by totaling all covered Benefits provided to you whether you are a Subscriber or a Dependent while covered under this Plan, or while covered under any prior or subsequent health plan with Blue Shield Life or any of its affiliated companies which health plan is sponsored by the Employer (Policyholder) for the same group health plan, as defined in federal law known as ERISA. Benefits in excess of this amount are not covered under this Plan.

[5] Unless otherwise specified, Copayments/Coinsurance are calculated based on the Allowable Amount.

[6] Other Providers are not Preferred Providers and so for Services by Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include ambulance companies, nursing homes and certain labs (for a complete list of Other Providers see the Definitions section).

[7] For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[8] Bariatric Surgery Services for residents of designated counties must be provided by a Preferred Bariatric Surgery Services Provider. See the Plan Provider Definitions section and the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for complete information.

[9] See the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for a list of designated counties.

[10] If billed by your provider, you will also be responsible for an office visit Copayment/Coinsurance.

[11] Prior authorization by the Plan is required for all dialysis Services.

[12] For emergency room Services directly resulting in admission as an Inpatient to a Non-Preferred Hospital which Blue Shield Life determines are not emergencies, your Copayment/Coinsurance will be the Non-Preferred Hospital Outpatient Services Copayment/Coinsurance.

[13] No Benefits are provided for Family Planning Services by Non-Preferred or Non-Participating Providers.

[14] This Copayment/Coinsurance is in addition to the office visit Copayment/Coinsurance.

[15] Services by Non-Participating Home Health Care/Home Infusion Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be the Participating Agency Copayment/Coinsurance.

[16] Services by Non-Participating Hospice Agencies are not covered unless prior authorized by the Plan. When authorized by the Plan, these Non-Participating Agencies will be reimbursed at a rate determined by the Plan and the agency and your Copayment/Coinsurance will be the Participating Agency Copayment/Coinsurance.

[17] For Emergency Services by Non-Preferred Providers, your Copayment/Coinsurance will be the Preferred Provider Copayment/Coinsurance.

[18] Skilled Nursing Services are limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This 100-day maximum for skilled nursing Services is a combined maximum between Hospital and Skilled Nursing Facilities.

[19] For Services by MHSA Non-Participating Providers you are responsible for all charges above the Allowable Amount.

[20] All Inpatient Mental Health Services and Outpatient Partial Hospitalization Services and Outpatient electroconvulsive therapy Services (except for Emergency & urgent Services) must be prior authorized by the MHSA.

[21] For Emergency Services by MHSA Non-Participating Hospitals your Copayment/Coinsurance will be the MHSA Participating Hospital Copayment/Coinsurance based on Allowable Amount.

[22] For Outpatient Partial Hospitalization Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any Services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.

[23] This Copayment/Coinsurance includes both Outpatient facility and Professional (Physician) Services.

[24] This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan’s prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

[25] To obtain prescription Drugs at a Non-Participating Pharmacy, the Insured must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form for reimbursement. After the Calendar Year Deductible amount has been satisfied, the Insured will be reimbursed as shown in the Summary of Benefits.

[26] Note: For diaphragms, the Formulary Brand Name Copayment/Coinsurance applies.

[27] Your Copayment/Coinsurance will be assessed per provider per date of service.

[28] No Benefits are provided for Preventive Health Benefits by Non-Preferred or Non-Participating Providers.

[29] If Preventive Care Services are provided in a Preferred or Participating facility or in an Ambulatory Surgery Center, you may be responsible for an additional and separate Copayment/Coinsurance. See the Ambulatory Surgery Center Benefits and Hospital Benefits (Facility Services) sections in the Summary of Benefits for information on Copayments/Coinsurance.

[30] Copayments/Coinsurance for these Participating Physician office visits are not subject to the Calendar Year Deductible but do apply towards the Calendar Year maximum out-of-pocket responsibility. These Copayment/Coinsurance amounts apply only to charges for office visits with Participating Physicians in conjunction with the covered Services listed. Other covered Services received during or in connection with these office visits are paid at 80% of the Allowable Amount.

[31] For Services by certified occupational therapists and certified respiratory therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[32] For Services by free-standing skilled nursing facilities (nursing homes), which are Other Providers, you are responsible for all charges above the Allowable Amount.

[33] For Services by licensed speech therapists, which are Other Providers, you are responsible for all charges above the Allowable Amount.

[34] Special Transplant Benefits are limited to the procedures listed in the Covered Services section. See the Special Transplant Benefits Covered Services section for information on Services and requirements.

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including Plan Deductibles and Copayments, as well as some medical expenses not covered by your health Plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

How a Health Savings Account Works

An HSA is very similar to the flexible spending accounts currently offered by some employers. If you qualify for and set up an HSA with a qualified institution, the money deposited will be tax-deductible and can be used tax-free to reimburse you for many medical expenses. So, instead of using taxed income for medical ca re as you satisfy your Deductible, you may use 100% of every dollar invested (plus interest). And, as with an Individual Retirement Account, any amounts you do not use (or withdraw with penalty) can grow. Your principal and your returns may be rolled over from year to year to provide you with tax-deferred savings for future medical or other uses.

Please note that Blue Shield Life does not offer HSAs itself, and only offers high Deductible health plans.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your benefits administrator and consult with a financial advisor.

Introduction to the Blue Shield Life Shield Spectrum PPO Savings Plan

Benefits of this Plan differ substantially from traditional Blue Shield Life plans. If you have questions about your Benefits, contact Blue Shield Life before Hospital or medical Services are received.

This Plan is designed to reduce the cost of health care to you, the Insured. In order to reduce your costs, greater responsibility is placed on you.

You should read your Certificate carefully. Your Certificate tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment, Coinsurance and Deductible responsibilities.

When you need health care, present your Blue Shield Life I.D. card to your Physician, Hospital, or other licensed healthcare provider. Your I.D. card has your Subscriber and group numbers on it. Be sure to include these numbers on all claims you submit to Blue Shield Life.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Blue Shield Life Network of Preferred Providers" section).

You are responsible for following the provisions shown in the "Benefits Management Program" section of this booklet, including:

1. You or your Physician must obtain Blue Shield of California approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services, or obtain prior approval from the Mental Health Service Administrator (MHSA) for all non-Emergency Inpatient Mental Health and substance abuse Services. (See the "Blue Shield of California Preferred Providers" section for information.)
2. You or your Physician must notify Blue Shield of California (or the MHSA in the case of Mental Health or substance abuse Services) within 24 hours or by the end of the first business day following Emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Prior Authorization" in the "Benefits Management Program" section for a listing of services requiring prior authorization.

Failure to meet these responsibilities may result in your incurring a substantial financial liability. Some services may not be covered unless prior review and other requirements are met.

Note: Blue Shield Life or the MHSA will render a decision on all requests for prior authorization review within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Insured within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of an Insured or when the Insured is experiencing severe pain, Blue Shield Life will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Blue Shield Life Network of Preferred Providers

The Preferred Plan is specifically designed for you to use the Blue Shield Life Network of Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and Other Providers. Pre-

ferred Providers are listed in the Preferred Provider directories.

The California Department of Insurance has regulations that establish access standards for a plan's provider network in California. For purposes of these provider network access standards, the service area for this Plan is the State of California.

To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com, or by calling Customer Service at the telephone number provided on the last page of this Certificate. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by Blue Shield Life for services.

Blue Shield Life's Network of Preferred Providers agree to accept the Plan's payment, plus your payment of any applicable Deductibles, Copayments, Coinsurance, or amounts in excess of specified Benefit maximums as payment-in-full for covered Services, except as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability. This is not true of Non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the Copayments, Coinsurance and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision and in the Reductions section regarding Third Party Liability.

Providers do not receive financial incentives or bonuses from Blue Shield Life.

If you go to a Non-Preferred Provider, the Plan's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount the Plan pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a physician or hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Plan within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

For all Mental Health and substance abuse Services: The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of Mental Health Service Administrator (MHSA) Participating Providers.

Note that MHSA Participating Providers are only those Providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health and substance abuse Services to Insureds. A Blue Shield Life Network Preferred/Participating Provider may not be a MHSA Participating Provider. MHSA Participating Providers agree to accept the MHSA's payment, plus your payment of any applicable Deductible, Copayment or Coinsurance, or amounts in excess of Benefit maximums specified, as payment-in-full for covered Mental Health and substance abuse Services. This is not true of MHSA Non-Participating Providers; therefore, it is to your advantage to obtain Mental Health and substance abuse Services from MHSA Participating Providers.

It is your responsibility to ensure that the Provider you select for Mental Health and substance abuse Services is an MHSA Participating Provider. MHSA Participating Providers are indicated in the Behavioral Health Provider Directory. Additionally, Insureds may contact the MHSA directly for information on, and to select an MHSA Participating Provider by calling 1-877-214-2928.

Directories of Preferred Providers located in your area have been provided to you. Extra copies are available from the Plan. If you do not have the directories, please contact the Plan immediately and request them at the telephone number provided on the back page of this Certificate.

Continuity of Care by a Terminated Provider

Insureds who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield Life provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Financial Responsibility for Continuity of Care Services

If an Insured is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Insured to that provider for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area.

SUBMITTING A CLAIM FORM

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by the Plan if Services are rendered by a Non-Preferred Provider*. Payments to you for covered Services are in amounts identical to those made directly to providers. See section on Notice and Proof of Claim in this Certificate for information on filing a claim if a provider has not billed the Plan directly. Blue Shield Life will notify you of its determination within 30 days after receipt of the claim.

*Note: If the Insured's Employer is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and any subsequent amendments to ERISA, the Insured may assign payment to the Non-Preferred Provider who then will receive payment directly from Blue Shield Life.

ELIGIBILITY

If you are an Employee, you are eligible for coverage as an Insured the day following the date you complete the waiting period established by your Employer. Your spouse or Domestic Partner and all your Dependent children are eligible at the same time.

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period, they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer's next Open Enrollment Period. Blue Shield Life will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under a previous employer's plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish the Plan written proof of the loss of coverage.

Newborn infants of the Subscriber, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Subscriber's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by Blue Shield Life within 31 days from the date of birth or placement for adoption of such Dependent.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;
2. to add a Spouse after marriage or add a Domestic Partner after establishing a domestic partnership;
3. to add yourself and Spouse following the birth of a newborn or placement of a child for adoption;
4. to add yourself and Spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

A completed health statement may be required with the application. Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of both parents.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of such disabling condition. Blue Shield Life or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician's written certification within 60 days of the request for such information by the Employer or by the Plan. Proof of continuing disability and dependency must be submitted by the Employee as requested by Blue Shield Life but not more frequently than 2 years after the initial certification and then annually thereafter.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this Group Policy. See your Employer for further information.

Subject to the requirements described under the Continuation of Group Coverage provision in this Certificate, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this Plan when coverage would otherwise terminate.

EFFECTIVE DATE OF COVERAGE

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield Life, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date you made a written request for coverage or at the Employer's next Open Enrollment Period. Blue Shield Life will not consider applications for earlier effective dates.

If you declined coverage for yourself and your Dependents during the initial enrollment period because you or your Dependents were covered under another employer plan, and you or your Dependents subsequently lost coverage under that plan, you will not be considered a Late Enrollee. Coverage for you and your Dependents under this Plan will become effective on the date of loss of coverage, provided you enroll in this Plan within 31 days from the date of loss of coverage. You will be required to furnish the Plan written evidence of loss of coverage.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of marriage, establishment of domestic partnership, birth, or placement for adoption, you may request enrollment for yourself and your Dependents within 31 days. The effective date of enrollment for both you and your Dependents will depend on how you acquire your Dependent(s):

For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment;

For birth, the effective date will be the date of birth;

For a child placed for adoption, the effective date will be the date the Subscriber, Spouse, or Domestic Partner has the right to control the child's health care.

Once each Calendar Year, your Employer may designate a time period as an annual Open Enrollment Period. During that time period, you and your Dependents may transfer from another plan sponsored by your Employer to the Preferred Plan. A completed enrollment form must be forwarded to Blue Shield Life within the Open Enrollment Period. Enrollment becomes effective on the anniversary date of this Plan following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Subscriber, spouse or Domestic Partner has the right to control the child's health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by the Plan within 31 days. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer's next Open Enrollment Period.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group plan that was in effect with your Employer you and all your Dependents who were validly covered under the previous group plan on the date of discontinuance will be eligible under this Plan.

RENEWAL OF GROUP POLICY

Blue Shield Life will offer to renew the Group Policy except in the following instances:

1. non-payment of Premiums (see "Termination of Benefits" and "Reinstatement, Cancellation and Rescission Provisions");
2. fraud, misrepresentations or omissions;
3. failure to comply with Blue Shield Life's applicable eligibility, participation or contribution rules;
4. termination of plan type by Blue Shield Life;
5. Employer moves out of the service area;
6. association membership ceases.

All groups will renew subject to the above.

PREMIUMS

The monthly Premiums for you and your Dependents are indicated in your employer's Group Policy. The initial Premiums are payable on the effective date of this Plan, and subsequent Premiums are payable on the same date of each succeeding month. Premiums are payable in full on each transmittal date and must be made for all Subscribers and Dependents.

All Premiums required for coverage for you and your Dependents will be handled through your Employer, and must be paid to Blue Shield Life. Payment of Premiums will continue the Benefits of this Plan up to the date immediately before the next transmittal date, but not after.

The section on Premiums does not apply to a Subscriber who is enrolled under a Policy where monthly Premiums automatically increase, without notice, the first day of the month following an age change that moves the Subscriber into the next higher age category.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, and annual Copayment maximum amounts, are subject to change at any time. Blue Shield Life will provide at least 30 days' written notice of any such change.

Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

SERVICES FOR EMERGENCY CARE

The Benefits of this Plan will be provided for covered Services received anywhere in the world for the emergency care of an illness or injury.

Insureds who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

UTILIZATION REVIEW

State law requires that insurers disclose to Insureds and providers the process used to authorize or deny health care services under the Plan.

The Plan has completed documentation of this process ("Utilization Review"), as required under Section 10123.135 of the California Insurance Code.

To request a copy of the document describing this Utilization Review process, call the Customer Service Department at the number provided on the last page of this Certificate.

SECOND MEDICAL OPINION POLICY

If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan policy Benefit limitations and exclusions.

RETAIL-BASED HEALTH CLINICS

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com. See the Blue Shield Life Network of Preferred Providers section for information on the advantages of choosing a Preferred Provider.

NURSEHELP 24/7 AND LIFEREFERRALS 24/7

NurseHelp 24/7 and LifeReferrals 24/7 programs provide Insureds with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychosocial issues. Insureds may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

These programs include:

NurseHelp 24/7 – Insureds may call a registered nurse toll free via 1-877-304-0504, 24 hours a day, to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

Psychosocial support through LifeReferrals 24/7 – Insureds may call 1-800-985-2405 on an unlimited, 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling. Note: See Principal Benefits & Coverages, the Mental Health and Substance Abuse Benefits section for important information concerning this feature.

BLUE SHIELD LIFE ONLINE

Blue Shield Life's Internet site is located at http://www.blueshieldca.com. Insureds with Internet access and a Web browser may view and download healthcare information.

BENEFITS MANAGEMENT PROGRAM

Blue Shield Life has established the Benefits Management Program to assist you, your Dependents or provider in identifying the most appropriate and cost-effective course of treatment for which certain Benefits will be provided under this Plan and for determining whether the services are Medically Necessary. However, you, your Dependents and provider make the final decision concerning treatment. The Benefits Management Program includes: prior authorization review for certain services, emergency admission notification, Hospital Inpatient review, discharge planning, and case management if determined to be applicable and appropriate by Blue Shield.

In some cases, the Benefits Management Program requires you to contact Blue Shield Life and/or follow Blue Shield Life's recommendations. Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in reduced payment or non-payment if Blue Shield Life determines the service was not a covered Service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. Remember that all provisions of the Benefits Management Program also apply to your Dependents.

Blue Shield Life requires prior authorization for selected Inpatient and Outpatient services, supplies and Durable Medical Equipment; PKU related formulas and Special Food Products; admission into an approved Hospice Program; and certain radiology procedures. Prior authorization is required for all Inpatient Hospital and Skilled Nursing Facility services (except for Emergency Services*).

*See the paragraph entitled Emergency Admission Notification later in this section for notification requirements.

By obtaining prior authorization for certain services prior to receiving services, you and your provider can verify: (1) if Blue Shield Life considers the proposed treatment Medically Necessary, (2) if Plan Benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by Blue Shield Life. You and your provider may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

PRIOR AUTHORIZATION

For Services listed in the section below, you or your provider can determine before the service is provided whether a procedure or treatment program is a Covered Service and may also receive a recommendation for an alternative Service. Failure to contact the Plan as described below or failure to follow the recommendations of the Plan for these services will result in a reduced payment per procedure as described in the section entitled Reduced Payments for Failure to Use the Benefits Management Program.

For Services other than those listed in the sections below, you, your Dependents or provider should consult the Principal Benefits and Coverages (Covered Services) section of this booklet to determine whether a service is covered.

You or your Physician must call 1-800-343-1691 for prior authorization for the services listed in this section except for the Outpatient radiological procedures described in item 11. below and for treatment of mental illness listed in item 16. below.

For prior authorization for these radiological procedures, you or your Physician must call 1-888-642-2583.

You or your Physician must call the MHSA at 1-877-214-2928 for prior authorization of Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient electroconvulsive therapy (ECT) Services for the treatment of mental illness.

The Plan requires prior authorization for the following services:

1. Admission into an approved Hospice Program as specified under Hospice Program Benefits in the Covered Services section.
2. Clinical Trial for Cancer Benefits.

   Insureds who have been accepted into an approved clinical trial for cancer as defined under the Covered Services section must obtain prior authorization from Blue Shield Life in order for the routine patient care delivered in a clinical trial to be covered.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for Hospice Program Benefits and Clinical Trial for Cancer Benefits above will result in non-payment of services by Blue Shield Life.

3. Select injectable drugs administered in the Physician office setting.*

   *Prior authorization is based on Medical Necessity, appropriateness of therapy, or when effective alternatives are available.

   Note: Your Preferred or Non-Preferred Physician must obtain prior authorization for select injectable drugs administered in the Physician's office. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for select injectable drugs may result in non-payment by Blue Shield Life if the service is determined not to be a covered Service; in that event you may be financially responsible for services rendered by a Non-Preferred Physician.
4. Home Health Care Benefits from Non-Preferred Providers.
5. Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers.
6. Durable Medical Equipment Benefits, including but not limited to motorized wheelchairs, insulin infusion

pumps, and CPAP (Continuous Positive Air Pressure) machines.

7. Surgery Services which may be considered to be Cosmetic in nature rather than Reconstructive (e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction) and those Reconstructive Surgeries which may result in only minimal improvement in function or appearance. Reconstructive Surgery is limited to Medically Necessary surgeries and procedures as described in Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services), and Professional (Physician) Benefits in the Covered Services section.

8. Arthroscopic surgery of the temporomandibular joint (TMJ) Services.

9. Dialysis Services as specified under Dialysis Center Benefits and Hospital Benefits (Facility Services) in the Covered Services section.

Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for:

injectable drugs administered in the Physician office setting,

Home Health Care Benefits from Non-Preferred Providers,

Home Infusion/Home Injectable Therapy Benefits from Non-Preferred Providers,

Durable Medical Equipment Benefits,

cosmetic surgery Services,

arthroscopic surgery of the TMJ services, and

dialysis Services

as described above may result in non-payment of services by Blue Shield Life.

10. PKU Related Formulas and Special Food Products Benefits.

11. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis:

    CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnostic procedure utilizing Nuclear Medicine.

    Prior authorization is not required for these radiological services when obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this booklet for an explanation of how payment is made for out of state services.

12. Special Transplant Benefits as specified under Special Transplant Benefits in the Covered Services section.

13. All bariatric surgery.

14. Outpatient Speech Therapy Services as specified under Speech Therapy Benefits in the Covered Services section.

15. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).

16. Outpatient psychiatric Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services for the treatment of mental illness.

Failure to obtain prior authorization or to follow the recommendations of the Plan for:

PKU Related Formulas and Special Food Products Benefits,

Outpatient radiological procedures as specified above,

Special Transplant Benefits,

all bariatric surgery,

Outpatient Speech Therapy Services,

Hospital and Skilled Nursing Facility admissions, and

Outpatient psychiatric Partial Hospitalization and Outpatient ECT Services

as described above will result in a reduced payment as described in the Reduced Payments for Failure to Use The Benefits Management Program section or may result in non-payment if the Plan determines that the service is not a covered Service.

Other specific services and procedures may require prior authorization as determined by Blue Shield Life. A list of services and procedures requiring prior authorization can be obtained by your provider by going to http://www.blueshieldca.com or by calling 1-800-343-1691.

Hospital and Skilled Nursing Facility Admissions

Prior Authorization must be obtained from Blue Shield Life for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are Hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care, transplants, bariatric surgery, and Inpatient Mental Health or substance abuse Services described later in this section.

Prior Authorization for Other than Mental Health or Substance Abuse Admissions

Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, you or your Physician must contact Blue Shield Life at 1-800-343-1691 at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, the Plan should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. Blue Shield Life will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this Plan that the Services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact Blue Shield Life as described above or failure to follow the recommendations of Blue Shield Life will result in reductions in coverage per admission as described in the Reduced Payments for Failure to Use the Benefits Management Program section or may result in non-payment if Blue Shield Life determines that the admission is not a covered Service*.

*Note: For admissions for Special Transplant Benefits and for Bariatric Services for Residents of Designated Counties, failure to receive prior authorization in writing and/or failure to have the procedure performed at a Blue Shield Life-designated facility will result in non-payment of services by Blue Shield Life. See Transplant Benefits and Bariatric Surgery Benefits for Residents of Designated Counties in California under the Covered Services section for details.

Prior Authorization for Inpatient Mental Health or Substance Abuse Services, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

All Inpatient Mental Health and substance abuse Services, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, except for Emergency Services, must be prior authorized by the Mental Health Service Administrator (MHSA).

For an admission for Emergency Mental Health or substance abuse Services, the MHSA should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so or the Insured may be responsible for the reduction in coverage as described in the Reduced Payments for Failure to Use the Benefits Management Program section.

For prior authorization of Inpatient Mental Health and substance abuse Services, Intensive Outpatient Care, Outpatient Partial Hospitalization and Outpatient ECT Services, call the MHSA at 1-877-214-2928.

Failure to contact Blue Shield Life or the MHSA as described above or failure to follow the recommendations of Blue Shield Life will result in a reduction in coverage per admission as described in the Reduced Payments for Failure to Use The Benefits Management Program section and may result in reduction or non-payment if Blue Shield Life or the MHSA determines that the admission is not a covered Service. For Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, failure to contact Blue Shield Life or the MHSA as described above or failure to follow the recommendations of Blue Shield Life will result in non-payment of services by Blue Shield Life.

Note: Blue Shield Life or the MHSA will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Subscriber within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of an Insured or when the Insured is experiencing severe pain, Blue Shield Life will respond as soon as possible to accommodate the Insured's condition not to exceed 72 hours from receipt of the request.

EMERGENCY ADMISSION NOTIFICATION

If you are admitted for Emergency Services, Blue Shield Life should receive Emergency Admission Notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or you may be responsible for the reduction in coverage as described under the Reduced Payments for Failure to Use the Benefits Management Program section.

HOSPITAL INPATIENT REVIEW

Blue Shield Life monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of Hospital stays will be determined solely by your Physician in consultation with you. When a determination is made that the Insured no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

DISCHARGE PLANNING

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield Life will work with the Physician and Hospital discharge planners to determine whether benefits are available under this Plan to cover such care.

Case Management

The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of the Plan Benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate through a Blue Shield Life review. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the Benefit to which you would otherwise have been entitled under this Plan. The Plan is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative benefits will be for a specific period of time and will not be construed as a waiver of the Plan's right to thereafter administer this Plan in strict accordance with its express terms.

Reduced Payments for Failure to Use The Benefits Management Program

For non-emergency Services, payments may be reduced, as described below, when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization and Hospital and Skilled Nursing Facility Admissions sections of the Benefits Management Program.

1. Failure to contact Blue Shield Life or the MHSA (in case of a Mental Health admission) as described under the Prior Authorization section of the Benefits Management Program may result in a reduction in coverage of $250, in addition to the applicable Calendar Year Deductible, and may result in non-payment if Blue Shield Life or the MHSA determines that the service is not a covered Service. This reduction in coverage will be applicable to charges when a Subscriber or Dependent fails to follow the procedures described under the Prior Authorization section of the Benefits Management Program.
2. If this Plan provides Benefits for Hospital admissions for diagnosis or treatment of substance abuse, other than Inpatient substance abuse medical detoxification, failure to contact the MHSA as described under the Hospital and Skilled Nursing Facility Admissions section of the Benefits Management Program will result in an increase in the $250 reduction in coverage to $1,000, and may result in non-payment if the MHSA determines that the admission is not a covered Service.

Only one $250 or $1,000 reduction in coverage will apply to each Hospital or Skilled Nursing Facility admission for failure to follow the Benefits Management Program notification requirements or recommendations.

3. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, will result in non-payment of services by Blue Shield Life.
4. Failure to obtain prior authorization or to follow the recommendations of Blue Shield Life for covered, Medically Necessary enteral formulas and Special Food Products for the treatment of phenylketonuria (PKU) will result in a 50% reduction in the amount payable by Blue Shield Life after the calculation of the Deductible and any applicable Copayments required by this Plan. You will be responsible for the applicable Deductibles and/or Copayments and the additional 50% of the charges that are payable under this Plan.
5. Failure to obtain prior authorization for the radiological procedures listed in the Benefits Management Program section or to follow the recommendations of Blue Shield Life will result in Reduced Payment amounts described below per procedure and may result in non-payment for procedures which are determined not to be covered services.
6. For other covered Services requiring prior authorization that are not authorized in advance, Blue Shield Life will cover only 50% of any amount remaining after the Allowable Amount is reduced by applicable Deductible and/or Copayments required by this Plan. You will be responsible for both the non-covered 50% and for applicable Deductible and/or Copayments. Your 50% responsibility will not be included in the calculation of the Calendar Year maximum out-of-pocket responsibility.

For Services provided by a Non-Preferred Provider, the Insured will also be responsible for all charges in excess of the Allowable Amount.

Deductibles

1. Individual Coverage Deductible (applicable to 1 Insured coverage)

The Calendar Year per Insured Deductible amount is shown in the Summary of Benefits. After the Calendar Year Individual Coverage Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductible. The Individual Coverage Deductible must be satisfied once during each Calendar Year.

2. Family Coverage Deductible (applicable to 2 or more Insured coverage)

The Calendar Year per Family Deductible amount is shown in the Summary of Benefits. The Calendar Year Family Coverage Deductible must be satisfied for those Services to which it applies before Benefits will be provided for covered Services to any and all Insureds. This Deductible must

be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. Charges in excess of the Allowable Amount do not apply toward the Deductible. For those Services to which the Family Coverage Deductible applies, charges Incurred by one or all of the Insureds in combination will be used to calculate the Calendar Year Family Coverage Deductible.

These Calendar Year Deductibles will count towards the Calendar Year maximum out-of-pocket responsibility.

SERVICES NOT SUBJECT TO THE DEDUCTIBLE

The Calendar Year Deductible applies to all covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

MAXIMUM AGGREGATE PAYMENT AMOUNT

The maximum aggregate payment amount is shown in the Summary of Benefits. The maximum aggregate payment amount is determined by totaling all covered Benefits provided to you whether you are a Subscriber or a Dependent while covered under this Plan, or while covered under any prior or subsequent health plan with Blue Shield of California or any of its affiliated companies which health plan is sponsored by the Employer (Policyholder) for the same group health plan, as defined in federal law known as ERISA. Benefits in excess of this amount are not covered under this Plan.

PAYMENT

The Insured's Copayment and Coinsurance amounts, applicable Deductibles, and Copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on benefit and Copayment/Coinsurance maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

Out-of-Area Program: The BlueCard® Program

Benefits will be provided, according to paragraphs (1.), (2.), and (3.) below, for covered Services received outside of California within the United States. Blue Shield Life calculates the Insured's Copayment as a percentage of the Allowable Amount or dollar copayment, as defined in this Certificate. When covered Services are received in another state, the Insured's copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers.

1. Covered Services received from a provider who has contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred level. Insureds are responsible for the remaining Copayment.
2. Non-emergency covered Services received from providers who have not contracted with the local Blue Cross Blue and/or Shield plan are paid at the Non-Preferred level of the local Blue Cross and/or Blue Shield plan's Allowable Amount. Insureds are responsible for the remaining Copayment as well as any charges in excess of the local Blue Cross and/or Blue Shield plan's Allowable Amount.
3. Emergency Services received from providers who have not contracted with the local Blue Cross and/or Blue Shield plan are paid at the Preferred level of billed charges, except that services of physicians and hospitals are paid based on the Allowable Amount. Insureds are responsible for the remaining Copayment.

If you do not see a participating provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Blue Shield Life for payment. Blue Shield Life will notify you of its determination within 30 days after receipt of the claim. Blue Shield Life will pay you at the Non-Preferred Provider benefit level. Remember, your copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield Life and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the plan, are the Insured's responsibility and are not included in out-of-pocket calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require covered Services while traveling outside of California:

1. call *BlueCard Access®* at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go online at http://www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2. visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable copayment and plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from Blue Shield Life, the out-of-area provider should call 1-800-343-1691.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this plan will be provided for covered Services received anywhere in the world for emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered Services received outside of the United States through the BlueCard Worldwide® Network. If you need urgent care while out of the country, call either the toll-free BlueCard Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should call Blue Shield Life at 1-800-343-1691. For inpatient hospital care at participating hospitals, show your I.D. card to the hospital staff upon arrival. You are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments).

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Also for inpatient hospitalization, if you do not use the BlueCard Worldwide Network, you will have to pay the entire bill for your medical care and submit a claim form (with a copy of the bill) to Blue Shield Life.

Before traveling abroad, call your local Customer Service office for the most current listing of participating Hospitals world wide or you can go on-line at http://www.bcbs.com and select “Find a Doctor or Hospital”.

Calculation of your Deductibles, Copayments and maximum out-of-pocket responsibilities under the BlueCard Program:

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for covered services is calculated on the lower of:

1. The Allowable Amount for your covered services, or
2. The negotiated price that the local Blue Cross and/or Blue Shield plan passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the local Blue Cross and/or Blue Shield plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the local Blue Cross and/or Blue Shield plan use a basis for calculating Insured liability for covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Insured liability calculation methods that differ from the usual BlueCard Program method noted above or require a surcharge, Blue Shield Life would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

For any other providers, the amount you pay, if not subject to a flat dollar copayment, is calculated on the Allowable Amount for your covered services.

CALENDAR YEAR MAXIMUM OUT-OF-POCKET RESPONSIBILITY

1. INDIVIDUAL COVERAGE (APPLICABLE TO 1 INSURED COVERAGE)

The per Insured maximum out-of-pocket responsibility required each Calendar Year for covered Services* is shown in the Summary of Benefits.

Once the maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

2. FAMILY COVERAGE (APPLICABLE TO 2 OR MORE INSURED COVERAGE)

The per Family maximum out-of-pocket responsibility required each Calendar Year for covered Services* is shown in the Summary of Benefits.

Once the maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

*Note: Certain Services and amounts are not included in the Calendar Year maximum out-of-pocket responsibility calculations. These items are shown in the Summary of Benefits.

Charges for Services which are not covered, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and Reduced Payments Incurred under the Benefits Management Program are the Insured’s re-

sponsibility and are not included in the Calendar Year maximum out-of-pocket responsibility calculations.

For the Outpatient Prescription Drugs Benefit, if the Insured requests a brand name drug when a generic drug equivalent is available, the difference in cost that the Insured must pay is not included in the Calendar Year maximum out-of-pocket responsibility calculations. See the Outpatient Prescription Drugs Benefit section for details.

PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES)

Benefits are provided for the following Medically Necessary covered Services, subject to applicable Deductibles, Copayments and Coinsurance, and charges in excess of Benefit maximums, Preferred Provider provisions and Benefits Management Program provisions. Coverage for these Services is subject to all terms, limitations and exclusions of the Policy, to any conditions or limitations set forth in the benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this Certificate.

The Copayments and Coinsurance, if applicable, are shown in the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Insureds will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Insured Copayment.

Except as specifically provided herein, Services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

ALLERGY TESTING AND TREATMENT BENEFITS

Benefits are provided for allergy testing and treatment.

AMBULANCE BENEFITS

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport an Insured from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

AMBULATORY SURGERY CENTER BENEFITS

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

Note: Reconstructive Surgery and associated covered Services are only covered when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas, is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits Any such Services must be received while the policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;

- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

BARIATRIC SURGERY BENEFITS FOR RESIDENTS OF DESIGNATED COUNTIES IN CALIFORNIA

Benefits are provided for Hospital and professional Services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, from Blue Shield Life's Medical Director. Prior authorization is required for all Persons, whether residents of a designated or non-designated county.

Services for Residents of Designated Counties in California

For Persons who reside in a California county designated as having facilities contracting with Blue Shield Life to provide bariatric Services*, Blue Shield Life will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

1) performed at a Preferred Bariatric Surgery Services Hospital and by a Preferred Bariatric Surgery Services Physician that have contracted with Blue Shield Life to provide the procedure; and,
2) they are consistent with Blue Shield Life's medical policy; and,
3) prior authorization is obtained, in writing, from Blue Shield Life's Medical Director.

*See the list of designated counties below.

Blue Shield Life reserves the right to review all requests for prior authorization for these bariatric benefits and to make a decision regarding benefits based on a) the medical circumstances of each patient, and b) consistency between the treatment proposed and Blue Shield Life medical policy.

For Persons who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Preferred Bariatric Surgery Services Hospital by a Preferred Bariatric Surgery Services Physician will result in denial of claims for this benefit.

The following are designated counties in which Blue Shield Life has contracted with facilities and physicians to provide bariatric Services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement for Residents of Designated Counties in California

Persons who reside in designated counties and who have obtained written authorization from Blue Shield Life to receive bariatric Services at a Preferred Bariatric Surgery Services Hospital may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Person's home must be 50 or more miles from the nearest Preferred Bariatric Surgery Services Hospital. All requests for travel expense reimbursement must be prior approved by Blue Shield Life. Approved travel-related expenses will be reimbursed as follows:

1. Transportation to and from the facility up to a maximum of $130 per trip:
   a. for the Person for a maximum of 3 trips:

      1 trip for a pre-surgical visit,

      1 trip for the surgery, and

      1 trip for a follow-up visit.

   b. for one companion for a maximum of 2 trips:

      1 trip for the surgery, and

      1 trip for a follow-up visit.
2. Hotel accommodations not to exceed $100 per day:
   a. for the Person and one companion for a maximum of 2 days per trip,

      1 trip for a pre-surgical visit, and

      1 trip for a follow-up visit.

   b. for one companion for a maximum of 4 days for the duration of the surgery admission.

   All hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.
3. Related expenses judged reasonable by Blue Shield Life not to exceed $25 per day per Person up to a maximum of 4 days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Covered bariatric travel expenses are not subject to the Deductible and do not accrue to the maximum Calendar Year out-of-pocket responsibility.

Note: Bariatric surgery Services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

1. Services are consistent with Blue Shield Life's medical policy; and,
2. prior authorization is obtained, in writing, from Blue Shield Life's Medical Director.

For Persons who reside in non-designated counties, travel expenses associated with bariatric surgery Services are not covered.

Chiropractic Benefits

Benefits are provided for Medically Necessary Chiropractic Services rendered by a chiropractor. The chiropractic benefit includes the initial and subsequent office visits, an initial examination, adjustments, conjunctive therapy, and lab and X-ray Services up to the Benefit maximum.

Benefits are limited to a per Insured per Calendar Year visit maximum as shown in the Summary of Benefits.

Covered lab and X-ray Services provided in conjunction with this Benefit have an additional Coinsurance as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Clinical Trial for Cancer Benefits

Benefits are provided for routine patient care for Insureds who have been accepted into an approved clinical trial for cancer when prior authorized by the Plan, and:

1. the clinical trial has a therapeutic intent and the Insured's treating Physician determines that participation in the clinical trial has a meaningful potential to benefit the Insured with a therapeutic intent; and
2. the Insured's treating Physician recommends participation in the clinical trial; and
3. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits.

Routine patient care consists of those Services that would otherwise be covered by the Plan if those Services were not provided in connection with an approved clinical trial, but does not include:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

An approved clinical trial is limited to a trial that is

1. Approved by one of the following:
   a. one of the National Institutes of Health;
   b. the federal Food and Drug Administration, in the form of an investigational new drug application;
   c. the United States Department of Defense;
   d. the United States Veterans' Administration;

or

2. Involves a drug that is exempt under federal regulations from a new drug application.

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary:

a. blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary supplies;

c. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of Insulin.

For coverage of diabetes testing supplies, including lancets, lancet puncture devices, and blood and urine testing strips and test tablets, and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug Benefit.

Diabetes Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable an Insured to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed

by the Insured's Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by Physicians, registered dieticians or registered nurses who are certified diabetes educators.

DIALYSIS CENTER BENEFITS

Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

Included in this Benefit are Medically Necessary dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis.

Note: Prior authorization by Blue Shield Life is required for all dialysis services. See the Benefits Management Program section for details.

DURABLE MEDICAL EQUIPMENT BENEFITS

Medically Necessary Durable Medical Equipment for Activities of Daily Living supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, and the home prothrombin monitor for specific conditions as determined by the Plan. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

Medically Necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section, except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item*.

   *This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: See the Outpatient Prescription Drugs Benefits section for benefits for asthma inhalers and inhaler spacers.)

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

There is a combined per Person per Calendar Year Maximum on all Services covered under the Durable Medical Equipment Benefit. The Benefit maximum is shown on the Summary of Benefits. This maximum does not apply to oxygen or to Services covered under Diabetes Care Benefits.

Note: See the Diabetes Care Benefits section for devices, equipment and supplies for the management and treatment of diabetes.

For Insureds in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency.

FAMILY PLANNING BENEFITS

Benefits are provided for the following Family Planning Services without illness or injury being present.

Note: No benefits are provided for Family Planning Services from Non-Preferred Providers. No Benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fittings;
2. Intrauterine devices (IUDs) including insertion and/or removal;
3. Injectable contraceptives when administered by a Physician;
4. Voluntary sterilization (tubal ligation and vasectomy) and elective abortions. No benefits are provided for contraceptives, except as may be provided under the Outpatient Prescription Drug Benefits.

HOME HEALTH CARE BENEFITS

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the attending Physician, and included in a written treatment plan.

Services by a Non-Participating Home Health Care Agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by the Plan.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Insured per Calendar Year visit maximum as shown in the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8

hours per day by any of the following professional providers:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2., or 3. above;
5. Medical social worker.

For the purpose of this Benefit, visits from home health aides of 4 hours or less shall be considered as one visit.

In conjunction with professional Services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan and related laboratory Services are covered to the extent the Benefits would have been provided had the Insured remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefit or under the supplemental Benefit for Outpatient Prescription Drugs.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: See the Hospice Program Benefits section for information about when an Insured is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS

Benefits are provided for home infusion and IV injectable therapy, including home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutritional Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing must be prior authorized by Blue Shield Life.

This Benefit does not include medications, drugs, Insulin, insulin syringes and certain Home Self-Administered Injectables covered under the Outpatient Prescription Drug Benefit.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion agencies must be prior authorized by the Plan.

HOSPICE PROGRAM BENEFITS

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Insured requests admission to and is formally admitted to an approved Hospice Program. The Insured must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Plan. (Note: Insureds with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Insureds can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider.

Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by the Plan.

All of the Services listed below must be received through the Participating Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Persons do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Insured to the extent that

these needs are not met by the Insured's other providers.

7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain an Insured at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Insureds are allowed to change their Participating Hospice Agency only once during each Period of Care. Insureds can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Participating Provider recertifies that the Insured is Terminally ill.

DEFINITIONS:

Bereavement Services – services available to the immediate surviving family members for a period of at least one year after the death of the Insured. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Insured.

Continuous Home Care – home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

Home Health Aide Services – services providing for the personal care of the Terminally Ill Insured and the performance of related tasks in the Insured's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

Homemaker Services – services that assist in the maintenance of a safe and healthy environment and services to enable the Insured to carry out the treatment plan.

Hospice Service or Hospice Program – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an Insured who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

1. Considers the Insured and the Insured's family in addition to the Insured, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Insured and their family.
3. Requires the interdisciplinary team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Insureds who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Insured's death to assist the family to cope with social and emotional needs associated with the death.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Insured's home or primary place of residence to the extent appropriate based on the medical needs of the Insured.
8. Is provided through a Participating Hospice.

Interdisciplinary Team – the hospice care team that includes, but is not limited to, the Insured and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

Medical Direction – Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Insured's Participating Provider, as requested,

with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

Period of Care – the time when the Participating Provider recertifies that the Insured still needs and remains eligible for hospice care even if the Insured lives longer than one year. A Period of Care starts the day the Insured begins to receive hospice care and ends when the 90 or 60- day period has ended.

Period of Crisis – a period in which the Insured requires continuous care to achieve palliation or management of acute medical symptoms.

Plan of Care – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of an Insured and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

Respite Care Services – short–term Inpatient care provided to the Insured only when necessary to relieve the family members or other persons caring for the Insured.

Skilled Nursing Services – nursing Services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Insured's provider to the Insured and his family that pertain to the palliative, supportive services required by the Insured with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Subscriber or Dependent assessment, evaluation, and case management of the medical nursing needs of the Insured, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Insured and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Insured and his family and are available on a 24-hour on-call basis.

Social Service/Counseling Services – those counseling and spiritual Services that assist the Insured and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

Terminal Disease or Terminal Illness – a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

Volunteer Services – services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Insured and his family during the remaining days of the Insured's life and to the surviving family following the Insured's death.

HOSPITAL BENEFITS (FACILITY SERVICES)

(Other than Mental Health and Substance Abuse Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, Dialysis Center Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California, which are described elsewhere under Covered Services)

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3. In conjunction with a covered delivery, routine nursery care for a newborn of the Insured, covered spouse or Domestic Partner.
4. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas, is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and

- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
6. Rehabilitation when furnished by the Hospital and approved in advance by the Plan under its Benefits Management Program.
7. Drugs and oxygen.
8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
9. X-ray examination and laboratory tests.
10. Radiation therapy and chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
11. Use of medical appliances and equipment.
12. Subacute Care.
13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
14. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when an Insured is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.
2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.
3. Radiation therapy and chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
4. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast provided to restore and achieve symmetry incident to a mastectomy, including treatment of physical complications of a mastectomy and lymphedemas, is covered. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Insured is under the age of seven or developmentally disabled regardless of age or when the Insured's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

Covered lab and x-ray Services provided in an Outpatient Hospital setting are described under the Outpatient X-ray, Pathology and Laboratory Benefits, Rehabilitation (Physical, Occupational, and Respiratory Therapy) Benefits, and Speech Therapy Benefits sections.

Emergency Room Services for Treatment of Illness or Injury

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Plan determines are not emergencies, will be paid as part of the Inpatient Hospital Services. The Insured Coinsurance for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown in the Summary of Benefits.

For Emergency Room Services directly resulting in an admission to a different Hospital, the Insured is responsible for the emergency room Insured Copayment/Coinsurance plus the appropriate admitting Hospital Services Insured Copayment/Coinsurance as shown in the Summary of Benefits.

Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits

Benefits are provided for Hospital and professional Services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an accidental injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Insured as determined by the Plan;

   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.
3. Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
4. surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically Necessary treatment of maxilla and mandible (Jaw Joints and Jaw Bones); or
6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity.

No benefits are provided for:

1. services performed on the teeth, gums (other than tumors) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ;
3. dental implants (endosteal, subperiosteal or transosteal);
4. any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
5. Alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth;
6. Fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions and Reductions, General Exclusions for additional services that are not covered.

Mental Health and Substance Abuse Benefits

The Plan's Mental Health Service Administrator (MHSA) administers and delivers the Plan's Mental Health and substance abuse care Services.

All Non-Emergency Inpatient Mental Health and substance abuse Services and Outpatient Partial Hospitalization, Intensive Outpatient Care, and Outpatient ECT Services must be prior authorized by the MHSA including those obtained outside of California. See the "Out-Of-Area Program: The BlueCard Program" section of this certificate for an explanation of how payment is made for out of state Services. For prior authorization, Insureds should contact the MHSA at 1-877-214-2928. (See the Benefits Management Program section for complete information.)

Benefits are provided for the following covered Mental Health and substance abuse conditions, subject to applicable Deductibles, Copayments, and Coinsurance, MHSA Participating Provider provisions, Benefits Management Program provisions, and other limitations and exclusions.

Benefits are provided, as described below, for the diagnosis and treatment of Mental Health and substance abuse conditions. All Non-Emergency Inpatient Mental Health and substance abuse Services, Intensive Outpatient Care and all Outpatient Partial Hospitalization and Outpatient ECT Services must be prior authorized by the MHSA.

The Copayments and Coinsurance for covered Mental Health and substance abuse Services, if applicable, are shown in the Summary of Benefits.

Note: For all Inpatient Hospital care, except for Emergency Services, failure to contact the MHSA prior to obtaining Services will result in the Insured being responsible for a reduced payment as outlined in the Hospital and Skilled Nursing Facility Admissions paragraphs of the Benefits Management Program section. For Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services, failure to contact Blue Shield Life or the MHSA as described above or failure to follow the recommendations of Blue Shield Life will result in non-payment of services by Blue Shield Life.

1. Inpatient Mental Health Services

Benefits are provided for psychiatric Inpatient Services in connection with hospitalization for the treatment of mental illness (including treatment of Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of a Child). Residential care is not covered.

Note: See Hospital Benefits (Facility Services), Inpatient Services for Treatment of Illness or Injury for information on Medically Necessary Inpatient substance abuse detoxification.

(If Inpatient substance abuse treatment, except for acute medical detoxification, is selected as an optional benefit by your Employer, an accompanying insert provides the benefit description, limitations and Copayments/Coinsurance.)

2. Outpatient Facility and Office Care

Benefits are provided for Outpatient Facility and Office care for Severe Mental Illnesses or Serious Emotional Disturbances of a Child and for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child & for substance abuse care.

Outpatient or office Mental Health Services and substance abuse care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child are limited to a combined per Insured per Calendar Year visit maximum as shown in the Summary of Benefits. Note: This does not apply to Outpatient Partial Hospitalization Services.

The initial Mental Health Services or substance abuse care visit to determine the condition and diagnosis of the Insured will be paid as if the condition was a Severe Mental Illness or a Serious Emotional Disturbance of a Child.

If the outcome of the initial visit determines that the condition is other than a Severe Mental Illness or a Serious Emotional Disturbance of a Child, the visit will count towards the Calendar Year maximum.

No benefits are provided for Outpatient or office care from MHSA Non-Participating Providers for Mental Health Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for treatment of substance abuse, except for the initial visit. Note: This does not apply to Outpatient Partial Hospitalization Services.

3. Outpatient Hospital Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

Benefits are provided for Hospital and professional Services in connection with Partial Hospitalization, Intensive Outpatient Care and ECT for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child).

4. Psychological testing

Psychological testing is a covered Benefit when provided to diagnose a mental illness.

No benefits are provided for:

1. telephone psychiatric consultations;
2. testing for intelligence or learning disabilities.

5. Psychosocial Support through LifeReferrals 24/7

Notwithstanding the Benefits provided elsewhere in this section, the Insured also may call 1-800-985-2405 on an unlimited, 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals and counseling.

In California, support may include, as appropriate, a referral to a counselor for a maximum of three no charge, face-to-face visits within a six-month period. These visits will not accrue to the Benefit maximums that are applicable to Mental Health and Substance Abuse Benefits.

In the event that the Services required of an Insured are most appropriately provided by a psychiatrist or the condition is not likely to be resolved in a brief treatment regimen, the Insured will be referred to the MHSA intake line to access their Mental Health and substance abuse Services which are described elsewhere in this section.

ORTHOTICS BENEFITS

Benefits are provided for orthotic appliances, including:

1. shoes only when permanently attached to such appliances;
2. special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
3. Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
4. Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
5. initial fitting and replacement after the expected life of the orthosis is covered.

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. No benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet. No benefits are provided for backup or alternate items.

Note: See the Diabetes Care Benefits section for devices, equipment, and supplies for the management and treatment of diabetes.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Part D premiums.

Outpatient Prescription Drug Benefit

Benefits are provided for Medically Necessary Outpatient prescription Drugs, which meet all the requirements specified in this section, are prescribed by a Physician, and are obtained from a licensed pharmacy. Benefits are limited to Medically Necessary Drugs which are approved by the Food and Drug Administration (FDA), and which require a prescription under Federal or California law. Drug coverage is based on the use of Blue Shield's Outpatient Prescription Drug Formulary, which is updated on an ongoing basis by Blue Shield's Pharmacy and Therapeutics Committee. Non-Formulary Drugs may be covered subject to higher Copayments. Select Drugs and Drug dosages and most Home Self-Administered Injectables require prior authorization by Blue Shield for Medical Necessity, appropriateness of therapy or when effective, lower cost alternatives are available. Your Physician may request prior authorization from Blue Shield. Coverage for selected Drugs may be limited to a specific quantity as described in the section entitled "Limitations on Quantity of Drugs that May Be Obtained Per Prescription or Refill".

Outpatient prescription Drugs are subject to the Calendar Year Deductible.

Outpatient Drug Formulary

Medications are selected for inclusion in Blue Shield's Outpatient Drug Formulary based on safety, efficacy, FDA bioequivalency data and then cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by Blue Shield's Pharmacy and Therapeutics Committee during scheduled meetings four times a year.

Insureds may call the Blue Shield Customer Service department at the number listed on their Blue Shield Life Identification Card to inquire if a specific drug is included in the Formulary. The Customer Service department can also provide Insureds with a printed copy of the Formulary. Insureds may also access the Formulary through the web site at http://www.blueshieldca.com.

Benefits may be provided for Non-Formulary Drugs subject to higher Copayments.

This benefit includes access to Blue Shield Life's Participating Pharmacy Network. By presenting your Blue Shield Life ID card to a Participating Pharmacy you will pay Blue Shield Life's contracted rate for covered medication. This will significantly reduce your out of pocket costs for covered medications. Please see the section "Obtaining Outpatient Prescription Drugs at a Participating Pharmacy" for more details.

Definitions

Brand Name Drugs — FDA approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Drugs — (1) Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by Federal or California law, (2) Insulin, and disposable hypodermic Insulin needles and syringes (3) pen delivery systems for the administration of Insulin as Medically Necessary, (4) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (5) oral contraceptives and diaphragms, and (6) smoking cessation Drugs which require a prescription – coverage limited to one 24-week course of treatment per lifetime, (7) inhalers and inhaler spacers for the management and treatment of asthma.

Note: No prescription is necessary to purchase the items shown in (2), (3) and (4) above; however, in order to be covered these items must be ordered by your Physician.

Formulary — A comprehensive list of Drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee for use under the Blue Shield Prescription Drug Program which is designed to assist Physicians in prescribing Drugs that are Medically Necessary and cost effective. The Formulary is updated periodically. If not otherwise excluded, the Formulary includes all Generic Drugs.

Generic Drugs — Drugs that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Drug, (2) contain the same active ingredient as the Brand Name Drug, and (3) cost less than the Brand Name Drug equivalent.

Home Self-Administered Injectables — Home Self-Administered Injectable medications are defined as those Drugs which are Medically Necessary, administered more often than once a month by patient or family member, administered subcutaneously or intramuscularly, deemed safe for self-administration as determined by Blue Shield's Pharmacy and Therapeutics Committee and prior authorized by Blue Shield. Intravenous (IV) medications (i.e. those medications administered directly into a vein) are not considered Home Self-Administered Injectable Drugs. Home Self-Administered Injectables are listed in Blue Shield's Outpatient Drug Formulary.

Note: Home Self-Administered Injectable medications should be obtained from a Blue Shield Specialty Pharmacy, as described below.

Non-Formulary Drugs — Drugs determined by the Blue Shield's Pharmacy and Therapeutics Committee as being duplicative or as having preferred Formulary Drug alternatives available. Benefits are provided for Non-Formulary Drugs and are always subject to the Non-Formulary Copayment.

Non-Participating Pharmacy — a pharmacy which does not participate in the Blue Shield Life Pharmacy Network.

Participating Pharmacy — a pharmacy which participates in the Blue Shield Life Pharmacy Network. These Participating Pharmacies have agreed to a contracted rate for covered prescriptions for Blue Shield Subscribers and Dependents.

To select a Participating Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Customer Service number on your Blue Shield Life Identification Card.

Specialty Pharmacy Network – select Participating Pharmacies contracted by Blue Shield to provide covered Home Self-Administered Injectables. These pharmacies offer 24-hour clinical services and provide prompt home delivery of Home Self-Administered Injectables.

To select a Specialty Pharmacy, you may go to http://www.blueshieldca.com or call the toll-free Customer Service number on your Blue Shield Life Identification Card.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain prescription Drugs at a Participating Pharmacy, the Insured must present his Blue Shield Life Identification Card. Note: Except for covered emergencies and Drugs for emergency contraception, claims for drugs obtained without using the Blue Shield Life Identification Card will be denied.

With the presentation of the Blue Shield Life Identification Card, outpatient prescription Drugs obtained at a Participating Pharmacy, or Home Self-Administered Injectables obtained from a Specialty Pharmacy through the use of your Blue Shield Life Identification Number, are paid as shown in the Summary of Benefits.

Once the Calendar Year Deductible has been satisfied, the Insured is responsible for paying the applicable Copayment for each new and refill prescription Drug. The pharmacist will collect from the Insured the applicable Copayment at the time the Drugs are obtained.

Note: If the Participating Pharmacy contracted rate charged by the Participating Pharmacy is less than or equal to the Insured's Copayment, the Insured will only be required to pay the Participating Pharmacy contracted rate.

If the Insured requests a Brand Name Drug when a Generic Drug equivalent is available, the Insured is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Insured must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

If the prescription specifies a Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Generic Drug equivalent is not available, the Insured is responsible for paying the applicable Brand Name Drug Copayment.

Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy

1. To obtain prescription Drugs at a Non-Participating Pharmacy, the Insured must first pay all charges for the prescription and submit a completed prescription drug claim form for reimbursement. After the Calendar Year Deductible amount has been satisfied, the Insured will be reimbursed as shown in the Summary of Benefits. Claims must be received within 1 year from the date of service to be considered for payment.

2. Drugs obtained at a Non-Participating Pharmacy for a covered emergency, including Drugs for emergency contraception.

   When prescription Drugs are obtained at a Non-Participating Pharmacy due to a covered emergency, the Insured must first pay all charges for the prescription, and then submit a completed Prescription Drug Claim Form noting "emergency request" on the form to Blue Shield Pharmacy Services - Emergency Claims, P.O. Box 7168, San Francisco, CA 94120. After the Calendar Year Deductible amount has been satisfied, the Insured will be reimbursed the purchase price of covered prescription Drug(s) minus any applicable Copayment(s). Claim forms may be obtained from the Blue Shield Service Center. Claims must be received within 1 year from the date of service to be considered for payment.

Covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to:

1. The Deductible for Preferred Providers, and
2. The out-of-pocket responsibility for Preferred Providers.

Obtaining Outpatient Prescription Drugs through the Mail Service Prescription Drug Program

For the Insured's convenience, when Drugs have been prescribed for a chronic condition and the Insured's medication dosage has been stabilized, he may obtain the Drug through the mail service prescription drug program. Prior to using

this mail service program, the Insured must have received the same medication and dosage through the Blue Shield Life pharmacy network for at least two months.

To obtain prescription Drugs through the mail service program, the Insured should submit the applicable mail service Copayment*, order form, and his Blue Shield Life Insured number to the address indicated on the mail service envelope. Insureds should allow up to 14 days to receive the Drugs. The Insured's Physician must indicate a prescription quantity which is equal to the amount to be dispensed.

Home Self-Administered Injectables, except for Insulin, are not available through the mail service prescription drug program.

*Until the Calendar Year Deductible is satisfied, the Insured is responsible for payment of 100% of the contracted rate for the Drug to the mail service Pharmacy prior to your prescription drugs being sent.

Outpatient prescription Drugs obtained through the mail service prescription drug program are paid as shown in the Summary of Benefits.

Once the Calendar Year Deductible has been satisfied, the Insured is responsible for the applicable mail service prescription drug Copayment for each new or refill prescription Drug.

Note: If the Participating Pharmacy contracted rate is less than or equal to the Insured's Copayment, the Insured will only be required to pay the Participating Pharmacy contracted rate.

If the Insured requests a Mail Service Brand Name Drug when a Mail Service Generic Drug equivalent is available, the Insured is responsible for paying the difference between the contracted rate for the Mail Service Brand Name Drug and its Mail Service Generic Drug equivalent, as well as the applicable Mail Service Generic Drug Copayment. This difference in cost that the Insured must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

If the prescription specifies a Mail Service Brand Name Drug and the prescribing Physician has written "Dispense As Written" or "Do Not Substitute" on the prescription, or if a Mail Service Generic Drug equivalent is not available, the Insured is responsible for paying the applicable Mail Service Brand Name Drug Copayment.

You are responsible for payment of the Deductible and/or Copayment amount for the Drug to the mail service pharmacy prior to your prescription being sent to you. To obtain the Participating Pharmacy contracted rate amount, please contact the mail service pharmacy at 1-866-346-7200. The TTY telephone number is 1-866-346-7197.

Prior Authorization Process for Select Formulary and Non-Formulary Drugs and Most Home Self-Administered Injectables

Select Formulary Drugs, as well as most Home Self-Administered Injectables may require prior authorization for Medical Necessity. Select Non-Formulary Drugs may require prior authorization for Medical Necessity, and to determine if lower cost alternatives are available and just as effective. Your Physician may request prior authorization by submitting supporting information to Blue Shield. Once all required supporting information is received, prior authorization approval or denial, based upon Medical Necessity, is provided within 5 business days or within 72 hours for an expedited review.

Submitting a Claim

The submission of a prescription drug claim is required for reimbursement if you utilized a Non-Participating Pharmacy.

Each claim submission should contain your name, home address, Insured number, the patient's name and a copy of your pharmacy label receipt(s) for the prescription Drug(s) being claimed. Prescription drug claim forms are provided upon request from Blue Shield Life at the address and telephone number as listed at the back of this Certificate. These forms are also available online at www.blueshieldca.com. Prescription drug claim forms should be submitted to:

Argus Health Systems, Inc.
Department 191
PO Box 419019
Kansas City, MO 64141-6019

Claims must be received within 1 year from the date of service to be considered for payment.

Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill

1. Outpatient prescription Drugs are limited to a quantity not to exceed a 30-day supply. Some prescriptions are limited to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee.
2. Mail service prescription Drugs are limited to a quantity not to exceed a 90-day supply. If the Insured's Physician indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.

3. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

Exclusions

No benefits are provided under the Outpatient Prescription Drugs Benefit for or on account of the following (please note, certain services excluded below may be covered under other benefits/portions of this Certificate – you should refer to the applicable section to determine if drugs are covered under that Benefit):

1. Any drugs provided or administered while the Insured is an Inpatient, or in a Physician's office (see the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections);
2. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility (see the Hospital Benefits (Facility Services) and Skilled Nursing Facilities Benefits sections);
3. Drugs (except as specifically listed as covered under this Outpatient Prescription Drugs Benefit) which can be obtained without a prescription or for which there is a non-prescription drug that is the identical chemical equivalent (i.e., same active ingredient and dosage) to a prescription drug;
4. Drugs for which the Insured is not legally obligated to pay, or for which no charge is made;
5. Drugs that are considered Experimental or Investigational in nature;
6. Medical devices or supplies, except as specifically listed as covered herein (see the Durable Medical Equipment Benefits, Orthotics Benefits, and Prosthetic Appliances Benefits sections);
7. Blood or blood products (see the Hospital Benefits (Facility Services) section);
8. Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
9. Dietary or nutritional products (see the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefits sections);
10. Injectable drugs which are not self-administered, and all injectable drugs for the treatment of infertility. Other injectable medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Family Planning Benefits, and Preventive Health Benefits sections;
11. Appetite suppressants or drugs for body weight reduction except when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield Life;
12. Drugs when prescribed for smoking cessation purposes (over the counter or by prescription), except to the extent that smoking cessation prescription drugs are specifically listed as covered under the "Drugs" definition in this Benefit;
13. Contraceptive devices (except diaphragms), injections or implants, except as specifically listed;
14. Compounded medications if: (1) there is a medically appropriate Formulary alternative, or, (2) there are no FDA-approved indications. Compounded medications that do not include at least one Drug, as defined, are not covered;
15. Replacement of lost, stolen or destroyed prescription Drugs;
16. Pharmaceuticals that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions if they are provided to an Insured enrolled in a Hospice Program through a Participating Hospice Agency;
17. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to antibiotics prescribed to treat infection nor to medications prescribed to treat pain;
18. Drugs obtained from a Pharmacy not licensed by the National Association of Boards of

Pharmacies, unless Medically Necessary for a covered Emergency;

19. Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;

20. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

OUTPATIENT X-RAY, PATHOLOGY AND LABORATORY BENEFITS

Benefits are provided for diagnostic X-ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Routine laboratory Services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Benefits are provided for genetic testing for certain conditions when the member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Blue Shield Life medical policy. (Note: See the section on Pregnancy and Maternity Care Benefits for genetic testing for prenatal diagnosis of genetic disorders of the fetus).

See the Radiological Procedures Benefits (Requiring Prior Authorization) and Benefits Management Program sections for radiological procedures which require prior authorization by the Plan.

PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS BENEFITS

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. All Benefits must be prior authorized by the Plan and must be prescribed and/or ordered by the appropriate health care professional.

PODIATRIC BENEFITS

Benefits are provided for office visits, surgical procedures, and other covered Services customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures provided in conjunction with this Benefit are described under the Professional (Physician) Benefits section. Covered lab and X-ray Services provided in conjunction with this Benefit are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

PREGNANCY AND MATERNITY CARE BENEFITS

Benefits are provided for pregnancy and complications of pregnancy, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, and post-delivery care. (Note: See the Section on Outpatient X-ray, Pathology and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Insured qualifies for an extension of Benefits as described elsewhere in this Certificate.

For Outpatient routine newborn circumcisions, for the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by Blue Shield Life.

Note: The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

PREVENTIVE HEALTH BENEFITS

Preventive Health Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

Note: No benefits are provided for Preventive Health Services from Non-Preferred Providers.

Benefits are provided for the following Preventive Health Services without illness or injury being present:

1. Annual Health Appraisal Exam

For Insureds and Dependents age 3 and over, Benefits are provided for one Annual Health Appraisal Exam in a Calendar Year.

Annual Health Appraisal Exams consist of the Office Visit and the Services listed below.

a. annual routine physical examination including:

   1) pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) except for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel;

   2) vision/hearing screenings to determine the need for eye refractions or audiograms*

      *when provided to a Dependent child through 18 years of age.

b. routine laboratory Services based on Blue Shield Life's Preventive Health Guidelines. These guidelines are derived from the most recent version with all updates of the *Guide to Preventive Services* of the U.S. Preventive Services Task Force as convened by the U.S. Public Health Service. Except for routine Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests which are covered as indicated in item c. below, routine laboratory Services include but are not limited to:

   1) tuberculin test;

   2) screening for blood lead levels in children at risk for lead poisoning, as determined and prescribed by a Doctor of Medicine;

   3) venereal disease tests as recommended in Blue Shield Life's Preventive Health Guidelines;

   4) fecal occult blood test (FOBT) for Insureds age 50 and older.

c. One annual mammography and Papanicolaou test (Pap test) or other FDA (Food and Drug Administration) approved cervical cancer and human papillomavirus virus (HPV) screening tests.

2. Well Baby Care Benefits

Benefits are provided for Services of a Physician for a Dependent child less than 3 years of age. Well Baby Care Benefits consist of the Services listed below.

a. office visits including:

   1) vision/hearing screening,

   2) immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U. S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC).

b. routine laboratory Services in connection with the Well Baby Care Services including:

   1) tuberculin test,

   2) screening for blood lead levels in children at risk for lead poisoning, as determined and prescribed by a Doctor of Medicine.

3. Colorectal Cancer Screening

For Insureds age 50 and older, Benefits are provided based on Blue Shield's Preventive Health Guidelines. These guidelines regarding examinations and tests are derived from the most recent version with all updates of the *Guide to Preventive Services* of the U.S. Preventive Services Task Force as convened by the U.S. Public Health Service and those of the American Cancer Society, including frequency and patient age recommendations.

4. Osteoporosis Screening

Benefits are provided for osteoporosis screening for Insureds age 65 and older or 60 and older if at increased risk.

(Note: See the Outpatient X-ray, Pathology and Laboratory Benefits section for information on coverage of genetic testing and diagnostic procedures.)

PROFESSIONAL (PHYSICIAN) BENEFITS

(Other than Dialysis Center Benefits, Hospice Program Benefits, Preventive Health Benefits, Mental Health and Substance Abuse Benefits, and Bariatric Surgery Benefits for Residents of Designated Counties in California which are described elsewhere under Covered Services)

Professional Services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician Office Visits. A list of urgent care providers may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com.

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;

3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
4. Asthma self-management training and education to enable an Insured to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;
5. Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room;
6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;
7. Surgical procedures. When multiple surgical procedures are performed during the same operation, Benefits for the secondary procedure(s) will be determined based on the Plan's Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;
8. Reconstructive Surgery and associated covered Services when determined by the Plan to be Medically Necessary and only to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery on either breast and surgically and non-surgically implanted prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas, are covered. Any such Services must be received while the Policy is in force with respect to the Insured. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

   No benefits will be provided for the following surgeries or procedures unless determined by the Plan to be Medically Necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and which will result in more than minimal improvement in function or appearance:

   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
   - Surgery to reform or reshape skin or bone;
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
   - Hair transplantation; and
   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

   This limitation shall not apply when breast reconstruction is performed subsequent to a Medically Necessary mastectomy, including surgery on either breast to achieve or restore symmetry.
9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10. Extra time spent when a Physician is detained to treat an Insured in critical condition;
11. Necessary preoperative treatment;
12. Treatment of burns.

PROSTHETIC APPLIANCES BENEFITS

Medically Necessary Prostheses for Activities of Daily Living are covered. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

Benefits are provided for Medically Necessary Prostheses for Activities of Daily Living, including the following:

1. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

No benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided). No benefits are provided for backup or alternate items.

Benefits are provided for contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia following cataract surgery when no intraocular lens has been implanted. Note: These contact lenses will not be covered under your Plan if your Employer provides supplemental Benefits for vision care that cover contact lenses through a vision plan purchased through Blue Shield. There is no coordination of benefits between the health Plan and the vision plan for these Benefits.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Surgically implanted prostheses including, but not limited to,

Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

RADIOLOGICAL PROCEDURES BENEFITS (REQUIRING PRIOR AUTHORIZATION)

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by the Plan under the Benefits Management Program. Failure to obtain this authorization will result in the Service being paid at a reduced amount or may result in non-payment for procedures which are determined not to be covered Services.

See the Benefits Management Program section for complete information.

1. CT (Computerized Tomography) scans;
2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and,
5. any cardiac diagnostic procedure utilizing Nuclear Medicine.

REHABILITATION (PHYSICAL, OCCUPATIONAL AND RESPIRATORY THERAPY) BENEFITS

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan for as long as continued treatment is Medically Necessary and when rendered in the provider's office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. The Plan reserves the right to periodically review the provider's treatment plan and records. If the Plan determines that continued treatment is not Medically Necessary and not provided with the expectation that the patient has restorative potential pursuant to the treatment plan, the Plan will notify the Insured of this determination and benefits will not be provided for services rendered after the date of the written notification.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation Services rendered in the home.

Note: Covered lab and X-ray Services provided in conjunction with this Benefit, are paid as shown under the Outpatient X-Ray, Pathology and Laboratory Benefits section.

SKILLED NURSING FACILITY BENEFITS

(Other than Hospice Program Benefits, which are described elsewhere under Covered Services)

Benefits are provided for Medically Necessary Services provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility or Skilled Nursing Facility Unit of a Hospital, up to the Benefit maximum as shown in the Summary of Benefits. The Benefit maximum is per Insured per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

SPEECH THERAPY BENEFITS

Initial Outpatient Benefits for Speech Therapy Services are covered when diagnosed and ordered by a Physician and provided by an appropriately licensed speech therapist, pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, or (2) evaluate the effectiveness of treatment, and when rendered in the provider's office or Outpatient department of a Hospital. Before initial services are provided, you or your provider should determine if the proposed treatment will be covered by following Blue Shield Life's prior authorization procedures. (See the section on the Benefits Management Program.)

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs.

Continued Outpatient Benefits will be provided for Medically Necessary Services as long as continued treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records will be reviewed periodically. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the Insured will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under the Home Health Care Benefits and Hospice Program Benefits sections, no Outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See the Home Health Care Benefits section for information on coverage for Speech Therapy Services rendered in the home.

See the Inpatient Services for Treatment of Illness or Injury section for information on Inpatient Benefits and the Hospice Program Benefits section.

TRANSPLANT BENEFITS – CORNEA, KIDNEY OR SKIN

Benefits are provided for Hospital and professional Services provided in connection with human organ transplants only to the extent that:

1. they are provided in connection with the transplant of a cornea, kidney, or skin; and
2. the recipient of such transplant is a Subscriber or Dependent.

Benefits are provided for Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank and will be charged against the maximum aggregate payment amount.

Transplant Benefits – Special

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting as a Blue Shield Life Provider to provide the procedure or in the case of Insureds accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield Life, (2) prior authorization is obtained, in writing, from the Plan's Medical Director and (3) the recipient of the transplant is a Subscriber or Dependent.

The Plan reserves the right to review all requests for prior authorization for these Special Transplant Benefits, and to make a decision regarding benefits based on (1) the medical circumstances of each Insured, and (2) consistency between the treatment proposed and the Plan's medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this provision:

1. Human heart transplants;
2. Human lung transplants;
3. Human heart and lung transplants in combination;
4. Human liver transplants;
5. Human kidney and pancreas transplants in combination;
6. Human bone marrow transplants; including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
7. Pediatric human small bowel transplants;
8. Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank. Benefits will be charged against the maximum aggregate payment amount.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions

Unless exceptions to the following are specifically made elsewhere in this Certificate, no benefits are provided for services:

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation (Physical, Occupational, and Respiratory Therapy) Benefits and Hospice Program Benefits sections;
3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns, and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the Insured's home;
6. for substance abuse treatment or rehabilitation on an Inpatient, Partial Hospitalization or Outpatient basis, except as specifically listed under Mental Health and Substance Abuse Benefits;
7. for Outpatient Mental Health Services, except as specifically listed under Mental Health and Substance Abuse Benefits;
8. for hearing aids, except as specifically provided under Prosthetic Appliances Benefits;
9. for mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Preferred Providers;

10. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
11. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistance devices, except as specifically listed under Prosthetic Appliances Benefits;
12. for routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;
13. for or incident to acupuncture;
14. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;
15. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); however, drugs and medicines which 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 the California Insurance Code, Section 10123.195 have been met;
16. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits;
17. for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;
18. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
19. for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;
20. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement, (e.g., non-custom made or over-the-counter shoe inserts or arch supports) except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
21. which are Experimental or Investigational in nature, except for Services for Insureds who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;
22. for learning disabilities or behavioral problems or social skills training/therapy;
23. for hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
24. for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

25. for or incident to services and supplies for treatment of the teeth and gums (except for tumors) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
26. incident to organ transplant, except as explicitly listed under Transplant Benefits;
27. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by a Plan consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
    - Lower eyelid blepharoplasty;
    - Spider veins;
    - Services or procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
    - Hair removal by electrolysis or other means; and
    - Reimplantation of breast implants originally provided for cosmetic augmentation;
28. for Reconstructive Surgery and procedures in situations: 1) where there is another more appropriate surgical procedure that is approved by a Plan Physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins, or 3) as limited in the Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services) and Professional (Physician) Benefits sections;
29. for penile implant devices and surgery, and any related services, except for any resulting complications and Medically Necessary Services;
30. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
31. for which the Insured is not legally obligated to pay, or for services for which no charge is made;
32. incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of such injury or disease;
33. in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
34. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits and PKU Related Formulas and Special Food Products Benefits, and except as provided through a Participating Hospice Agency;
35. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
36. for contraceptives, except as specifically included in Family Planning Benefits and under the Outpatient Prescription Drugs Benefit; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drugs Benefit; no benefits are provided for contraceptive implants;
37. for genetic testing except as described in the section on Outpatient X-ray, Pathology and Laboratory Benefits;

38. for non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
39. incident to bariatric surgery Services, except as specifically provided under Bariatric Surgery Benefits for Residents of Designated Counties in California;
40. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy Benefits under a Blue Shield health plan;
41. for services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;
42. not specifically listed as a Benefit.

MEDICAL NECESSITY EXCLUSION

The Benefits of this Plan are intended only for Services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. The Plan reserves the right to review all claims to determine if a service or supply is Medically Necessary. The Plan may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. The Plan may limit or exclude benefits for services which are not necessary.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

1. Your Blue Shield Life group plan will provide benefits before Medicare in the following situations:
   a. When you are eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
   b. When you are eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
   c. When you are eligible for Medicare solely due to end stage renal disease during the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
2. Your Blue Shield Life group plan will provide benefits after Medicare in the following situations:
   a. When you are eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
   b. When you are eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
   c. When you are eligible for Medicare solely due to end stage renal disease after the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
   d. When you are retired and age 65 years or older.

When your Blue Shield Life group plan provides benefits after Medicare, the combined benefits from Medicare and your Blue Shield Life group plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive benefits from Medicare (based on the lower of Blue Shield Life's Allowable Amount or the Medicare allowed amount). Your Blue Shield Life group plan Deductible and Copayments will be waived.

When you are eligible for Medi-Cal

Medi-Cal always provides benefits last.

When you are a qualified veteran

If you are a qualified veteran your Blue Shield Life group plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Veteran's Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Blue Shield Life group plan will pay the reasonable value or Blue Shield Life's Allowable Amount for covered services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and your Blue Shield Life group plan will equal, but not exceed, what Blue Shield Life would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield Life's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how Blue Shield Life coordinates your group plan benefits in the above situations.

EXCEPTION FOR OTHER COVERAGE

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Plan.

CLAIMS REVIEW

The Plan reserves the right to review all claims to determine if any exclusions or other limitations apply. The Plan may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants to evaluate claims.

REDUCTIONS — THIRD-PARTY LIABILITY

If an Insured is injured through the act or omission of another person (a "third party"), the Plan shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution or other available remedy to recover the reasonable costs of the Services provided to the Insured paid by the Plan on a fee-for-service basis.

The Insured is required to:

1. Notify the Plan in writing of any actual or potential claim or legal action which such Insured anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate with the Plan to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and
3. Provide the Plan with a lien, in the amount of reasonable costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

An Insured's failure to comply with 1. through 3. above shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan.

Further, if the Insured receives services from a Participating Hospital for such injuries, the Hospital has the right to collect from the Insured the dif-

ference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Insured for medical expenses. The Plan Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

TERMINATION OF BENEFITS

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this Plan.

Coverage for you or your Dependents terminates at 12:01 a.m. Pacific Time on the earliest of these dates: (1) the date the Group Policy is discontinued, (2) the last day of the month in which the Insured's employment terminates, unless a different date has been agreed to between the Plan and your Employer, (3) fifteen (15) days following the date of mailing of the notice to the Employer that Premiums are not paid (see "Cancellation for Non-Payment of Premiums – Notices"), or (4) on the last day of the month in which you or your Dependents become ineligible. A spouse also becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see the Individual Conversion Plan provision, and, if applicable, the Continuation of Group Coverage provision in this Certificate for information on continuation of coverage.

If your employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of Premiums will keep your coverage in force for such period of time as specified in such Act(s). Your employer is solely responsible for notifying you of the availability and duration of family leaves.

Blue Shield Life may terminate your and your Dependent's coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or Blue Shield Life; see the Cancellation/Rescission for Fraud, Misrepresentations or Omissions provision;
2. Permitting use of your Insured identification card by someone other than yourself or your Dependents to obtain Services;
3. Obtaining or attempting to obtain Services under the Group Policy by means of false, materially misleading, or fraudulent information, acts or omissions;
4. Abusive or disruptive behavior which: (1) threatens the life or well-being of Plan personnel and providers of Services, or, (2) substantially impairs the ability of the Plan to arrange for services to the Insured, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Insured or to other patients.

If a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield Life within the 31 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 32nd day at 12:01 a.m. Pacific Time.

REINSTATEMENT, CANCELLATION AND RESCISSION PROVISIONS

Reinstatement

If you had been making contributions toward coverage for you and your Dependents and voluntarily cancelled such coverage, you may apply for reinstatement. You or your Dependents must wait until the earlier of 12 months from the date of application to be reinstated or at the Employer's next open enrollment period. Blue Shield Life will not consider applications for earlier effective dates.

Cancellation Without Cause

This group Plan may be cancelled by your Employer at any time provided written notice is given to Blue Shield Life to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Non-Payment of Premiums - Notices

Blue Shield Life may cancel this group Plan for non-payment of Premiums. If your Employer fails to pay the required Premiums when due, Blue Shield Life will mail your Employer a Prospective Notice of Cancellation at least 15 days before any cancellation of coverage. This notice will provide information to your Employer regarding the consequences of your Employer's failure to pay the Premiums due within 15 days of the date the notice was mailed.

If payment is not received from your Employer within 15 days of the date the Prospective Notice of Cancellation is mailed, Blue Shield Life will cancel the Group Policy at the end of that 15 day period and coverage for you and all your Dependents will end on that date. Blue Shield Life will send your Employer a Notice Confirming Termination of

Coverage. Your Employer must provide you with a copy of the Notice Confirming Termination of Coverage.

In addition, Blue Shield Life will send you a HIPAA certificate which will state the date on which your coverage terminated, the reason for the termination, and the number of months of creditable coverage which you have. The certificate will also summarize your rights for continuing coverage on a guaranteed issue basis under HIPAA and on Blue Shield Life's conversion plan. For more information on conversion coverage and your rights to HIPAA coverage, please see the section on "Availability of Blue Shield Life Individual Plans."

Cancellation/Rescission for Fraud, Misrepresentations or Omissions

Blue Shield Life may cancel the Group Policy for fraud or misrepresentation by your Employer, or with respect to coverage of Employees or Dependents, for fraud or misrepresentation of the Employee, Dependent, or their representative.

If you are hospitalized or undergoing treatment for an ongoing condition and the Group Policy is cancelled for any reason, including non-payment of Premiums, no benefits will be provided unless you obtain an Extension of Benefits.

Misrepresentations or omissions on an application or a health statement (if a health statement is required by the Employer) may result in the cancellation or rescission of this group Plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

In the event the Policy is rescinded or cancelled, either by Blue Shield Life or your Employer, it is your Employer's responsibility to notify you of the rescission or cancellation.

Right of Cancellation

If you are making any contributions toward coverage for yourself or your Dependents, you may cancel such coverage to be effective at the end of any period for which Premiums have been paid.

If your Employer does not meet the applicable eligibility, participation and contribution requirements of the Group Policy, Blue Shield Life will cancel this Plan after 30 days' written notice to your Employer.

Any Premiums paid Blue Shield Life for a period extending beyond the cancellation date will be refunded to your Employer. Your Employer will be responsible to Blue Shield Life for unpaid Premiums prior to the date of cancellation.

Blue Shield Life will honor all claims for covered Services provided prior to the effective date of cancellation.

See the Cancellation and Rescission provision for termination for misrepresentations or omissions.

Extension of Benefits

If an Insured becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Group Policy terminates, Blue Shield Life will extend the Benefits of this Plan, subject to all limitations and restrictions, for covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) 12:01 a.m. on the day following a period of twelve months from the date coverage terminated; (2) the date the Insured is no longer Totally Disabled; (3) the date on which the Insured's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Insured that is not subject to a pre-existing condition exclusion. The time the Insured was covered under this Plan will apply toward the replacement plan's pre-existing condition exclusion.

No extension will be granted unless the Plan receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Plan.

Coordination of Benefits

When an Insured who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for Hospital or medical expenses, such Insured will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are Incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the Insured is also entitled to benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the Insured as an Employee will

provide its benefits before the plan covering the Insured as a Dependent.

The plan which covers the Insured as a Dependent of an Insured whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, will determine its benefits before a plan which covers that Insured as a Dependent of an Insured whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the plan which does not have the provisions of this paragraph will determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order:

   First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the step-parent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent child.

3. If the above rules do not apply, the plan which has covered the Insured for the longer period of time will determine its benefits first, provided that:

   a. a plan covering an Insured as a laid-off or retired Employee, or as a Dependent of that Insured will determine its benefits after any other plan covering that Insured as an Employee, other than a laid-off or retired Employee, or such Dependent; and

   b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

If this Plan is the primary carrier in the case of an Insured, then this Plan will provide its Benefits without making any reduction because of benefits available from any other plan, except that Physician Members and other Participating Providers may collect any difference between their billed charges and this Plan's payment, from the secondary carrier(s).

If this Plan is the secondary carrier in the order of payments, and Blue Shield Life is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will pay the benefits that would be due as if it were the primary plan, provided that the Insured (1) assigns to Blue Shield Life the right to receive benefits from the other plan to the extent of the difference between the benefits which Blue Shield Life actually pays and the amount that Blue Shield Life would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with Blue Shield Life in obtaining payment of benefits from the other plan, and (3) allows Blue Shield Life to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, Blue Shield Life may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan. Blue Shield Life shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Blue Shield Life in excess of the maximum amount of payment necessary to satisfy these provisions, Blue Shield Life shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

Blue Shield Life may release to or obtain from any organization or person any information which Blue Shield Life considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish Blue Shield Life with such information as may be necessary to implement these provisions.

GROUP CONTINUATION COVERAGE AND INDIVIDUAL CONVERSION PLAN

CONTINUATION OF GROUP COVERAGE

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Applicable to Insureds when the Insured's Employer (Policyholder) is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Insured's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), an Insured will be entitled to elect to continue group coverage under this Plan if the Insured would otherwise lose coverage because of a Qualifying Event that occurs while the policyholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Insured if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Insured will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Insured is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, an Insured is entitled to benefits if at the time of the qualifying event such Insured is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the Subscriber:
    a. the termination of employment (other than by reason of gross misconduct); or
    b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the policyholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

    *Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

    a. the death of the Subscriber; or
    b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
    c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
    d. the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or
    e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
    f. a Dependent child's loss of Dependent status under this Plan.
3. For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1. With respect to COBRA enrollees

The Insured is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, the Subscriber's Medicare entitlement or the Employer's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Insured by first class mail of the Insured's right to continue group coverage under this Plan. The Insured must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Insured's right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event.

If the Insured does not notify the COBRA administrator within 60 days, the Insured's coverage will terminate on the date the Insured would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees

The Insured is responsible for notifying the Plan in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Insured from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying the Plan in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When the Plan is notified that a Qualifying Event has occurred, the Plan will, within 14 days, provide written notice to the Insured by first class mail of the Insured's right to continue group coverage under this Plan. The Insured must then give the Plan notice in writing of the Insured's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Insured's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to the Plan by first-class mail or other reliable means.

If the Insured does not notify the Plan within 60 days, the Insured's coverage will terminate on the date the Insured would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the Employer, and the Insured had elected Cal-COBRA continuation coverage under the previous plan, the Insured may choose to continue to be covered by this Plan for the balance of the period that the Insured could have continued to be covered under the previous plan, provided that the Insured notify the Plan within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Continuation of Group Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Insured's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Insured to continue group coverage under this Plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact the Plan for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify the Plan at least 30 days before COBRA termination.

Payment of Premiums

Premiums for the Insured continuing coverage shall be 102 percent of the applicable group premium rate if the Insured is a COBRA enrollee, or 110 percent of the applicable group premium rate if the Insured is a Cal-COBRA enrollee, except for the Insured who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 shall be 150 percent of the applicable group premium rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, premiums for Cal-COBRA coverage shall be 110 percent of the applicable group premium rate for months 30 through 36.

If the Insured is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all premium contributions to Blue Shield Life in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit premiums directly to Blue Shield Life. The initial premiums must be paid within 45 days of the date the Insured provided written notification to the Plan of the election to continue coverage and be sent to Blue Shield Life by first-class or other reliable means. The premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Insured from continuation coverage.

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Insured's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as premiums are timely paid.

Termination of Continuation of Group Coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this Group Policy (if the Employer continues to provide any group benefit plan for employees, the Insured may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required premiums to the COBRA administrator or the Employer or to the Plan as applicable. Coverage will end as of the end of the period for which premiums were paid;

3. the Insured becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the Insured;
4. the Insured becomes entitled to Medicare;
5. the Insured no longer resides in the Plan's service area;
6. the Insured commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

Continuation of Group Coverage for Insureds on Military Leave

Continuation of group coverage is available for Insureds on military leave if the Insured's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Insureds who are planning to enter the Armed Forces should contact their Employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, and Labor Code requirements for Medical Disability.

CONTINUATION OF GROUP COVERAGE AFTER COBRA AND/OR CAL-COBRA

The following section only applies to enrollees who became eligible for Continuation of Group Coverage After COBRA and/or Cal-COBRA prior to January 1, 2005.

Certain former Employees and their Dependent spouses or Dependent Domestic Partners (including a spouse who is divorced from the current Employee/former Employee and/or a spouse who was married to the Employee/former Employee at the time of that Employee/former Employee's death, or a Domestic Partner whose partnership with the current Employee/former Employee has terminated and/or a Domestic Partner who was in a Domestic Partner relationship with the Employee/former Employee at the time of that Employee/former Employee's death) may be eligible to continue group coverage beyond the date their COBRA and/or Cal-COBRA coverage ends. Blue Shield will offer the extended coverage to former Employees of employers that are subject to the existing COBRA or Cal-COBRA, and to the former Employees' Dependent spouses, including divorced or widowed spouses as defined above, or Dependent Domestic Partners, including surviving Domestic Partners or Domestic Partners whose partnership was terminated as defined above. This coverage is subject to the following conditions:

1. The former Employee worked for the Employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended.
2. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)
3. The former Employee was eligible for and elected COBRA and/or Cal-COBRA for himself and his Dependent Domestic Partner (a former Domestic Partner, i.e., a surviving Domestic Partner or Domestic Partner whose partnership has been terminated as defined above, is also eligible for continuation of group coverage after COBRA and/or Cal-COBRA.)

Items 1., 2. and 3. above are not applicable to a former spouse or former Domestic Partner electing continuation coverage. The former spouse or former Domestic Partner must elect such coverage by notifying the Plan in writing within 30 calendar days prior to the date that the former spouse's or former Domestic Partner's initial COBRA and/or Cal-COBRA benefits are scheduled to end.

If elected, this coverage will begin after the COBRA and/or Cal-COBRA coverage ends and will be administered under the same terms and conditions as if COBRA and/or Cal-COBRA had remained in force.

For Insureds who transfer to this coverage from COBRA, premiums for this coverage shall be 213 percent of the applicable group premium rate, or 102 percent of the applicable age adjusted group premium rate. For Insureds who transfer to this coverage from Cal-COBRA, premiums for this coverage shall be 213 percent of the applicable group premium rate, or 110 percent of the applicable age adjusted group premium rate. Payment is due at the time the Employer's payment is due.

Termination of Continuation Coverage after COBRA and/or Cal-COBRA

This coverage will end automatically on the earliest of the following dates:

1. the date the former Employee, spouse or Domestic Partner or former spouse or former Domestic Partner reaches 65;
2. the date the Employer discontinues this Policy and ceases to maintain any group health plan for any active Employees;
3. the date the former Employee, spouse or Domestic Partner, or former spouse or former Domestic Partner transfers to another health plan, whether or not the benefits of the other health plan are less valuable than those of the health plan maintained by the employer;
4. the date the former Employee, spouse or Domestic Partner, or former spouse or former Domestic Partner, becomes entitled to Medicare;
5. for a spouse or Domestic Partner, or former spouse or former Domestic Partner, five years from the date the

spouse's or Domestic Partner's, COBRA or Cal-COBRA coverage would end.

AVAILABILITY OF BLUE SHIELD LIFE INDIVIDUAL PLANS

Blue Shield Life's Individual Plans described below may be available to Insureds whose group coverage, COBRA or Cal-COBRA coverage, or Continuation of Group Coverage After COBRA and/or Cal-COBRA is terminated or expires while covered under this group Plan. (Note: Only Individual Conversion Coverage is available to Insureds who are terminated from Continuation of Group Coverage After COBRA and/or Cal-COBRA.)

INDIVIDUAL CONVERSION PLAN

Continued Protection

Regardless of age, physical condition, or employment status, you may continue Blue Shield Life protection when you retire, leave the job, or become ineligible for group coverage. If you have held group coverage for three or more consecutive months, you and your enrolled Dependents may apply to transfer to an individual conversion plan then being issued by Blue Shield Life.

Your Employer is solely responsible for notifying you of the availability, terms, and conditions of the individual conversion plan within 15 days of termination of the Plan policy.

An application and first Premium payment for the individual conversion plan must be received by Blue Shield Life within 63 days of the date of termination of your group coverage. However, if the Group Policy is replaced by your Employer with similar coverage under another policy within 15 days, transfer to the individual conversion health plan will not be permitted. You will not be permitted to transfer to the individual conversion plan under any of the following circumstances:

1. You failed to pay amounts due the Plan;
2. You were terminated by the Plan for good cause or for fraud or misrepresentation;
3. You knowingly furnished incorrect information or otherwise improperly obtained the Benefits of the Plan;
4. You are covered or eligible for Medicare;
5. You are covered or eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; and,
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in your group Plan.

A conversion plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for Dependent coverage under the group Plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse or Domestic Partner of a Subscriber if their marriage or domestic partnership has been terminated;
5. Dependents, when continuation of coverage under COBRA and/or Cal-COBRA expires, or is terminated.

When a Dependent reaches the limiting age for coverage as a Dependent, or if a Dependent becomes ineligible for any of the other reasons given above, it is your responsibility to inform Blue Shield Life. Upon receiving notification, Blue Shield Life will offer such Dependent an individual conversion plan for purposes of continuous coverage.

Guaranteed Issue Individual Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and under California law, you may be entitled to apply for certain of Blue Shield Life's individual health plans on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons if you meet the other eligibility requirements, you live or work in Blue Shield Life's service area and you agree to pay all required Premiums). You may also be eligible to purchase similar coverage on a guaranteed issue basis from any other health plan that sells individual coverage for hospital, medical or surgical benefits. Not all Blue Shield Life individual plans are available on a guaranteed issue basis under HIPAA. To be eligible, you must meet the following requirements:

- You must have at least 18 or more months of creditable coverage.
- Your most recent coverage must have been group coverage (COBRA and Cal-COBRA are considered group coverage for these purposes).
- You must have elected and exhausted all COBRA and/or Cal-COBRA coverage that is available to you.
- You must not be eligible for nor have any other health insurance coverage, including a group health plan, Medicare or Medi-Cal.
- You must make application to Blue Shield Life for guaranteed issue coverage within 63 days of the date of termination from the group plan.

If you elect Conversion Coverage, "Continuation of Group Coverage After COBRA and/or Cal-COBRA", or other Blue Shield Life individual plans, you will waive your right to this guaranteed issue coverage. For more information, contact a Blue Shield Life Customer Service representative at the telephone number noted on your ID Card.

GENERAL PROVISIONS

LIABILITY OF INSUREDS IN THE EVENT OF NON-PAYMENT BY THE PLAN

In accordance with the Plan's established policies, and by statute, every contract between the Plan and its Participating Providers and Preferred Providers stipulates that the Insured shall not be responsible to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Insured's Group Policy. Participating Providers and Preferred Providers have agreed to accept the Plan's payment as payment-in-full for covered Services, except for the Deductibles, Copayments, Coinsurance, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Insured is responsible for all amounts the Plan does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Insured is responsible for any charges above the Benefit maximums.

ASSIGNMENT

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield Life. Possession of a Blue Shield Life ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Insured must be a Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Plan.

Participating Providers and Preferred Providers are paid directly by the Plan. The Insured or the provider of Service may not request that payment be made directly to any other party.

If the Insured receives Services from a Non-Preferred Provider and the Insured's Employer is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and any subsequent amendments to ERISA, payment will be made directly to the Insured, and the Insured is responsible for payment to the Non-Preferred Provider. The Insured or the provider of Service may not request that the payment be made directly to the provider of Service.

If the Insured receives Services from a Non-Preferred Provider and the Insured's Employer is not subject to ERISA and any subsequent amendments to ERISA, the Insured may assign payment to the Non-Preferred Provider who then will receive payment directly from Blue Shield Life.

PLAN INTERPRETATION

Blue Shield Life shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive benefits under this Plan. Blue Shield Life shall exercise this authority for the benefit of all Insureds entitled to receive Benefits under this Plan.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield Life protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield Life will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD LIFE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed in the back of this Certificate, or by accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:

Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

Blue Shield Life may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed

by Blue Shield Life. You agree to assist Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

INDEPENDENT CONTRACTORS

Providers are neither agents nor employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, or other provider or their employees.

ENTIRE CONTRACT

The contract, including appendices, attachments or other documents incorporated by reference form the entire agreement between Blue Shield Life and the Policyholder. Any statement made by the Policyholder or any Insured shall, in the absence of fraud, be deemed a representation and not a warranty. Such statements will not be used to deny a claim or void coverage unless contained in a written application.

TIME LIMIT ON CERTAIN DEFENSES

After an Insured has been covered under this policy for 3 consecutive years, Blue Shield Life will not use any misstatement, except a fraudulent misstatement, made in an individual application to deny a claim or reduce coverage.

GRACE PERIOD

After payment of the first premium, the Policyholder is entitled to a grace period of 31 days for the payment of any premium due. During this grace period, the policy will remain in force. However, the Policyholder will be liable for payment of premiums accruing during the period the policy continues in force.

NOTICE AND PROOF OF CLAIM

Notice and Claim Forms

In the event the provider of Service does not bill Blue Shield Life directly, you should use a Blue Shield Life Insured's Statement of Claim form in order to receive reimbursement. To receive a claim form, written notice of a claim must be given to Blue Shield Life within 20 days of the date of Service. If this is not possible, Blue Shield Life must be notified as soon as it is reasonably possible to do so.

When Blue Shield Life receives Notice of Claim, Blue Shield Life will send you an Insured's Statement of Claim form for filing proof of a claim. If Blue Shield Life fails to furnish the necessary claim forms within 15 days, you may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

Proof of Claim

Blue Shield Life must receive written proof of claim no later than 90 days after the date of service for which claim is being made from a contracted professional provider and no later than 180 days for claims from non-contracted professional providers. If Blue Shield Life is not the primary payor under coordination of benefits, claims must be received within 90 days from the date of payment or date of contest, denial or notice from the primary payor.

Send a copy of your itemized bill to the Blue Shield Life service center listed on the last page of this Certificate.

A claim will not be reduced or denied for failure to provide proof within this time if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible. However, no claim will be paid if proof is received more than one year after the date of loss, unless the Insured was legally unable to notify Blue Shield Life.

PAYMENT OF BENEFITS

Time and Payment of Claims

Claims will be paid promptly upon receipt of proper written proof and determination that Benefits are payable.

Payment of Claims

Participating Providers and Preferred Providers are paid directly by Blue Shield Life.

If the Insured receives Services from a Non-Preferred Provider*, payment will be made directly to the Subscriber, and the Insured is responsible for payment to the Non-Preferred Provider (except that Hospital charges are generally paid directly to the Hospital).

*Note: If the Insured's Employer is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) and any subsequent amendments to ERISA, the Insured may assign payment to the Non-Preferred Provider who then will receive payment directly from Blue Shield Life.

Refer to the Outpatient Prescription Drug Benefit for information on reimbursement of prescription drug claims.

COMMENCEMENT OF LEGAL ACTION

Any suit or action to recover benefits under this Plan, or damages concerning the provision of coverage or benefits, the processing of claims, or any other matter arising out of this Plan, may not be brought prior to the expiration of 60 days after written proof of claim has been furnished and must be commenced no later than three years after the date the coverage for benefits in question were first denied.

CUSTOMER SERVICE

FOR ALL SERVICES OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE

If you have a question about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact the Plan's Customer Service Department as noted on the last page of this Certificate.

The hearing impaired may contact the Plan's Customer Service Department through the Plan's toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: Blue Shield Life has established a procedure for our Subscribers and Dependents to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. Blue Shield Life shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number provided at the back of this Certificate.

FOR ALL MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Plan's Mental Health Service Administrator (MHSA). should be contacted for questions about Mental Health and substance abuse Services, MHSA network Providers, or Mental Health and substance abuse Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-214-2928

Blue Shield of California
Life & Health Insurance Company
Mental Health Service Administrator
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

Note: The MHSA has established a procedure for our Insureds to request an expedited decision. An Insured, Physician, or representative of an Insured may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of an Insured, or when the Insured is experiencing severe pain. The MHSA shall make a decision and notify the Insured and Physician as soon as possible to accommodate the Insured's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the number listed above.

GRIEVANCE PROCESS

Blue Shield Life has established a grievance procedure for receiving, resolving and tracking Insureds' grievances with Blue Shield Life.

FOR ALL SERVICES OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE

Insureds, a designated representative, or a provider on behalf of the Insured, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Insureds may contact the Plan at the telephone number as noted on the last page of this Certificate. If the telephone inquiry to Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Insured may request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Insured may also submit the grievance online by visiting our web site at http://www.blueshieldca.com.

Blue Shield Life will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Insureds to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

FOR ALL MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Insureds, a designated representative, or a provider on behalf of the Insured, may contact the MHSA by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Insureds may contact the MHSA at the telephone number as noted below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Insured may request this Form from the MHSA's Customer Service Department. If the Insured wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Insured may also submit the grievance to the MHSA online by visiting http://www.blueshieldca.com.

1-877-214-2928

Blue Shield of California
Life & Health Insurance Company
Mental Health Service Administrator
Attn: Customer Service
P. O. Box 880609
San Diego, CA 92168

The MHSA will acknowledge receipt of a grievance within 5 calendar days. Grievances are resolved within 30 days. The grievance system allows Insureds to file grievances for at least 180 days following any incident or action that is the subject of the Insured's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

If the grievance involves an MHSA Non-Participating Provider, the Insured should contact the appropriate Blue Shield Life Customer Service Department as shown on the last page of this Certificate.

Note: If your Employer's health Plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.

EXTERNAL INDEPENDENT MEDICAL REVIEW

If your grievance involves a claim or services for which coverage was denied by Blue Shield Life or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield Life and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Insurance will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield Life; if the external reviewer determines that the service is Medically Necessary, Blue Shield Life will promptly arrange for the Service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

CALIFORNIA DEPARTMENT OF INSURANCE REVIEW

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider.

If you have a complaint against Blue Shield of California Life & Health Insurance Company, you should contact Blue Shield Life first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number from 8 a.m. – 6 p.m., Monday – Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website http://www.insurance.ca.gov.

DEFINITIONS

PLAN PROVIDER DEFINITIONS

Whenever any of the following terms are capitalized in this Certificate, they will have the meaning stated below:

Alternate Care Services Providers — Durable Medical Equipment suppliers, individual certified orthotists, prosthetists and prosthetist-orthotists.

Blue Shield Life Providers or Blue Shield Life's Network — the network of contracting providers available to Blue Shield Life as an affiliate of Blue Shield of California.

Doctor of Medicine — a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

Hospice or Hospice Agency — an entity which provides Hospice services to Terminally Ill persons and holds a license, currently in effect as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.
2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.
3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services.

Note: MHSA Non-Participating Providers may include Blue Shield Life Preferred/Participating Providers if the Provider does not also have an agreement with the MHSA.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health and substance abuse Services.

Non-Participating Home Health Care and Home Infusion Agency — an agency which has not contracted with Blue Shield Life and whose services are not covered unless prior authorized by Blue Shield Life.

Non-Participating/Non-Preferred Providers — any provider who has not contracted with Blue Shield Life to accept Blue Shield Life's payment, plus any applicable Deductible, Copayment, Coinsurance or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services.

Note: This definition does not apply to Mental Health and substance abuse Services. For Non-Participating/Non-Participating Providers for Mental Health and substance abuse Services, see the Mental Health Service Administrator (MHSA) Non-Participating Provider definition above.

Non-Preferred Bariatric Surgery Services Providers — any provider that has not contracted with Blue Shield to furnish bariatric surgery services and accept reimbursement at negotiated rates, and that has not been designated as a contracted bariatric surgery services provider by Blue Shield. Non-Preferred Bariatric Surgery Services Providers may include Blue Shield Preferred/Participating Providers if the Provider does not also have an agreement with Blue Shield to provide bariatric surgery services.

Note: Bariatric surgery services are not covered for Persons who reside in designated counties in California if the service is provided by a Non-Preferred Bariatric Surgery Services Provider. (See the Bariatric Surgery Benefits for Residents of Designated Counties in California section under Covered Services for more information.)

Other Providers —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; certificated acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.
2. Healthcare Organizations — nurses registries; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical Services on an Outpatient basis.

Participating Ambulatory Surgery Center — an Outpatient surgery facility which:

1) is either licensed by the state of California as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,
2) provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital; and,
3) has contracted as a Blue Shield Life Network Provider to provide services on an Outpatient basis.

Participating Home Health Care and Home Infusion Agency — an agency which has contracted as a Blue Shield Life Network Provider to furnish services and accept reimbursement at negotiated rates, and which has been designated as a Participating Home Health Care and Home Infusion agency by the Plan. (See Non-Participating Home Health Care and Home Infusion agency definition above.)

Participating Hospice or Participating Hospice Agency — an entity which: 1) provides Hospice services to Terminally Ill persons and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747,

or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has contracted as a Blue Shield Life Network Provider.

Participating Physician — a Physician who has contracted as a Blue Shield Life Network Provider and agreed to accept the Plan's payment, plus Insured payments of any applicable Deductibles, Copayments and Coinsurance, as payment-in-full for covered Services.

Participating Provider — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted as a Blue Shield Life Network Provider to furnish Services and to accept Blue Shield Life's payment, plus applicable Deductibles, Copayments and Coinsurance, as payment in full for covered Services.

Note: This definition does not apply to Mental Health and substance abuse Services or Hospice Program Services. For Participating Providers for Mental Health and substance abuse Services and Hospice Program Services, see the Mental Health Service Administrator (MHSA) Participating Providers and Participating Hospice or Participating Hospice Agency definitions above.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has enrolled with the Plan as a Physician Member.

Preferred Bariatric Surgery Services Provider — a Preferred Hospital or a Physician Member that has contracted with Blue Shield to furnish bariatric surgery Services and accept reimbursement at negotiated rates, and that has been designated as a contracted bariatric surgery Services provider by Blue Shield.

Preferred Dialysis Center — a dialysis services facility which has contracted with Blue Shield Life to provide dialysis services on an Outpatient basis and accept reimbursement at negotiated rates.

Preferred Hospital — a Hospital contracted as a Blue Shield Life Network Provider and which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Plan.

Note: For Participating Providers for Mental Health and substance abuse Services, see the Mental Health and substance abuse Service Administrator (MHSA) Participating Provider definition above.

Preferred Provider — a Physician Member, a Preferred Hospital, a Preferred Dialysis Center, or a Participating Provider. Note: For Participating Providers for Mental Health and substance abuse Services, see the Mental Health and substance abuse Service Administrator (MHSA) Participating Provider definition above.

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Health Services as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country.

ALL OTHER DEFINITIONS

Whenever any of the following terms are capitalized in this Certificate, they will have the meaning stated below:

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent, external source.

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

Allowable Amount — the Blue Shield Life Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Blue Shield Life Allowance, unless otherwise specified for a particular service elsewhere in this Certificate, is:

1. For a Participating Provider, the amount that the Provider and Blue Shield Life have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a non-participating provider anywhere within or outside of the United States who provides Emergency Services:
    a. For physicians and hospitals – the Out of Network Emergency Allowable;
    b. All other providers – the provider's billed charge for covered Services, unless the provider and the local Blue Cross and/or Blue Shield Life have agreed upon some other amount; or
3. For a non-participating provider in California, including an Other Provider, who provides Services on other than an emergency basis, the amount Blue Shield Life would have allowed for a Participating Provider performing the same service in the same geographical area; or
4. For a provider anywhere, other than in California, within or outside of the United States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross

and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

5. For a non-participating provider (i.e., that does not contract with a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides Services on other than an emergency basis, the amount that the local Blue Cross and/or Blue Shield Life would have allowed for a Non-Participating Provider performing the same services.

Benefits (Services) — those Services which an Insured is entitled to receive pursuant to the Group Policy.

Blue Shield Life (Blue Shield) — the Blue Shield of California Life & Health Insurance Company, a California corporation licensed as a life and disability insurer.

Calendar Year — a period beginning on January 1 of any year and terminating on January 1 of the following year.

Calendar Year Deductible — the initial amount an Individual or Family must pay in a Calendar Year for certain covered Services before becoming entitled to receive Benefit payments for those Services from the Plan.

Chronic Care — care (different from Acute Care) furnished to treat an illness, injury or condition, which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary.

Close Relative — the spouse, Domestic Partner, children, brothers, sisters, or parents of an Insured.

Coinsurance – the percentage of the Allowable Amount or billed charges that an Insured is required to pay for specific Covered Services after meeting any applicable Deductible.

Copayment — the fixed dollar amount that an Insured is required to pay for specific Covered Services after meeting any applicable Deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those Services which an Insured is entitled to receive pursuant to the terms of the Group Policy.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care and/or supervisory care by a Physician) or care furnished to an Insured who is mentally or physically disabled, and

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or
2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

Dependent —

1. a Subscriber's legally married spouse who is not legally separated from the Subscriber;

   or,

2. a Subscriber's Domestic Partner;

   or,

3. a Subscriber's, spouse's, or Domestic Partner's unmarried child or child who is not one of the partners in a domestic partnership (including any stepchild or child placed for adoption or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction) who is not covered for Benefits as a Subscriber and who is:

   a. primarily dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance; or

   b. dependent upon the Subscriber, spouse, or Domestic Partner for medical support pursuant to a court order; and is

   c. less than 19 years of age; or

   d. less than 24 years of age, if enrolled as a full-time student and if proof of student status is submitted to and received by Blue Shield Life.* (This item d. does not apply to a child of a legal guardian unless a court has specifically ordered that the guardianship continue beyond the attainment of age 19.) Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student); and who has been enrolled and accepted by the Plan as a Dependent and has maintained membership in accordance with the Policy.

   *Note: For approved full-time students as described in 3.d. above:

   (1) any break in the school calendar shall not disqualify the Dependent from coverage;

   (2) the coverage for a Dependent on an approved medical leave of absence will not be terminated for a period of 12 months or the date on which

the coverage should terminate per the provisions of the Plan, whichever comes first;

(3) for a medical leave of absence from school to be approved by Blue Shield Life, the Insured must submit documentation or certification of the Medical Necessity of the leave. This submission should be sent to Blue Shield Life at least 30 days prior to the first day of the leave or, if not possible, must be sent no later than 30 days after the leave commences.

4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 24, if Dependent has been a full-time student), and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner submits to the Plan a Physician's written certification of disability within 60 days from the date of the Employer's or the Plan's request; and

   c. thereafter, certification of continuing disability and dependency from a Physician is submitted to the Plan on the following schedule:

      (1) within 24 months after the month when the Dependent would otherwise have been terminated; and

      (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

Domestic Partner — an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

1. Both partners are (a) 18 years of age or older and (b) of the same sex or different sex;

2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same principal residence;

3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Domiciliary Care — care provided in a Hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

Durable Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment.

Emergency Services — Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part.

Employee — an individual who meets the eligibility requirements set forth in the Group Policy between Blue Shield Life and your employer.

Employer (Policyholder) — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 2 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Enrollment Date — the first day of coverage, or if there is a waiting period, the first day of the waiting period (typically, date of hire).

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Family Coverage — Coverage provided for 2 or more Insureds, as defined herein.

Group Policy — the contract issued by Blue Shield Life to the policyholder that establishes the rights and obligations of Blue Shield Life and the policyholder.

Incurred — a charge will be considered to be "Incurred" on the date the particular service or supply which gives rise to it is provided or obtained.

Individual (Self-only) Coverage — Coverage provided for only one Subscriber, as defined herein.

Infertility — either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of Infertility, or (2) because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or (3) because of the inability to conceive a pregnancy after six cycles of artificial insemination supervised by a physician. These initial six cycles are not a benefit of this Plan.

Inpatient — an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

Insured — either a Subscriber or Dependent.

Intensive Outpatient Care Program — an Outpatient Mental Health (or substance abuse) treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least 3 hours per day, 3 times per week.

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent shall not be considered a Late Enrollee if any of the following paragraphs (1.), (2.), (3.), (4.), (5.), (6.), or (7.) is applicable:

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
    a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and
    b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
    c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
    d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The employer offers multiple health benefit plans and the eligible Employee elects this Plan during an open enrollment period; or
3. A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medi-Cal and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
6. For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medi-Cal premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or
7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domes-

tic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Medical Necessity (Medically Necessary) —

The Benefits of this Plan are provided only for Services which are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Plan, are:
    a. consistent with the Plan's medical policy;
    b. consistent with the symptoms or diagnosis;
    c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
    d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield Life will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient Services not Medically Necessary include hospitalization:
    a. for diagnostic studies that could have been provided on an Outpatient basis;
    b. for medical observation or evaluation;
    c. for personal comfort;
    d. in a pain management center to treat or cure chronic pain; and
    e. for Inpatient Rehabilitation that can be provided on an Outpatient basis.
4. The Plan reserves the right to review all claims to determine whether Services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Mental Health Service Administrator (MHSA) — The MHSA is a specialized health care service plan that will underwrite and deliver the Plan's Mental Health and substance abuse Services through a separate network of MHSA Participating Providers.

Mental Health Services — see definition of Psychiatric Care.

Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period — that period of time set forth in the policy during which eligible employees and their Dependents may transfer from another health benefit plan sponsored by the employer to the Preferred Plan.

Orthosis (Orthotics) — an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of movable body parts.

Out of Network Emergency Allowable — In California: The lower of (1) the provider's billed charge, or (2) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a non-Plan Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered; Outside of California: The lower of (1) the provider's billed charge, or, (2) the amount, if any, established by the laws of the state to be paid for Emergency Services.

Outpatient — an individual receiving services but not as an Inpatient.

Partial Hospitalization/Day Treatment Program — a treatment program that may be free-standing or Hospital-based and provides services at least 5 hours per day and at least 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Physical Therapy — treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Blue Shield of California Life & Health Insurance Company and/or the Blue Shield Life Shield Spectrum PPO Savings Plan.

Premium — the monthly prepayment that is made to the Plan on behalf of each Insured by the Policyholder.

Prosthesis (Prosthetics) — an artificial part, appliance or device used to replace a missing part of the body.

Psychiatric Care (Mental Health Services) — psychoanalysis, psychotherapy, counseling, medical management,

or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist, for diagnosis or treatment of a mental or emotional disorder or the mental or emotional problems associated with an illness, injury, or any other condition.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible.

Rehabilitation — Inpatient or Outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. Rehabilitation services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

Residential Care — services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Insureds who do not qualify for Acute Care or Skilled Nursing Services.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
   a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;
   b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes Medically Necessary healthcare services and Medically Necessary supplies furnished incident to those services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;
2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment, under the direction of a Physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Subscriber — an individual who satisfies the eligibility requirements of an Employee, who has been enrolled and accepted by Blue Shield Life as a Subscriber, and has maintained Blue Shield Life coverage under the Group Policy.

As used in this Certificate, a Subscriber also means an Insured.

Total Disability (or Totally Disabled) —

1. in the case of an Employee or Insured otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;
2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary

activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請撥打1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신1-866-346-7198 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は, 1-866-346-7198 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم 1-866-346-7198. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

Inpatient Substance Abuse Treatment

Summary of Benefits

Benefit	Insured Copayment	
Benefits are provided for Inpatient substance abuse care (including Partial Hospitalization[1]) as described in this Rider. Benefits are limited to a combined maximum of 30 days each Calendar Year.		
	MHSA Participating Provider	**MHSA Non-Participating Provider**
Hospital Facility Services	20%[2]	40% of up to $175 per day and charges above $175[3]
Professional (Physician) Services	20%[2]	40% (and charges above the Allowable Amount)

[1]Partial Hospitalization/Day Treatment Program is a treatment program that may be free-standing or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

[2]Coinsurance is calculated based on the negotiated rate with the MHSA Participating Provider.

[3]Blue Shield: Life payment not to exceed $105.00 per day

Introduction

In addition to the benefits listed in your Certificate of Insurance, your Plan provides coverage for Inpatient substance abuse care Services as described herein. (Note: This additional benefit does not include Inpatient substance abuse medical detoxification which is a basic medical benefit of your Plan.) All Services must be Medically Necessary. Residential care is not covered.

Blue Shield of California Life & Health Insurance Company (Blue Shield Life) has contracted with a Mental Health Services Administrator (MHSA) to administer and deliver Mental Health and Outpatient substance abuse care Services as well as the Inpatient substance abuse care Services described in this Rider. All Non-Emergency Inpatient substance abuse care Services must be prior authorized by the MHSA. For prior authorization for Inpatient substance abuse care Services, Insureds should call the MHSA at 1-877-214-2928.

For questions about these Inpatient substance abuse care benefits, or for assistance in selecting an MHSA Participating Provider, Insureds should call the MHSA at 1-877-214-2928.

Benefits

Inpatient substance abuse care (including Partial Hospitalization*) — Benefits are provided for Inpatient Services limited to a combined maximum of 30 days each Calendar Year. All Services must be Medically Necessary. Residential care is not covered.

Inpatient Hospital, Partial Hospitalization, or any combination of these Services are covered up to the maximum calendar days per year as shown in the Summary of Benefits, with one (1) Hospital day counting as one (1) calendar day and two (2) Partial Hospitalization days counting as one (1) calendar day.

Failure to obtain authorization before admission as required under the Benefits Management Program will result in an additional payment of $1,000 for each Hospital admission.

These Inpatient substance abuse care Services do not count toward the Insured's Maximum Calendar Year Copayment Responsibility.

This benefit is subject to the general provisions, limitations and exclusions listed in your *Certificate of Insurance*.

Please be sure to retain this document. It is not a Policy but is a part of your *Certificate of Insurance.*

Customer Service

1-800-642-6155

The hearing impaired may call Blue Shield Life's Customer Service Department
through the toll-free TTY number at 1-800-241-1823.

Benefits Management Program Telephone Numbers

For Prior Authorization: 1-800-343-1691

For Prior Authorization of Benefits Management Program Radiological Services: 1-888-642-2583

For Prior Authorization for Inpatient Mental Health and substance abuse Services, contact the
Mental Health Service Administrator at: 1-877-214-2928

Please refer to the Benefits Management Program section of this Certificate of Insurance booklet for information.

Please direct correspondence to:

Blue Shield of California Life & Health Insurance Company
P.O. Box 272540
Chico, CA 95927-2540