

# Important Disclosures

Large Group Plan

**Virtual Blue EPO Savings Disclosure Form (101+)**

Provider Network: Tandem  
Value

Blue Shield of California is an independent member of the Blue Shield Association

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## Notice

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**This disclosure form is only a summary. Consult the Evidence of Coverage and the Group Health Service Contract to determine the governing contractual provisions.**

The Evidence of Coverage (EOC) and the Group Health Service Contract (Contract) disclose the terms and conditions of your coverage. You should read this disclosure form and the EOC completely and carefully. If you or a covered family member have special health care needs, you should read any relevant sections closely.



Consult the health plan benefits and coverage matrix for additional information.

Applicants for coverage under this plan have a right to view the EOC prior to enrollment. Applicants may contact Blue Shield for additional information about this plan's Benefits. Call Customer Service at 1-888-373-2750.

Blue Shield will furnish a copy of the EOC upon request. This 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.

Blue Shield does not provide tax advice. If you have questions about health savings accounts or other tax-favored arrangements that are compatible with HDHPs under federal law, you should consult with your tax advisor.

### **Virtual Blue program**

Blue Shield has contracted with providers that specialize in virtual care to expand your access to telehealth services under the Virtual Blue program. Virtual Blue program services offer you an alternative to in-person office visits at no out-of-pocket cost a \$0 Copayment. See the [Virtual Blue program](#) section of the EOC for more information.

## General disclosures

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### **Principal Benefits and coverages**

Your plan includes certain Benefits and coverages, including coverage for acute and subacute care. Blue Shield provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the Medical Management Programs; and
- The terms, conditions, limitations, and exclusions of this EOC.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. Blue Shield's Medical Management Programs work with your provider to ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

Review your Summary of Benefits and your EOC to understand the specifics and costs associated with your principal Benefits and coverages.



### Principal Benefits and Coverages




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Acupuncture services

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Allergy testing and immunotherapy Benefits

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Ambulance services

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Bariatric surgery Benefits

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Chiropractic services

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Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits

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Diabetes care services

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Diagnostic X-ray, imaging, pathology, laboratory, and other testing services

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Dialysis Benefits

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Durable medical equipment

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## Principal Benefits and Coverages

Emergency Benefits

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Family planning and Infertility Benefits

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Home health services

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Hospice program services

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Hospital services

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Medical treatment of the teeth, gums, jaw joints, and jaw bones

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Mental Health and Substance Use Disorder Benefits

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Physician and other professional services

---

PKU formulas and special food products

---

Podiatric services

---

Pregnancy and maternity care

---

Prescription Drug Benefits

---

Preventive Health Services

---

Reconstructive Surgery Benefits

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Rehabilitative and habilitative services

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Skilled Nursing Facility (SNF) services

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Transplant services



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Urgent care services

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### **Principal exclusions and limitations on Benefits**

Review your EOC to learn more about this plan's general exclusions and limitations. Prescription Drug Benefits have additional exclusions and limitations.

	<h2 style="text-align: center;">General exclusions and limitations</h2> 
1	<p>This plan does not cover services received from Non-Participating Providers or MHA Non-Participating Providers, except:</p> <ul style="list-style-type: none"> <li>• For Emergency or Urgent Services;</li> <li>• When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances;</li> <li>• Inter-Plan Arrangements, including the BlueCard® and Blue Shield Global® Core programs described in the Out-of-area services section of the EOC; and</li> <li>• When prior authorized by Blue Shield or the MHA.</li> </ul>
2	<p>This plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary. This exclusion does not apply to services which Blue Shield is required by law to cover for Reconstructive Surgery.</p>
3	<p>Routine physical examinations solely for:</p> <ul style="list-style-type: none"> <li>• Immunizations and vaccinations, by any mode of administration, for the purpose of travel; or</li> <li>• Licensure, employment, insurance, court order, parole, or probation.</li> </ul> <p>This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.</p>
4	<p>Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.</p>
5	<p>Routine foot care items and services that are not Medically Necessary, including:</p> <ul style="list-style-type: none"> <li>• Callus treatment;</li> <li>• Corn paring or excision;</li> <li>• Toenail trimming;</li> <li>• Over-the-counter shoe inserts or arch supports; or</li> <li>• Any type of massage procedure on the foot.</li> </ul> <p>This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.</p>
6	<p>Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care.</p>



## General exclusions and limitations



	<p>Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.</p> <p>Domiciliary care is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.</p>
7	Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.
8	Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the <i>Home infusion and injectable medication services</i> and <i>PKU formulas and special food products</i> sections of the EOC, or as provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
9	Hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.
10	<p>Orthoptics or vision training except when Medically Necessary, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the <i>Prosthetic equipment and devices</i> section of the EOC.</p> <p>Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.</p>
11	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the <i>Prosthetic equipment and devices</i> section of the EOC.
12	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the <i>Medical treatment of the teeth, gums, or jaw joints and jaw bones</i> , <i>Pediatric dental Benefits</i> , and <i>Hospital services</i> sections of the EOC.
13	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.



## General exclusions and limitations



14	<p>Unless selected as an optional Benefit by your Employer, any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.</p>
15	<p>Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits or to items specifically described in the <i>Durable medical equipment</i> or <i>Diabetes care services</i> sections of the EOC.</p>
16	<p>Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.</p>
17	<p>Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.</p>
18	<p>Services provided by an individual or entity that:</p> <ul style="list-style-type: none"> <li>• Is not appropriately licensed or certified by the state to provide health care services;</li> <li>• Is not operating within the scope of such license or certification; or</li> <li>• Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services.</li> </ul> <p>This exclusion does not apply to Behavioral Health Treatment Benefits listed under the <i>Mental Health and Substance Use Disorder Benefits</i> section of the EOC or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.</p>



## General exclusions and limitations



19	<p>Select physical and occupational therapies, such as:</p> <ul style="list-style-type: none"> <li>• Massage therapy, unless it is performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider. Massage is considered not Medically Necessary when performed as the solitary treatment or prescribed to an individual who presents with no complications;</li> <li>• Training or therapy for the treatment of learning disabilities or behavioral problems;</li> <li>• Social skills training or therapy;</li> <li>• Vocational, educational, recreational, art, dance, music, or reading therapy; and</li> <li>• Testing for intelligence or learning disabilities.</li> </ul> <p>This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.</p>
20	<p>Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the <i>Diabetes care services</i> section of the EOC, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.</p>
21	<p>Services or Drugs that are Experimental or Investigational in nature.</p>
22	<p>Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to:</p> <ul style="list-style-type: none"> <li>• Drugs;</li> <li>• Medicines;</li> <li>• Supplements;</li> <li>• Tests;</li> <li>• Vaccines;</li> <li>• Devices; and</li> <li>• Radioactive material.</li> </ul> <p>However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health &amp; Safety Code Section 1367.21 have been met.</p>
23	<p>The following non-prescription (over-the-counter) medical equipment or supplies:</p> <ul style="list-style-type: none"> <li>• Oxygen saturation monitors;</li> <li>• Prophylactic knee braces; and</li> <li>• Bath chairs.</li> </ul>



## General exclusions and limitations



24	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, and food delivery services.
25	Disposable supplies for home use except as provided under the <i>Durable medical equipment</i> , <i>Home health services</i> , and <i>Hospice program services</i> sections of the EOC, or the Prescription Drug Benefit.
26	Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.
27	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
28	Drugs dispensed by a Physician or Physician's office for outpatient use.
29	Hospital care programs or services provided in a home setting (Hospital-at-home programs).
30	Drugs and services that you are not legally obligated to pay, or for which you are not charged. This exclusion does not apply to Preventive Health Services, or FDA-approved contraceptive Drugs and devices, or Drugs with a USPSTF rating of A or B.



## Outpatient prescription Drug exclusions and limitations



1	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
2	Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, Drugs used to slow or reverse the effects of skin aging or to treat hair loss.
3	Medical devices or supplies, except as listed in the <i>Durable medical equipment</i> section of the EOC. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices.
4	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy, or included on a government exclusion list.
5	Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B when prescribed by a Physician or to over-the-counter contraceptive Drugs and devices.
6	Prescription Drugs that are repackaged by an entity other than the original manufacturer.
7	Replacement of lost, stolen, or destroyed Drugs.
8	Immunizations and vaccinations solely for the purpose of travel.
9	Compounded medications unless all of the following requirements are met: <ul style="list-style-type: none"> <li>• A compounded medication includes at least one Drug;</li> <li>• The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound);</li> <li>• There are no FDA-approved, commercially-available, medically-appropriate alternatives; and</li> <li>• The compounded medication is self-administered.</li> </ul>
10	A manufacturer's product may be excluded when the same or similar Drug (one with the same active ingredient or same therapeutic effect) is available under this Prescription Drug Benefit. Any dosage or formulation of a Drug may be excluded when the same Drug is available under the <a href="#">Prescription Drug Benefit</a> in a different dosage or formulation.



## Outpatient prescription Drug exclusions and limitations



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Drugs for weight loss when prescribed solely for the purpose of losing weight, except for Medically Necessary treatment of Class III obesity when prior authorized. This exclusion does not apply to items or services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

## **Prepayments fees**

Your Employer is responsible for a monthly payment to Blue Shield for health care coverage for the Subscriber and any enrolled Dependents. This monthly payment is a Premium. Any amount the Subscriber must contribute to the Premium is set by your Employer.

The contract states the monthly Premiums for this plan for the Subscriber and any enrolled Dependents. Blue Shield will give your Employer written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. Your Employer is responsible for letting you know of any changes. Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

## **Other charges**

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Blue Shield Allowable Amount.

Your Cost Share includes any:

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

## **Allowable Amount**

The Allowable Amount is the maximum amount Blue Shield will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Blue Shield's payment to the provider is the difference between the Allowable Amount and your Cost Share.

Participating Providers agree to accept the Allowable Amount as payment in full for Covered Services, except as stated in the *Exception for other coverage and Reductions – third party liability* sections of the EOC. When you see a Participating Provider, you are responsible for your Cost Share.

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

Non-Participating Providers do not agree to accept the Allowable Amount as payment in full for Covered Services. When you see a Non-Participating Provider, you are responsible for:

- Your Cost Share; and
- All charges over the Allowable Amount.

## Calendar Year Deductible

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

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

Amounts you pay over the Allowable Amount do not count toward your Deductible.

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for an individual Member and an entire Family.

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

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

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

### Prior carrier Deductible credit

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

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

## Copayment and Coinsurance

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

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

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

## **Calendar Year Out-of-Pocket Maximum**

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Your Cost Share includes Deductible, Copayment, and Coinsurance and these count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

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

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

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

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

- Charges for services that are not covered; and
- Charges over the Allowable Amount.

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

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

## **Accrual balance**

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

## **Choice of Physicians and providers**

This plan covers care from Participating Providers. You do not need a referral. However, some services do require prior authorization.

## Participating Providers

Participating Providers have a contract with Blue Shield and agree to accept Blue Shield's Allowable Amount as payment in full for Covered Services.

With an EPO plan, there is generally no coverage for services from Non-Participating Providers.

If a provider leaves this plan's network, the status of the provider will change from Participating to Non-Participating.

## Non-Participating Providers

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowable Amount as payment in full for Covered Services. You may be responsible for the total amount billed by a Non-Participating Provider. All Covered Services must be received from a Participating Provider in the Blue Shield Tandem PPO network or an MHSa Participating Provider, except:

- For Emergency or Urgent Services;
- When you receive care at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings), some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances;
- Inter-Plan Arrangements, including the BlueCard® and Blue Shield Global® Core programs described in the *Out-of-area services* section of the EOC;
- Services provided by a 988 center, Mobile Crisis Team, or other provider of Behavioral Health Crisis Services; and
- When prior authorized by Blue Shield or the MHSa.

### Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. If it was not your choice to see a Non-Participating Provider for these services, your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above the Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

### If you cannot find a Participating Provider

Call Customer Service if you need help finding a Participating Provider who can provide the care you need close to home. If a Participating Provider is not available, you can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be

obtained from a Participating Provider, we will approve your request and you will only be responsible for the Participating Provider Cost Share.

## **Second medical opinion**

You can consult a Participating or Non-Participating Provider for a second medical opinion in situations including but not limited to:

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

You do not need prior authorization from Blue Shield or your Primary Care Physician for a second medical opinion.

## **Continuity of care**



Continuity of care may be available if:

- Blue Shield or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

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

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

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

 <b>Continuity of care with a Former Participating Provider</b> 	
<b>Qualifying conditions</b>	<b>Timeframe</b>
Undergoing a course of institutional or inpatient care	90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner

Continuity of care with a Former Participating Provider	
Qualifying conditions	Timeframe
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.

To request continuity of care, visit [blueshieldca.com](https://blueshieldca.com) and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and may review your request for Medical Necessity.

Under Federal law, the Former Participating Provider must accept Blue Shield's or the MHPA's Allowable Amount as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Participating Provider at the Participating Provider Cost Share.

### **Care outside of California**

If you need medical care while traveling outside of California, you're covered. Blue Shield has relationships with health plans in other states through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care in those geographic areas.



See the *Out-of-area services* section of the EOC for more information about receiving care while outside of California. To find participating providers while outside of California, visit [bcbs.com](https://bcbs.com).

## **Emergency Services**



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

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

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the services provided at a Participating Provider facility at the applicable Participating Provider Cost Share. Services provided at a Non-Participating Provider facility will not be covered.

## **Reimbursement provisions**

When you see a Participating Provider, your provider submits the claim to Blue Shield. However, you may need to submit the claim to Blue Shield for the following services when received from a Non-Participating Provider:

- For Emergency or Urgent Services;
- When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances; and
- Inter-Plan Arrangements, including the BlueCard® and Blue Shield Global® Core programs described in the Out-of-area services section.

Claim forms are available at [blueshieldca.com](https://www.blueshieldca.com) or by contacting the Benefit Administrator. Please submit your claim form and medical records within one year of the service date.

## **Facilities**



Visit [blueshieldca.com](https://www.blueshieldca.com) or use the Blue Shield mobile app and click on **Find a Doctor** for a list of your plan's **Participating Providers**.

We update our provider directories periodically to reflect changes in our provider networks. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHPA Participating Provider prior to obtaining coverage.

**Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Customer Service at 1-888-373-2750.**

For the most up-to-date listings, check our online directories in the Find a Doctor section of [blueshieldca.com](https://www.blueshieldca.com) or by calling Customer Service.

## **Renewal provisions**

Blue Shield has the right to change the Benefits and terms of this plan as the law permits. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Premiums; and
- Limitations and exclusions.

Blue Shield will give your Employer written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. Your Employer is responsible for letting you know of any changes. Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

## **Individual continuation of Benefits**

If your employment with your current Employer ends, you and any covered Dependents may qualify for continued group coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See the Continuation of group coverage section of the EOC for more information on COBRA continuation coverage.

## **Termination of Benefits**

Your coverage will end if:

- Your Employer cancels or does not renew coverage;
- The Subscriber cancels coverage; or
- Blue Shield cancels or rescinds coverage.

Please refer to the EOC for additional information.

### **If your Employer cancels coverage**

Your Employer may cancel coverage at any time. To cancel coverage, your Employer must provide written notice to Blue Shield and its Employees.

### **If the Subscriber cancels coverage**

If the Subscriber decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by your Employer.

### **Reinstatement**

If the Subscriber voluntarily cancels coverage, the Subscriber can contact the Employer for reinstatement options.

## **If Blue Shield cancels coverage**

Blue Shield can cancel coverage if:

- You are no longer eligible for coverage in this plan;
- Your Employer fails to meet Blue Shield's Employer eligibility, participation, and contribution requirements;
- Blue Shield terminates this plan; or
- You or your Employer commit fraud or intentional misrepresentation of material fact.

Blue Shield will provide 30 days' advance written notice of cancellation of coverage to your Employer if your Employer fails to meet Blue Shield's Employer eligibility, participation, and contribution requirements. It is your Employer's responsibility to provide a copy of the notice to its Employees.

## **Cancellation for Employer's nonpayment of Premiums**

Blue Shield can cancel coverage if your Employer does not pay the required Premiums in full and on time. Your Employer is responsible for all Premiums during the term of coverage, including the 30-day grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the date coverage ends.

## **Cancellation or rescission for fraud or intentional misrepresentation of material fact**

Blue Shield may cancel or rescind your coverage if you, your Dependent, or your Employer commit fraud or intentional misrepresentation of material fact. It is your Employer's responsibility to notify you if the Contract is rescinded or canceled. Rescission voids the Contract as if it never existed. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. The Employer must provide enrolled Employees with a copy of the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.



## NOTICES AVAILABLE ONLINE

### Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: [blueshieldca.com/notices](https://blueshieldca.com/notices). You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

### Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en [blueshieldca.com/notices](https://blueshieldca.com/notices). Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

### 非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 [blueshieldca.com/notices](https://blueshieldca.com/notices)。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。