Benefit Booklet

San Francisco Health Service System (SFHSS)
Blue Shield of CA PPO 20
Group Number: W0072990
Effective Date: January 1, 2024

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Summary of Benefits

San Francisco Health Service System Fund (CCSF)
Effective January 1, 2024
PPO Plan

Blue Shield of CA PPO 20

This Summary of Benefits shows the amount you will pay for Covered Services under this plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: **Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at member.accolade.com or blueshieldca.com, or by calling Accolade Customer Service at 1-866-336-0711.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Calendar Year medical Deductible	*Individual coverage*	$250	$500
	Family coverage	$250: individual	$500: individual
		$750: Family	$1,500: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$10,950	$10,950
Family coverage	$10,950: per individual	$10,950: per individual

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		80%	✔
Preventive immunizations	$0		$0	
Physician services				
Primary care office visit	80%	✔	80%	✔
Specialist care office visit	80%	✔	80%	✔
Physician home visit	80%	✔	80%	✔
Physician or surgeon services in an Outpatient Facility	80%	✔	80%	✔
Physician or surgeon services in an inpatient facility	80%	✔	80%	✔
Other professional services				
Other practitioner office visit	80%	✔	80%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	80%	✔	80%	✔
Up to $1,000 maximum per Member, per Calendar Year.				
Chiropractic services	80%	✔	80%	✔
Up to $1,000 maximum per Member, per Calendar Year.				
Teladoc consultation	80%	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		80%	✔
• Injectable contraceptive	$0		80%	✔
• Diaphragm fitting	$0		80%	✔
• Intrauterine device (IUD)	$0		80%	✔
• Insertion and/or removal of intrauterine device (IUD)	$0		80%	✔
• Implantable contraceptive	$0		80%	✔
• Tubal ligation	$0		80%	✔
• Vasectomy	$0		80%	✔
• Diagnosis and Treatment of the Cause of Infertility	80%	✔	80%	✔
Infertility Services				

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Natural or stimulated artificial inseminations. *Limited to 6 procedures per lifetime.*	80%		80%	
• Gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro fertilization (IVF) [8] *Limited to 2 procedures per lifetime.*	80%		80%	
• Intracytoplasmic sperm injection (ICSI)	80%		80%	
• Embryo transportation related network disruption[9] *Limited to 1 instance and within the 1 year of storage. Up to $500 maximum.*	80%		80%	
• Testicular sperm aspiration/microsurgical epididymal sperm aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm *Limited to 1 procedure per lifetime.*	80%		80%	
• Electroejaculation	80%		80%	
• Embryo biopsy for preimplantation screening (PGS) or diagnosis (PGD)	80%		80%	
• Cryopreservation of sperm, oocytes, ovarian tissue, testicular tissue, embryos *Limited to 1 retrieval and 1 year of storage per lifetime.*	80%		80%	
Podiatric services	80%	✔	80%	✔
Medical nutrition therapy, not related to diabetes *Combined with diabetic medical nutrition therapy, up to 4 visits per Member, per Calendar Year.*	80%	✔	80%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	80%	✔	80%	✔
Physician services for pregnancy termination	80%	✔	80%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency Services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	80%	✔	80%	✔
Emergency room services for a non-emergency medical condition[5]	80%	✔	80%	✔
Emergency room Physician services	80%	✔	80%	✔
Urgent care center services	80%	✔	80%	✔
Ambulance services *This payment is for emergency or authorized transport.*	80%	✔	80%	✔
Outpatient Facility services				
Ambulatory Surgery Center	80%	✔	80%	✔
Outpatient Department of a Hospital: surgery	80%	✔	80%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	80%	✔	80%	✔
Inpatient facility services				
Hospital services and stay	80%	✔	80%	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	80%	✔	Not covered	
• Physician inpatient services	80%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services				
Participating Provider benefits for bariatric surgery services are limited to $60,000 during the entire period you are covered under the Plan. *Non-Participating Provider benefits for bariatric surgery services are limited to $10,000 during the entire period you are covered under the Plan.*				
Inpatient facility services	80%	✔	80%	✔
Outpatient Facility services	80%	✔	80%	✔
Physician services	80%	✔	80%	✔
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	80%	✔	80%	✔
• Outpatient Department of a Hospital	80%	✔	80%	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	80%	✔	80%	✔
• Outpatient Department of a Hospital	80%	✔	80%	✔
Other outpatient Non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, Non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	80%	✔	80%	✔
• Outpatient Department of a Hospital	80%	✔	80%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	80%	✔	80%	✔
• Outpatient Department of a Hospital	80%	✔	80%	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	80%	✔	80%	✔
Outpatient Department of a Hospital	80%	✔	80%	✔
Speech Therapy services				
Office location	80%	✔	80%	✔
Outpatient Department of a Hospital	80%	✔	80%	✔
Durable medical equipment (DME)				
DME	80%	✔	80%	✔
Breast pump	$0		80%	✔
Orthotic equipment and devices	80%	✔	80%	✔
Prosthetic equipment and devices	80%	✔	80%	✔
Home health care services *Up to 120 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	80%	✔	80%	✔
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	80%	✔	80%	✔
Hemophilia home infusion services *Includes blood factor products.*	80%	✔	80%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Skilled Nursing Facility (SNF) services				
Up to 120 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.				
Freestanding SNF	80%	✔	80%	✔
Hospital-based SNF	80%	✔	80%	✔
Hospice program services				
Pre-Hospice consultation	80%	✔	80%	✔
Routine home care	80%	✔	80%	✔
24-hour continuous home care	80%	✔	80%	✔
Short-term inpatient care for pain and symptom management	80%	✔	80%	✔
Inpatient respite care	80%	✔	80%	✔
Reconstructive surgery services				
Outpatient Facility services	80%	✔	80%	✔
Inpatient facility services	80%	✔	80%	✔
Physician services	80%	✔	80%	✔
Medical treatment of the teeth, gums, jaw joints, and jaw bones				
Outpatient Facility services	80%	✔	80%	✔
Inpatient facility services	80%	✔	80%	✔
Physician services	80%	✔	80%	✔
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	80%	✔	80%	✔
• Self-management training	80%	✔	80%	✔
• Medical nutrition therapy	80%	✔	80%	✔
Combined with medical nutrition therapy not related to diabetes, up to 4 visits per Member, per Calendar Year.				
Dialysis services	80%	✔	80%	✔
PKU product formulas and special food products	80%	✔	80%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Allergy serum billed separately from an office visit	80%	✔	80%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $2,500 maximum per ear, per Member, per 36 months.*	80%		80%	
Clinical trials for treatment of cancer or life-threatening diseases or conditions	Regular medical services for Members enrolled in clinical trials will be covered at the same Cost Shares as any other services (office visit, inpatient, outpatient, etc.)			

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	80%	✔	80%	✔
Intensive outpatient care	80%	✔	80%	✔
Behavioral Health Treatment in an office setting	80%	✔	80%	✔
Behavioral Health Treatment in home or other non-institutional setting	80%	✔	80%	✔
Office-based opioid treatment	80%	✔	80%	✔
Partial Hospitalization Program	80%	✔	80%	✔
Psychological Testing	80%	✔	80%	✔
Inpatient services				
Physician inpatient services	80%	✔	80%	✔
Hospital services	80%	✔	80%	✔
Residential Care	80%	✔	80%	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

*This Plan cross accumulates Participating Provider and Non-Participating Provider Calendar Year Deductibles.*This means that any amounts you pay towards your Participating Provider Calendar Year Deductible also count towards your Non-Participating ProviderCalendar Year Deductible. Also, any amounts you pay towards your Non-Participating Provider Calendar Year Deductible counts towards your Participating Provider Calendar Year Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year. Charges for Services which are specifically excluded from accumulating to the OOPM, contained within the Benefit Booklet, do not count towards the OOPM.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan cross accumulates Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your Non-Participating Provider OOPM. Also, any amounts you pay towards your Non-Participating Provider OOPM counts towards your Participating Provider OOPM.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit by a Participating Provider. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Fresh or Frozen Transfer Cycles:

Embryo, gamete or zygote fresh or frozen transfer cycles must be received in conjunction with any of the following Covered Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).

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9 **Embryo Transportation:**

Network Disruption is defined as when a facility closes and/or the Member moves during the covered year of storage, the Member will be reimbursed up to the limit of $500.

Plans may be modified to ensure compliance with Federal requirements.
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Introduction

Welcome! We are happy to have you as a Member of the San Francisco Health Service System (SFHSS) health Plan (Plan).

This health Plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on the terms of the Plan, as described in further detail in this Benefit Booklet.

About this Benefit Booklet

The Benefit Booklet describes the health care coverage that is provided under the Plan. The Benefit Booklet tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your Plan (Covered Services);
- Which services are not covered under your Plan;
- When and how you must get prior authorization for certain services; and
- Important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Benefit Booklet includes a *Summary of Benefits* section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care.

Please read this Benefit Booklet carefully. Some topics in this document are complex. For additional explanation on these topics, you may be directed to a section at the back of the Benefit Booklet called *Other important information about your Plan*. Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Benefit Booklet in your files for future reference.

Tables and images

In this Benefit Booklet, you will see the following tables and images to highlight key information:

 This table provides easy access to information 
Phone numbers and addresses
Answers to commonly-asked questions
Examples to help you better understand important concepts

This box tells you where to find additional information about a specific topic.

This box alerts you to information that may require you to take action.

"You" means the Member

In this Benefit Booklet, "you" or "your" means any Member enrolled in the Plan, including the Participant and all Dependents. "Your Employer" means the San Francisco Health Service System.

Capitalized words have a special meaning

Some words and phrases in this Benefit Booklet may be new to you. Key terms with a special meaning within this Benefit Booklet are capitalized and defined in the *Definitions* section.

About this Plan

This is a Preferred Provider Organization (PPO) plan. In a PPO plan, you have the flexibility to choose the providers you see. You can receive care from Participating Providers or Non-Participating Providers. See the *How to access care* section for information about Participating and Non-Participating Providers.

How to contact Customer Service

If you have questions at any time, we're here to help. Visit member.accolade.com to ask your Health Assistant a question or to:

- Download forms;
- View or print a temporary ID card;
- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

Accolade's Customer Service contact information appears at the bottom of every page.

Contacting Customer Service

If you need information about	*You should contact*
Medical Benefits, including prior authorization and claims submission	Accolade Customer Service: 1-866-336-0711

Contacting Customer Service	
If you need information about	***You should contact***
Prior authorization of radiological services	National Imaging Associates: (888) 642-2583

If you are hearing impaired, you may contact Accolade Customer Service at member.accolade.com.

Your bill of rights

	As a Member, 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 Plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you.
5	Have reasonable access to appropriate medical and mental health services in accordance with the terms of your Plan.
6	Participate actively with your Physician in decisions about your medical and mental health care. To the extent the law permits, 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	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your Physician, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
9	Receive Preventive Health Services.
10	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
11	Have confidential health records, except when the law requires or permits disclosure. 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.

	As a Member, you have the right to:
14	Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care.
15	Voice complaints or grievances about your Plan or the care provided to you.
16	Make recommendations on the Claims Administrator's Member rights and responsibilities policies.

Your responsibilities

	As a Member, you have the responsibility to:
1	Carefully read all plan materials, including this Benefit Booklet, immediately after you are enrolled so you understand how to: • Use your Benefits; • Minimize your out-of-pocket costs; and • Follow the provisions of your Plan as explained in the Benefit Booklet.
2	Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.
3	Provide, to the extent possible, information needed for you to receive appropriate care.
4	Understand your health problems and take an active role in developing treatment goals with your Physician, whenever possible.
5	Follow the treatment plans and instructions you and your Physician agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6	Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7	Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8	Communicate openly with your Physician so you can develop a strong partnership based on trust and cooperation.
9	Offer suggestions to improve the Plan.
10	Help the Claims Administrator maintain accurate and current records by providing timely information regarding changes in your address, family status, and other plan coverage.
11	Notify the Claims Administrator as soon as possible if you are billed inappropriately or if you have any complaints or grievances.
12	Treat all Plan personnel respectfully and courteously.
13	Pay your Participant Contributions, Copayments, Coinsurance, and charges for non-Covered Services in full and on time.

As a Member, you have the responsibility to:	
14	Follow the provisions of the Claims Administrator's Medical Management Programs.

How to access care

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

Health care professionals and facilities

This Plan covers care from Participating Providers and Non-Participating Providers. You do not need a referral. However, some services do require prior authorization. See the *Medical Management Programs* section for information about prior authorization.

Participating Providers

Participating Providers have a contract with the Claims Administrator and agree to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services. As a result, when you receive Covered Services from a Participating Provider, you will not be responsible for any costs in excess of the applicable Cost Share. When you receive Covered Services from a Non-Participating Provider, you will be responsible for the applicable Cost Share and may also be responsible for additional costs, such as charges from the Non-Participating Provider that are over the Allowable Amount and charges for services above any maximum Benefit allowance.

Some services will not be covered unless you receive them from a Participating Provider. See the *Summary of Benefits* section to find out which Covered Services must be received from a Participating Provider.

If a provider leaves this Plan's network, the status of the provider will change from Participating to Non-Participating. See the *Continuity of Care* section for more information on how to continue treatment with a Non-Participating Provider.

Call Accolade Customer Service or visit ***member.accolade.com*** or ***blueshieldca.com*** and click on ***Find a Doctor*** for a list of your plan's ***Participating Providers***.

Non-Participating Providers

Non-Participating Providers do not have a contract with the Claims Administrator to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services.

Except for Emergency Services and services received at a Participating Provider facility (Hospital, Ambulatory Surgical Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, you will pay more for Covered Services from a Non-Participating Provider.

Non-Participating Providers at a Participating Provider Hospital or Ambulatory Surgical Center

When you receive care at one of these types of Participating Provider facilities, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional changes above the Allowable Amount, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants
Physician Specialists, such as dermatologists and cardiologists
Physical, occupational, and speech therapists
Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers
Hospitals
Freestanding labs and radiology centers
Ambulatory Surgery Centers

ID cards

The Claims Administrator will provide the Participant and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at member.accolade.com.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice.

Continuity of care

Continuity of care with a Former Participating Provider may be available if your provider leaves the Claims Administrator network or the Claims Administrator no longer contracts with your Participating Provider for the services you are receiving.

Continuity of care may also be available to you when your Employer terminates its contract with the Claims Administrator and contracts with a new third-party

administrator (TPA) that does not include the Claims Administrator's Participating Provider in its network.

If your Former Participating Provider is no longer available to you for one of the reasons noted above, the Claims Administrator 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:

Continuity of care with a Former Participating Provider	
Qualifying condition	***Timeframe***
• Ongoing treatment for a serious and complex condition; • Ongoing institutional or inpatient care; • Ongoing pregnancy care, including care immediately after giving birth; • Scheduled, nonelective surgery, including postoperative care; or • Treatment for a terminal illness	90 days from the date you were notified that the Former Participating Provider is no longer available to you or until the treatment concludes, whichever is sooner

To request continuity of care, please call Accolade Customer Service. The Claims Administrator will confirm your eligibility and may review your request for Medical Necessity.

The Former Participating Provider must accept the Claims Administrator's Allowable Amount as payment in full for 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.

See the *Your payment information* section for more information about the Allowable Amount.

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 the Claims Administrator or your Physician for a second medical opinion.

Care outside of California

If you currently reside or are traveling outside of California, you're covered. The Claims Administrator has relationships with health plans in all other states, Puerto Rico, and the U.S. Virgin Islands through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care from participating and non-participating providers in those geographic areas.

See the ***Out-of-area services*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***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, the Claims Administrator 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 Participating or Non-Participating Provider Cost Share for that non-emergency Covered Service.

For the lowest out-of-pocket expenses, you can go to a Participating Physician's office for emergency room follow-up services, such as suture removal and wound checks.

If you cannot find a Participating Provider

Call Accolade 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.

Other ways to access care

For non-emergencies, it may be faster and easier to access care in one of the following ways. For more information, please call Accolade Customer Service or visit member.accolade.com.

Retail-based health clinics

Retail-based health clinics are conveniently located within stores and pharmacies. They are staffed with nurse practitioners who can provide basic medical care on a walk-in basis.

The Cost Share for Covered Services at a Participating retail-based health clinic is the same as the Cost Share at your Physician's office.

Teladoc

Teladoc provides health consultations by phone or secure online video. Teladoc general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc is a supplemental service that is not intended to replace care from your Physician.

How to access Teladoc

Teladoc service	*Ways to access*	*Availability*
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladoc	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment

Telebehavioral health services

Online telebehavioral health services for Mental Health and Substance Use Disorder Conditions are available through the Claims Administrator. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider.

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

Ambulatory Surgery Centers

Many of the more common, uncomplicated, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Health advice and education

Your Plan provides several ways for you to get health advice and access to health education and wellness services. These resources are available to you at no extra cost.

Health and wellness resources

Your Plan gives you access to a variety of health education and wellness services, such as:

- Prenatal and other health education programs;
- Healthy lifestyle programs to help you get more active, quit smoking, lower stress, and much more; and
- A health update newsletter.

Call Accolade Customer Service or visit member.accolade.com or blueshieldca.com/bewell to explore these resources.

Medical Management Programs

The Medical Management Programs are services that can help you coordinate your care and treatment. They include utilization management and care management. The Claims Administrator uses utilization management to help you and your providers identify the most appropriate and cost-effective way to use the Benefits of this plan. Care management and palliative care can help you access the care you need to manage serious health conditions and complex treatment plans.

For written information about the Claims Administrator's ***Utilization Management Program***, call Accolade Customer Service or visit member.accolade.com or blueshieldca.com.

Prior authorization

Coverage for some Benefits requires pre-approval from the Claims Administrator. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. The prior authorization process also identifies Benefits that are only covered from Participating Providers or in a specific clinical setting.

If you see a Participating Provider, your provider must obtain prior authorization when required. When prior authorization is required but not obtained, the Claims Administrator may deny payment to your provider. You are not responsible for the Claims Administrator's portion of the Allowable Amount if this occurs, only your Cost Share.

If you see a Non-Participating Provider, you or your provider must obtain prior authorization when required. When prior authorization is required but not obtained, and the services provided are determined not to be a Benefit of the Plan or Medically Necessary, the Claims Administrator may deny payment and you will be responsible for all billed charges.

You do not need prior authorization for Emergency Services or emergency Hospital admissions at Participating or Non-Participating facilities. For non-emergency inpatient services, your provider should request prior authorization at least five business days before admission.

Call Accolade Customer Service or visit member.accolade.com or blueshieldca.com and click on Prior Authorization List for more details about medical and surgical services and select prescription Drugs that require prior authorization.

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization.

Frequently-utilized services that require prior authorization

Benefit	*Services that require prior authorization*
Medical	• Surgery • Prescription Drugs administered by a Health Care Provider • Non-emergency inpatient facility services, such as Hospitals and Skilled Nursing Facilities • Non-emergency ambulance services • Routine patient care received while enrolled in a clinical trial • Hospice program enrollment
Radiological and nuclear imaging	• CT (Computerized Tomography) scan • MRI (Magnetic Resonance Imaging) • MRA (Magnetic Resonance Angiography) • PET (Positron Emission Tomography) scan • Diagnostic cardiac procedure utilizing nuclear medicine
Mental health and substance use disorder	• Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Behavioral Health Treatment • Electroconvulsive therapy • Psychological testing • Partial Hospitalization Program • Intensive Outpatient Program • Transcranial magnetic stimulation

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical and mental health and substance use disorder requests	Within five business days
Expedited medical and mental health and substance use disorder requests	Within 72 hours

Expedited requests include urgent medical requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

While you are in the Hospital (inpatient utilization review)

When you are admitted to the Hospital, your stay will be monitored for continued Medical Necessity. If it is no longer Medically Necessary for you to receive an inpatient level of care, the Claims Administrator will send a written notice to you, your provider, and the Hospital. If you choose to stay in the Hospital past the date indicated in this notice, you will be financially responsible for all inpatient charges after that date. Exceptions to inpatient utilization review include maternity and mastectomy care.

For maternity, the minimum length of an inpatient stay is 48 hours for a normal, vaginal delivery and 96 hours for a C-section. The provider and mother together may decide that a shorter length of stay is adequate.

For mastectomy, you and your provider determine the Medically Necessary length of stay after the surgery.

After you leave the Hospital (discharge planning)

You may still need care at home or in another facility after you are discharged from the Hospital. The Claims Administrator will work with you, your provider, and the Hospital's discharge planners to determine the most appropriate and cost-effective way to provide this care.

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your Plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. An Accolade care management nurse may contact you to see how we might help you manage your health condition. You may also request care management support by calling Accolade Customer Service. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and
- Identify community resources to lend support as you learn to manage a chronic health condition.

Alternative services may be offered when they are medically appropriate and only utilized when you, your provider, and the Claims Administrator mutually agree. The availability of these services is specific to you for a set period of time based on your health condition. The Claims Administrator does not give up the right to administer your Benefits according to the terms of this Benefit Booklet or to discontinue any alternative services when they are no longer medically appropriate. The Plan is not obligated to cover the same or similar alternative services for any other Member in any other instance.

Managing a serious illness (palliative care services)

The Claims Administrator covers palliative care services if you have a serious illness. Palliative care provides relief from the symptoms, pain, and stress of a serious illness to help improve the quality of life for you and your family.

Palliative care services include access to Physicians and case managers who are specially trained to help you:

- Manage your pain and other symptoms;
- Maximize your comfort, safety, autonomy, and well-being;
- Navigate a course of care;
- Make informed decisions about therapy;
- Develop a survivorship plan; and
- Document your quality-of-life choices.

Your payment information

Paying for coverage

The Employer is responsible for funding the payment of claims for Benefits under this Plan.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Claims Administrator's Allowable Amount.

Your Cost Share includes any:

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

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Allowable Amount

The Allowable Amount is the lower of either the Claims Administrator's Agreed Amount, or the Claims Administrator's Reasonable Amount.

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

Generally, the Claims Administrator will pay its portion of the Allowable Amount and you will pay your Cost Share. If there is a payment dispute between the Claims Administrator and a Participating Provider over Covered Services you receive, the Participating Provider must resolve that dispute with the Claims Administrator. You are not required to pay for the Claims Administrator'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 the Claims Administrator begins payment. The Claims Administrator will pay for some Covered Services before you meet your Deductible.

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

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

- An individual Member and an entire Family; and
- Participating Providers and Non-Participating Providers.

If your Plan has individual coverage and you enroll a Dependent, your Plan will have Family coverage. Any amount you have paid toward the Deductible for your Plan with individual coverage will be applied to both the individual Deductible and the Family Deductible for your new Plan.

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

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 any applicable Deductible, Copayment, and Coinsurance and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year. If you want information about your Out-of-Pocket Maximum, you can call Accolade Customer Service.

Some plans may have a separate Out-of-Pocket Maximum for:

- An individual Member and an entire Family;
- Participating Providers and Non-Participating Providers; and
- Participating Providers and combined Participating and Non-Participating Providers.

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

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

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

- Charges for Services which are specifically excluded from accumulating to the Out-of-Pocket Maximum.

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

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

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Services until you reach any applicable Deductible. Once you reach any applicable Deductible, the Claims Administrator will pay the Allowable Amount for Covered Services, minus your Copayment or Coinsurance amounts, until you reach your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services. Exceptions are described above.

EXAMPLE
Cost to visit the doctor

Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

Example: You visit the doctor for a sore throat. You have received Covered Services throughout the year and have already met your $500 Deductible. However, you have not yet met your $1,000 Out-of-Pocket Maximum.

Deductible: **$500**

Amount paid to date toward Deductible: **$500**

Out-of-Pocket Maximum: **$1,000**

Amount paid to date toward Out-of-Pocket Maximum: **$500**

Participating Provider Copayment: **$30**

Non-Participating Provider Copayment: **$40**

The Claims Administrator's Allowable Amount for the doctor's visit: **$100**

Non-Participating Provider billed charge for the doctor's visit: **$140**

	Participating Provider	***Non-Participating Provider***
You pay	**$30** ($30 Copayment)	**$80** ($40 Copayment plus $40 for charges over Allowable Amount)
The Claims Administrator pays	$70 (Allowable Amount minus your Cost Share)	$60 (Allowable Amount minus your Cost Share)
Total payment to the doctor	$100 (Allowable Amount)	$140 (Billed charge)

In this example, because you have already met your Deductible, you are responsible for:

- Participating Provider: the Copayment; or
- Non-Participating Provider: the Copayment plus all charges over the Allowable Amount.

Claims

When you receive health care services, a claim must be submitted to request payment for Covered Services. A claim must be submitted even if you have not yet met your Deductible. The Claims Administrator uses claims information to track dollar amounts that count toward your Deductible and Out-of-Pocket Maximum.

When you see a Participating Provider, your provider submits the claim to the Claims Administrator. When you see a Non-Participating Provider, you must submit the claim to the Claims Administrator.

For claim forms, please call Accolade Customer Service or visit member.accolade.com or blueshieldca.com. Please submit your claim form and medical records within one year of the service date. Claims submitted more than one year after the service date will be denied.

See the *Out-of-Area services* section in the *Other important information about your plan* section for more information on claims outside of California.

How to submit a claim

Type of claim	*What to submit*	*Where to submit it*	*Due date*
Medical services	• The Claims Administrator claim form; and • The itemized bill from your provider	Blue Shield of California P.O. Box 272540 Chico, CA 95927	Within one year of the service date

Claim processing and payments

The Claims Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The Claims Administrator cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by the Claims Administrator to the provider.

When you receive Covered Services from a Non-Participating Provider, the Claims Administrator may send the payment to the Participant, or directly to the Non-Participating Provider.

The Participant is responsible to ensure that ***the Non-Participating Provider*** receives the ***full billed amount***, whether or not the Claims Administrator makes payment to the Non-Participating Provider.

Your coverage

This section explains eligibility and enrollment for this Plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this Plan

You are eligible to enroll in the Plan if you meet the eligibility rules as defined in the San Francisco Health Service System (SFHSS) Member Rules, which are available at www.sfhss.org/san-francisco-health-service-system-member-rules. An eligible Member may have eligible Dependents as defined in the SFHSS Member Rules, your child or your Spouse or Domestic Partner's child as defined by the SFHSS Eligibility Rules.

An eligible Dependent child age 26 or older can remain enrolled as a Dependent if the child meets the eligibility rules as defined in the San Francisco Health Service System (SFHSS) Rules which are available at https://sfhss.org/san-francisco-health-service-system-member-rules.

> If both partners in a marriage or Domestic Partnership are eligible SFHSS Members and Participants, they are not eligible to be Dependents of each other. You may enroll a child as a Dependent of either parent but not both.

Enrollment and effective dates of coverage

As an SFHSS Member, you can enroll in coverage for yourself and your Dependents during your initial enrollment period, your Employer's annual open enrollment period, or if you qualify for a special enrollment period.

Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage, as determined by San Francisco Health Service System (SFHSS) Member Rules. The Benefits of this plan are not available before the effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. You will have an annual open enrollment period set by your Employer. Your Employer will notify its SFHSS Members of the open enrollment period each year.

Special enrollment period

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Qualifying Event.

A special enrollment period gives you at least 30 days from a Qualifying Event to apply for or change coverage for yourself or your Dependents. See the *Special enrollment period* section for more information. You should notify your Employer as soon as possible if you experience a Qualifying Event that requires a change in your coverage.

Common Qualifying Events
Change in Dependents
Loss of coverage under another employer health plan or other health insurance
Loss of eligibility in a government program

For a complete list of Qualifying Events, see ***Special enrollment period*** on page 75 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Participant. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the SFHSS Member or Dependents qualify for a special enrollment period, coverage will begin no later than the 1st of the month following the date Blue Shield receives the request for special enrollment from your Employer.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

- Newborn;
- Adopted child;
- Child placed for adoption;
- Child placed in foster care; or
- Child for whom the Participant, spouse, or Domestic Partner is the court-appointed legal guardian.

For coverage to continue beyond 31 days for a newborn, adopted child, or child placed for adoption, the Participant must ***notify and submit the required documentation to your Employer within 30 days*** of birth, adoption, or placement for adoption.

Plan changes

The Plan Sponsor 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;
- Participant Contributions; and
- Limitations and exclusions.

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.

Coordination of benefits

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits determines which plan will pay first when both plans have responsibility for paying the medical claim. For more information, see the *Coordination of benefits, continued* section.

When coverage ends

Your coverage will end if:

- You are no longer eligible for coverage in this Plan;
- Your Employer terminates or discontinues the Plan;
- The Participant cancels coverage; or
- The Claims Administrator cancels or rescinds coverage.

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

If your Employer terminates or discontinues the Plan

Your Employer may terminate or discontinue the Plan at any time.

If the Participant cancels coverage

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

Reinstatement

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

If the Claims Administrator cancels coverage

The Claims Administrator can cancel your coverage if you or your Dependent commit fraud or intentional misrepresentation of material fact.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

The Claims Administrator may cancel or rescind your coverage if you or your Dependent commit fraud or intentional misrepresentation of material fact. The Claims Administrator will send the Notice of Cancellation or Rescission to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation or Rescission. Rescission voids the coverage as if it never existed, between the party which committed the fraud or intentional

misrepresentation of material fact and Blue Shield. Cancellation or rescission is effective on the date specified in the Notice of Cancellation or Rescission and the Notice of End of Coverage.

Continuation of group coverage

Please examine your options carefully before declining this coverage.

You can continue coverage under this Plan when your Employer is subject to Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended.

Your benefits under the group continuation of coverage provisions will be identical to the Benefits you would have received as an active Participant if the qualifying event had not occurred. Any changes in the coverage available to active Participants will also apply to group continuation coverage.

COBRA

You may elect to continue group coverage under this Plan if you would otherwise lose coverage because of a COBRA qualifying event. Please contact your Employer for detailed information about COBRA continuation coverage, including eligibility, election of coverage, and COBRA dues.

COBRA qualifying event

A qualifying event is defined as a loss of coverage as a result of any one of the following occurrences.

- With respect to the Participant:
  - the termination of employment (other than by reason of gross misconduct); or
  - the reduction of hours of employment to less than the number of hours required for eligibility.
- With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Participant or Domestic Partner during a COBRA continuation period may be immediately added as Dependents, provided the Employer 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 Participant elects to enroll.
  - the death of the Participant; or
  - the termination of the Participant's employment (other than by reason of such Participant's gross misconduct); or
  - the reduction of the Participant's hours of employment to less than the number of hours required for eligibility; or
  - the divorce or legal separation of the Participant from the Dependent spouse or termination of the domestic partnership; or
  - the Participant's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
  - a Dependent child's loss of Dependent status under this Plan.

- With respect to a Participant 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.
- With respect to any of the above, such other qualifying event as may be added to Title X of COBRA.

Notification of a qualifying event

You are responsible for notifying your 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 Member's death, termination, or reduction of hours of employment, the Member'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 you by first class mail of your right to continue group coverage under this Plan. You must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of your right to continue group coverage or (2) the date coverage terminates due to the qualifying event.

If you do not notify the COBRA administrator within 60 days, your coverage will terminate on the date you would have lost coverage because of the qualifying event.

Duration and extension of group continuation coverage

In no event will continuation of group coverage under COBRA be extended for more than 3 years from the date the qualifying event has occurred which originally entitled you 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 Participant elects to enroll.

Payment of COBRA dues

COBRA dues for the Member continuing coverage shall be 102 percent of the applicable group dues rate, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability

determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group premium rate.

If you are contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all dues contributions to the Claims Administrator in the manner and for the period established under this Plan.

Effective date of the continuation of group coverage

The continuation of coverage will begin on the date your 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 COBRA dues are timely paid.

Termination of group continuation 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:

- Termination of the Plan (if your Employer continues to provide any group health benefit plan for SFHSS Members, you may be able to continue coverage with another plan);
- Failure to pay COBRA dues in full and on time to the Claims Administrator. Coverage will end as of the end of the period for which COBRA dues were paid;
- You become covered under another group health plan;
- You become entitled to Medicare; or
- You commit fraud or deception in the use of the services of this Plan.

Continuation of group coverage while on leave

Employers are responsible to ensure compliance with state and federal laws regarding leaves of absence, including the Family and Medical Leave Act and the Uniformed Services Employment and Re-employment Rights Act.

Family leave

The federal Family and Medical Leave Act of 1993 allow you to continue your coverage under this Plan while you are on family leave. Your Employer is solely responsible for notifying SFHSS Members of the availability and duration of family leaves.

Military leave

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) allows you to continue your coverage under this Plan while you are on military leave. If you are planning to enter the Armed Forces, you should contact your Employer for information about your rights under the (USERRA).

Your Benefits

This section describes the Benefits your plan covers. They are listed in alphabetical order so they are easy to find.

The Claims Administrator 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 Plan.

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. The Claims Administrator'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.

See the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Acupuncture services

Benefits are available for acupuncture evaluation and treatment. Acupuncture services must be provided by a Physician, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider. Benefits are limited to $1,000 per Calendar Year for any combination of Participating and Non-Participating Providers.

Contact the Claims Administrator with questions about acupuncture services or acupuncture Benefits.

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
- Preparation and provision of allergy serum; and
- Allergy serum injections.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

Benefits are available for ambulance services provided by a licensed ambulance or psychiatric transport van.

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and
- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

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

Bariatric surgery Benefits

Benefits are available for bariatric surgery services. These Benefits include facility and Physician services for the surgical treatment of morbid obesity.

Services for residents of designated California counties

The Claims Administrator has a network of Participating Providers for bariatric surgery services in certain designated counties within California. If you live in a designated county, services are only covered if you receive them from one of these Participating Providers.

Bariatric surgery services designated counties		
Imperial	Orange	San Diego
Kern	Riverside	Santa Barbara
Los Angeles	San Bernardino	Ventura

Travel expense reimbursement for residents of designated counties

You may be eligible for reimbursement of your travel expenses for bariatric surgery services if you meet the following conditions:

- Live in a designated county;
- Live at least 50 miles away from the nearest Bariatric Surgery Services Provider in the network;
- Receive prior authorization for travel expense reimbursement; and
- Submit receipts and any other documentation of your expenses to the Claims Administrator.

Reimbursable bariatric surgery travel expenses		
Expense type	***Maximum reimbursement***	***Limitations & exclusions***
Transportation to and from the facility	$130/roundtrip	• Maximum of 3 roundtrips (pre-surgery, surgery, follow-up) • 1 companion is covered for a maximum of 2 roundtrips (surgery & surgery follow-up)
Hotel accommodations	$100/day	• Maximum of 2 trips, 2 days/trip (pre-surgery & post-surgery follow-up) for you and 1 companion • 1 companion alone may be reimbursed for a maximum of 4 days during your surgery admission • Hotel stays are limited to 1 double-occupancy room. Only the room is covered. All other hotel expenses are excluded
Related reasonable expenses	$25/day/Member	• Maximum of 4 days/trip • Expenses for tobacco, alcohol, drugs, phone, television, delivery, and recreation are excluded

Services for residents of non-designated counties

If you do not reside in a designated county, bariatric surgery services are covered like other surgery services from Participating or Non-Participating Providers. See the *Hospital services* and *Physician and other professional services* sections for more information.

The Claims Administrator does not reimburse travel expenses associated with bariatric surgery services for residents of non-designated counties.

Limitations

Participating Provider Benefits for bariatric surgery are limited to $60,000 during the entire period you are covered under the Plan. Non-Participating Provider Benefits for bariatric surgery are limited to $10,000 during the entire period you are covered under the Plan.

Chiropractic services

Benefits are provided for chiropractic services performed by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, adjustments, and plain film X-ray services in a chiropractor's office. Benefits are limited to $1,000 per Calendar Year for any combination of Participating and Non-Participating Providers.

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

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

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

The clinical trial must have therapeutic intent and the treatment must meet one of the following requirements:

- Your Participating Provider determines that your participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by you; or
- You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate.

Coverage for routine patient care received while participating in a clinical trial requires prior authorization. Routine patient care is care that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial. The *Summary of Benefits* section lists your Cost Share for Covered Services. These Cost Share amounts are the same whether or not you participate in a clinical trial. Routine patient care does not include:

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-

threatening diseases or conditions, and the study or investigation meets one of the following requirements:

- It is a drug trial conducted under an investigational new drug application reviewed by the FDA;
- It is a drug trial exempt under federal regulations from a new drug application; or
- It is federally funded or approved by one or more of the following:
    - One of the National Institutes of Health;
    - The Centers for Disease Control and Prevention;
    - The Agency for Health Care Research and Quality;
    - The Centers for Medicare & Medicaid Services; or
    - A designated Agency affiliate or research entity as described in the Affordable Care Act, including the Departments of Veterans Affairs, Defense, or Energy if the study has been reviewed and approved according to Health and Human Services guidelines.

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately-licensed Health Care Provider who is certified as a diabetes educator.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including continuous blood glucose monitoring supplies and those designed to help the visually impaired;
- Insulin pens, syringes, pumps and all related necessary supplies;
- Blood and urine testing strips and tablets;
- Lancets and lancet puncture devices;
- Podiatric footwear and devices to prevent or treat diabetes-related complications;
- Medically Necessary foot care; and
- Visual aids, excluding eyewear and video-assisted devices, designed to help the visually impaired with proper dosing of insulin.

Your Plan also covers the replacement of a covered item after the expiration of its life expectancy.

Self-management training and medical nutrition therapy

Benefits are available for outpatient training, education, and medical nutrition therapy when directed or prescribed by your Physician. These services can help you manage your diabetes and properly use the devices, equipment, and supplies available to you. With self-management training, you can learn to monitor your condition and avoid frequent hospitalizations and complications.

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

Benefits are available for imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury.

Benefits include:

- Basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography;
- Advanced diagnostic radiological and nuclear imaging, including CT, PET, MRI and MRA scans;
- Clinical pathology services;
- Laboratory services;
- Other areas of Non-invasive diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, cardiovascular, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

Dialysis Benefits

Benefits are available for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting, or in your home.

Benefits include:

- Renal dialysis;
- Hemodialysis;
- Peritoneal dialysis; and
- Self-management training for home dialysis.

Benefits do not include:

- Comfort, convenience, or luxury equipment; or
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

- Mobility devices, such as wheelchairs;
- Peak flow meter for the self-management of asthma;
- Glucose monitor and continuous blood glucose monitoring supplies for the self-management of diabetes;

- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;
- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price; and
- Breast pumps.

Benefits do not include:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers;
- Exercise equipment;
- Routine maintenance, repair, or replacement of DME due to loss or misuse, except when authorized;
- Self-help or educational devices;
- Speech or language assistance devices, except as specifically listed;
- Wigs;
- Adult eyewear;
- Video-assisted visual aids for diabetics;
- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes. Self-applied continuous blood glucose monitoring supplies are also covered under the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

Orthotic equipment and devices

Benefits are available for orthotic equipment and devices you need to perform Activities of Daily Living. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for postoperative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts 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;
- Device fitting and adjustment;

- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities;
- Orthopedic shoes and other supportive devices for the feet, except as listed;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Prosthetic equipment and devices

Benefits are available for prosthetic appliances and devices used to replace a part of your body that is missing or does not function, and related supplies.

Benefits include:

- Tracheoesophageal voice prosthesis (e.g. Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- Supplies necessary for the operation of prostheses;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Speech or language assistance devices, except as listed;
- Dental implants;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Emergency Benefits

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

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

Benefits include:

- Physician services;
- Emergency room facility services; and
- Inpatient Hospital services to stabilize your Emergency Medical Condition.

After your condition stabilizes

Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

- Be released from the emergency room if you do not need further treatment;
- Receive additional inpatient treatment at the Participating Hospital; or
- Transfer to a Participating Hospital for additional inpatient treatment if you received treatment of your Emergency Medical Condition at a Non-Participating Hospital.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or unborn child, stabilize means delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

If you are admitted to the Hospital for Emergency Services, you should notify the Claims Administrator within 24 hours or as soon as possible after your condition has stabilized.

Family planning Benefits

Family planning

Benefits are available for family planning services without illness or injury.

Benefits include:

- Diagnosis and treatment of the cause of Infertility;
- Diaphragm fitting;
- Counseling, consulting, and education;
- Implantable contraceptives;
- Insertion and/or removal of intrauterine device (IUD);
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Tubal ligation; and
- Vasectomy.

Family planning services may also be covered under the Preventive Health Services Benefit and the Prescription Drug Benefits Rider, if your Employer selected it as an optional Benefit.

Infertility Benefits

Only the Member, spouse or Domestic Partner is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, ambulatory surgery center, related services and injectable drugs administered by a provider to a Member, spouse or Domestic Partner for the inducement of fertilization as described herein. No Benefits are provided when the infertile condition is caused by elective chemical or surgical sterilization procedures.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth.

Benefits are provided for a Member, spouse or Domestic Partner who meets the definition of Infertility for a medically appropriate diagnostic work-up, unless otherwise stated below, and the procedures listed below. A lifetime benefit maximum will be listed, if applicable:

- Six (6) natural (without ovum [oocyte or ovarian tissue (egg)] stimulation) or stimulated (with ovum [oocyte or ovarian tissue] stimulation) artificial inseminations per person per lifetime;
- Two (2) in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT) per person per lifetime;
  - Two (2) fresh or frozen transfer cycles per person per lifetime, which includes transfers performed during embryo, gamete or zygote transfer cycles. These Covered Services must be received in conjunction with any of the following Covered Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT);
- Intracytoplasmic sperm injection (ICSI);
- One (1) embryo transportation per person per lifetime, up to $500 maximum;
- One (1) microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), or testicular sperm aspiration (TESA) per person per lifetime, if the Member, spouse, or Domestic Partner has not had a previous vasectomy;
- Embryo biopsy for preimplantation genetic screening (PGS) or diagnosis (PGD);
- Cryopreservation of sperm/ oocytes/ovarian tissue/testicular tissue/embryos when retrieved from a Member, spouse or Domestic Partner covered within. Benefits are limited to one (1) retrieval and one (1) year of storage per person per lifetime. A current diagnosis of Infertility for a medically appropriate diagnostic work-up is not required for this Benefit.

Note: the lifetime benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

The Member, spouse or Domestic Partner is responsible for the Copayment or Coinsurance listed for all professional and Hospital Services, ambulatory surgery center and related services used in connection with any procedure covered under this Benefit, and injectable drugs administered by a provider during a course of

treatment to diagnose Infertility or induce fertilization. If your Employer selected the Prescription Drug Benefit as an optional Benefit, self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance. Procedures must be consistent with established medical practice in the treatment of Infertility and authorized by the Claims Administrator.

The Calendar Year Medical Deductible does not apply to these Covered Services and Copayments or Coinsurances for these Covered Services do not apply towards the Out-of-Pocket Maximum responsibility.

No Benefits are provided for:

- Outpatient prescription Drugs prescribed for self-administration, if your Employer did not select the Prescription Drug Rider;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical benefits portion of the Benefit Booklet;
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Claims Administrator health plan, Covered Services for Pregnancy and Maternity Care for the surrogate mother will be covered under that health plan;
- Services for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Member, spouse or Domestic Partner;
- Cryopreservation of sperm, oocytes, ovarian tissue, testicular tissue, or embryos from donors other than the Member, spouse, or Domestic Partner;
- Home ovulation prediction testing kits or home pregnancy tests;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; and
- Covered Services in excess of the lifetime benefit maximums.

Benefits are limited to a Member, spouse or Domestic Partner covered hereunder who meets the definition of Infertility as defined at the time services are provided.

Hearing Aid Services

Your Plan provides coverage for hearing aid services, subject to the conditions and limitations listed below.

The hearing aid services Benefit provides a combined maximum allowance as shown on the Summary of Benefits towards covered hearing aids and services as specified below. You are not required to use a Participating Provider to obtain these services as the Claims Administrator does not maintain a network of contracted providers for these services. You may obtain these services from any provider of your choosing and submit a claim to the Claims Administrator for reimbursement for Covered Services up to the combined maximum allowance. For information on submitting a claim, see the *Claims* section.

Hearing Aids and Ancillary Equipment

The Benefit allowance is provided for hearing aids and ancillary equipment up to the maximum per Member shown in the Summary of Benefits. You are responsible for the cost of any hearing aid services which are in excess of this Benefit allowance.

The hearing aid Benefit includes: a hearing aid instrument, monaural or binaural including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
- Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any 36-month period;
- Surgically implanted hearing devices.

The Calendar Year Deductible does not apply to the services provided in this hearing aid services Benefit.

Hearing aids and ancillary equipment are not included in the calculation of the Calendar Year Out-of-Pocket Maximum amount.

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

Benefits are available from a Participating home health care agency for diagnostic and treatment services received in your home under a written treatment plan approved by your Physician.

Benefits include:

- Intermittent home care for skilled services from:
  - Registered nurses;
  - Licensed vocational nurses;
  - Physical therapists;
  - Occupational therapists;
  - Speech and language pathologists;
  - Licensed clinical social workers; and
  - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

- Fewer than seven days per week; or
- Daily, for fewer than eight hours per day, up to 21 days.

Benefits are limited to a visit maximum as shown in the *Summary of Benefits* section for home health agency visits. For this Benefit, coverage includes:

- Up to four visits per day, two hours maximum per visit, with a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or licensed clinical social worker. A visit of two

hours or less is considered one visit. Nursing visits cannot be combined to provide Continuous Nursing Services.
- Up to four hours maximum per visit with a Home Health Aide. A visit of four hours or less is considered one visit.

Benefits do not include:

- Continuous Nursing Services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These services may also be described as "shift care" or "private-duty nursing."

Home infusion and injectable medication services

Benefits are available through a Participating home infusion agency for home infusion, enteral, and injectable medication therapy.

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Administration of parenteral nutrition formulations and solutions;
- Administration of enteral nutrition formulas and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

See the *PKU formulas and special food products* section for more information.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include:

- Insulin;
- Insulin syringes; and
- Services related to hemophilia, which are described below.

Hemophilia home infusion services

Benefits are available for hemophilia home infusion products and services for the treatment of hemophilia and other bleeding disorders. Benefits must be prior authorized and provided in the home or in an infusion suite managed by a Participating Hemophilia Home Infusion Provider.

Benefits include:

- 24-hour service;
- Home delivery of hemophilia infusion products;
- Blood factor product;
- Supplies for the administration of blood factor product; and
- Nursing visits for training or administration of blood factor products.

There is no Calendar Year visit maximum for hemophilia home infusion agency services.

Benefits do not include:

- In-home services to treat complications of hemophilia replacement therapy; or

- Self-infusion training programs, other than nursing visits to assist in administration of the product.

Most Participating home health care and home infusion agencies are not Participating Hemophilia Home Infusion Providers. For a list of Participating Hemophilia Home Infusion Providers, please call Accolade Customer Service or visit member.accolade.com or blueshieldca.com.

Hospice program services

Benefits are available through a Participating Hospice Agency for specialized care if you have been diagnosed with a terminal illness with a life expectancy of one year or less. When you enroll in a Hospice program, you agree to receive all care for your terminal illness through the Hospice Agency. Hospice program enrollment is prior authorized for a specified period of care based on your Physician's certification of eligibility. The period of care begins the first day you receive Hospice services and ends when the specified timeframe is over or you choose to receive care for your terminal illness outside of the Hospice program.

The authorized period of care is for two 90-day periods followed by unlimited 60-day periods, depending on your diagnosis. Your Hospice care continues through to the next period of care when your Physician recertifies that you have a terminal illness. The Hospice Agency works with your Physician to ensure that your Hospice enrollment continues without interruption. You can change your Participating Hospice Agency only once during each period of care.

A Hospice program provides interdisciplinary care designed to ease your physical, emotional, social, and spiritual discomfort during the last phases of life, and support your primary caregiver and your family. Hospice services are available 24 hours a day through the Hospice Agency.

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;
- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;

- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

- Services provided by a Non-Participating Hospice Agency, except in certain circumstances where there are no Participating Hospice Agencies in your area and services are prior authorized.

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
  - Semiprivate Hospital room, or private room if Medically Necessary;
  - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
  - General and specialized nursing care; and
  - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
  - Operating, recovery, labor and delivery, and other specialized treatment rooms;
  - Anesthesia, oxygen, medicines, and IV solutions;
  - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
  - Dialysis services and supplies;
  - Blood and blood products;
  - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
  - Radiation therapy, chemotherapy, and associated supplies;
  - Therapy services, including physical, occupational, respiratory, and speech therapy;
  - Acute detoxification;
  - Acute inpatient rehabilitative services; and
  - Emergency room services resulting in admission.

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

Benefits are available for outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues.

Benefits include:

- Treatment of odontogenic and non-odontogenic oral tumors (benign or malignant);
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;
- Surgical treatment of temporomandibular joint syndrome (TMJ);
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:
    - The Member is younger than seven years old; or
    - The Member is developmentally disabled; or
    - The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

- Diagnostic dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ;
- Preventive dental services such as cleanings, space maintainers, and habit control devices except as covered under the Preventive Health Services Benefit;
- Periodontal care such as hard and soft tissue biopsies and routine oral surgery including removal of teeth;
- Reconstructive or restorative dental services such as crowns, fillings, and root canals;
- Orthodontia for any reason other than cleft palate repair;
- Dental implants for any reason other than cleft palate repair;
- Any procedure to prepare the mouth for dentures or for the more comfortable use of dentures;
- 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; or
- Fluoride treatments for any reason other than preparation of the oral cavity for radiation therapy or for Benefits covered under Preventive Health Services.

Mental Health and Substance Use Disorder Benefits

The Claims Administrator administers Mental Health Services and Substance Use Disorder Services for Members. See the *Out-of-area services* section for an explanation of how Benefits are administered for out-of-state services.

A Participating Provider must get prior authorization from the Claims Administrator for all non-emergency Hospital admissions for Mental Health Services and Substance Use Disorder Services, and for certain outpatient Mental Health and Substance Use Disorder Services. See the *Medical Management Programs* section for more information about prior authorization.

Office visits

Benefits are available for professional office visits, including Physician office visits, for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions in an individual, Family, or group setting.

Benefits are also available for telebehavioral health online counseling services, psychotherapy, and medication management with a mental health or substance use disorder provider.

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions. You can receive these other outpatient services in a facility, office, home, or other non-institutional setting.

Other Outpatient Mental Health and Substance Use Disorder Services include, but are not limited to:

- Behavioral Health Treatment – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, prescribed by a Physician or licensed psychologist and provided under a treatment plan to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression;
- Intensive Outpatient Program – outpatient care for Mental Health Conditions or Substance Use Disorder Conditions when your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services at least five hours per day, four days per week when you are admitted directly or transferred from acute inpatient care following stabilization;
- Psychological Testing – testing to diagnose a Mental Health Condition; and
- Transcranial magnetic stimulation – a Non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Benefits do not include:

- Treatment for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health Conditions and Substance Use Disorder Conditions in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when you do not require acute inpatient care.

Medically Necessary inpatient substance use disorder detoxification is covered under the Hospital services Benefit.

Nutritional counseling

Benefits are available for medical education services provided in a Physician's office by a Physician or appropriately-licensed Health Care Provider.

Benefits are limited to four (4) visits per Calendar Year. This visit limit applies to Participating Providers and Non-Participating Providers combined.

Physician and other professional services

Benefits are available for services performed by a Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition.

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications;
- Administration of radiopharmaceutical medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment; and
- Teladoc general medical consultations.

See the *Mental Health and Substance Use Disorder Benefits* section for information on Mental Health and Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

Medical nutrition therapy

Benefits are provided for office visits for medical nutrition therapy for conditions other than diabetes. Treatment must be prescribed by a Physician and provided by a Registered Dietitian Nutritionist or other appropriately-licensed or certified Health Care Provider. You can continue to receive medical nutrition therapy as long as your treatment is Medically Necessary. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity. See the *Diabetes care services* section for information about medical nutrition therapy for diabetes.

PKU formulas and special food products

Benefits are available for formulas and special food products if you are diagnosed with phenylketonuria (PKU). The items must be part of a diet prescribed and managed by a Physician or appropriately-licensed Health Care Provider.

Benefits include:

- Enteral formulas;
- Parenteral nutrition formulations; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods including shakes, snack bars, used by the general population;
- Additives such as thickeners, enzyme products; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

Benefits are available for the diagnosis and treatment of conditions of the foot, ankle, and related structures. These services, including surgery, are generally provided by a licensed doctor of podiatric medicine.

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;
- Elective newborn circumcision within 18 months of birth; and
- Abortion and abortion-related services, including pre-abortion and follow-up services.

See the *Diagnostic X-ray, imaging, pathology, and laboratory services* and *Preventive Health Services* sections for information about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

The Newborns' and Mothers' Health Protection Act requires 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. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage. The Claims Administrator covers Preventive Health Services whether you receive them from a Participating Provider or from a Non-Participating Provider.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
  - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
  - Screening for HPV;
  - Screening for osteoporosis; and
  - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. See the *Family planning Benefits* section for more information.

If there is a new recommendation or guideline in any of the resources described above, the Claims Administrator will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the Plan Year that begins after that year.

Call Accolade Customer Service or visit ***member.accolade.com*** or ***blueshieldca.com/preventive*** for more information about ***Preventive Health Services***.

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to:
  - Improve function; or

    - Create a normal appearance to the extent possible;
- Surgery related to the treatment of gender dysphoria;
- Dental and orthodontic surgery services directly related to cleft palate repair; and
- Surgery and surgically-implanted prosthetic devices in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance;
- Reconstructive Surgery when there is a more appropriate procedure that will be approved; or
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

In accordance with the WHCRA, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered for either breast to restore and achieve symmetry following a mastectomy, and for the treatment of the physical complications of a mastectomy, including lymphedemas. For coverage of prosthetic devices following a mastectomy, see the *Durable medical equipment* section. Medically Necessary services will be determined by your attending Physician in consultation with you.

Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

Rehabilitative and habilitative services

Benefits are available for outpatient rehabilitative and habilitative services. Rehabilitative services help to restore the skills and functional ability you need to perform Activities of Daily Living when you are disabled by injury or illness. Habilitative services are therapies that help you learn, keep, or improve the skills or functioning you need for Activities of Daily Living.

These services include physical therapy, occupational therapy, and speech therapy. Your Physician or Health Care Provider must prepare a treatment plan. Treatment must be provided by an appropriately-licensed or certified Health Care Provider. You can continue to receive rehabilitative or habilitative services as long as your treatment is Medically Necessary.

The Claims Administrator may periodically review the provider's treatment plan and records for Medical Necessity.

See the *Hospital services* section for information about inpatient rehabilitative Benefits.

See the *Home health services* and *Hospice program services* sections for information about coverage for rehabilitative and habilitative services provided in the home.

Physical therapy

Physical therapy uses physical agents and therapeutic treatment to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents and therapeutic treatments include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage as a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan.

Occupational therapy

Occupational therapy is treatment to develop, improve, and maintain the skills you need for Activities of Daily Living, such as dressing, eating, and drinking.

Speech therapy

Speech therapy is used to develop, improve, and maintain vocal or swallowing skills that have not developed according to established norms or have been impaired by a diagnosed illness or injury. Benefits are available for outpatient speech therapy for the treatment of:

- A communication impairment;
- A swallowing disorder;
- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the *Summary of Benefits* section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

Transplant services

Benefits are available for tissue and kidney transplants and special transplants.

Tissue and kidney transplants

Benefits are available for facility and professional services provided in connection with human tissue and kidney transplants when you are the transplant recipient.

Benefits include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special transplants

Benefits are available for special transplants only if:

- The procedure is performed at a special transplant facility contracting with the Claims Administrator, or if you access this Benefit outside of California, the procedure is performed at a transplant facility designated by the Claims Administrator; and
- You are the recipient of the transplant.

Special transplants are:

- Human heart transplants;
- Human lung transplants;
- Human heart and lung transplants in combination;
- Human liver transplants;
- Human kidney and pancreas transplants in combination;
- 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;
- Pediatric human small bowel transplants; and
- Pediatric and adult human small bowel and liver transplants in combination.

Donor services

Transplant Benefits include coverage for donation-related services for a living donor, including a potential donor, or a transplant organ bank. Donor services must be directly related to a covered transplant for a Member of this plan.

Donor services include:

- Donor evaluation;
- Harvesting of the organ, tissue, or bone marrow; and
- Treatment of medical complications for 90 days after the evaluation or harvest procedure.

Travel and lodging expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Participating Provider for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up.
- Lodging for the patient (while not a Hospital inpatient) and one companion as described below.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Participating Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Member if the reimbursement exceeds the per diem rate.

- Transplant programs offer a combined overall lifetime maximum of $10,000 per Member for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries;
- Alcoholic beverages;
- Personal or cleaning supplies;
- Meals;
- Over-the-counter dressings or medical supplies;
- Deposits;
- Utilities and furniture rental, when billed separate from the rent payment;
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Participating Provider;
- Taxi fares (not including limos or car services);
- Economy or coach airfare;
- Parking;
- Trains;
- Boat;
- Bus;
- Tolls.

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health.

See the *Out-of-area services* section for information on urgent care services outside California.

Exclusions and limitations

This section describes the general exclusions and limitations that apply to all your plan Benefits.

	General exclusions and limitations
1	This Plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.
2	Routine physical examinations solely for: • Immunizations and vaccinations, by any mode of administration (oral, injection, or otherwise), for the purpose of travel; or • Licensure, employment, insurance, court order, parole, or probation. This exclusion does not apply to Medically Necessary services that the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.
3	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	Routine foot care items and services that are not Medically Necessary, including: • Callus treatment; • Corn paring or excision; • Toenail trimming; • Over-the-counter shoe inserts or arch supports; or • Any type of massage procedure on the foot. This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.
5	Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. 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. 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.
6	Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.

General exclusions and limitations	
7	Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the *Home infusion and injectable medication services* and *PKU formulas and special food products* sections, or as provided through a Participating Hospice Agency. This exclusion does not apply to Medically Necessary services that Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.
8	For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition.
9	Eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the *Prosthetic equipment and devices* section. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
10	Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the *Prosthetic equipment and devices* section.
11	Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections.
12	Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.
13	Treatment of sexual dysfunctions and sexual inadequacies. This exclusion does not apply to the treatment of organically-based conditions.
14	Home testing devices and monitoring equipment. This exclusion does not apply to items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
15	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.
16	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.

General exclusions and limitations	
17	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to Medically Necessary services that Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child services.
18	Select physical and occupational therapies, such as: • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; and • Vocational, educational, recreational, art, dance, music, or reading therapy. This exclusion does not apply to Medically Necessary services that the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.
19	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or nutritional counseling provided under the *Nutritional counseling* section, or to Medically Necessary services that the Claims Administrator is required by law to cover for Severe Mental Illnesses, Serious Emotional Disturbances of a Child, or Preventive Health Services.
20	Services or Drugs that are Experimental or Investigational in nature.
21	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. 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

	General exclusions and limitations
	prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.
22	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
23	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, and food delivery services.
24	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.
25	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 the Claims Administrator provides payment for such services, we will be entitled to establish a lien up to the amount paid by the Claims Administrator for the treatment of such injury or disease.
26	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), except as allowed through *Transplant services*.
27	Prescribed Drugs and medicines for outpatient care except as provided through a Participating Hospice Agency when the Member is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drugs Benefits or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section.
28	Rehabilitative Services, except as specifically provided in the *Home health services*, *Hospice program services*, *Hospital services*, or *Rehabilitative and habilitative services* sections.
29	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 the *Home health services*, *Hospice program services*, or *Rehabilitative and habilitative services* sections.
30	Hospital care programs or services provided in a home setting (Hospital-at-home programs).

Internal Appeals

Initial Internal Appeal

If you have received an Adverse Benefit Determination on a claim from the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may submit a request for an appeal to the Claims Administrator. Contact Accolade Customer Service via telephone or visit blueshieldca.com and include relevant information, such as:

- Your name;
- Member ID number;
- Date of service;
- Claim number;
- Provider name;
- Your explanation of what happened and why you believe the original determination was incorrect; and
- Any other supporting documents.

Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be submitted within 60 days after you receive notice of an Adverse Benefit Determination. The Claims Administrator will acknowledge receipt of an appeal within five calendar days. Appeals are resolved in writing within 60 days from the date of receipt by the Claims Administrator, unless qualified for an expedited decision.

Final Internal Appeal

If you are dissatisfied with the initial internal appeal determination by the Claims Administrator, the determination may be appealed in writing to the Claims Administrator within 15 days after the date of receipt of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefor. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse either you or your Health Care Provider for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 60 days from the date of receipt to the Claims Administrator. Written requests for final internal standard appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals

P.O. Box 5588
El Dorado Hills, CA 95762-0011

Expedited Appeal (Initial and Final)

You have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. To initiate a request for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Final Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health. The Claims Administrator will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon as possible to accommodate your condition, not to exceed 72 hours.

External Review

Standard External Review

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment, a rescission of coverage, or consideration of whether the Plan is complying with surprise billing and cost-share protections under the federal No Surprises Act, you, a designated representative, a provider or an attorney on your behalf, may request an external review with an Independent Review Organization.

Requests for external review must be submitted within four months after notice of the final internal appeal determination. The Independent Review Organization will provide a determination within 45 days after the Independent Review Organization receives the request for the external review. Instructions for submitting a request for external review will be outlined in the final internal appeal response letter.

Expedited External Review

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within **four months** from the Adverse Benefit Determination without participating in the initial or final internal appeal process.

To initiate a request for an expedited external review, you, a designated representative, a provider or an attorney on your behalf may fax a request to (844) 696-6071, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California
Attn: Expedited External Review
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Other Resources to Help You

For questions about your appeal rights, or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Other important information about your Plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document.

Your coverage, continued

Special enrollment period

For more information about special enrollment periods, see ***Special enrollment period*** on page 38 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when an eligible Participant or Dependent can enroll in, or change enrollment in, a health plan. The special enrollment period is 30 days following the date of a Qualifying Event except as otherwise specified below. The following are examples of Qualifying Events. For complete details and a determination of eligibility for special enrollment, please consult your Employer.

- Loss of eligibility for coverage, including the following:
  - The eligible SFHSS Member or Dependent loses coverage under another employer health benefit plan or other health insurance and meets all of the following requirements:
    - The SFHSS Member or Dependent was covered under another employer health benefit plan or had other health insurance coverage at the time the SFHSS Member was initially offered enrollment under this Plan;
    - If required by the Employer, the SFHSS Member certified, at the time of the initial enrollment, that coverage under another employer health benefit plan or other health insurance was the reason for declining enrollment provided that the SFHSS Member was given notice that such certification was required and that failure to comply could result in later treatment as a Late Enrollee;
  - The SFHSS Member or Dependent was eligible for coverage under Medicaid (e.g. Healthy Families Program or Medi-Cal) and such coverage was terminated due to loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage;
  - The eligible SFHSS Member or Dependent loses coverage due to legal separation, divorce, loss of dependent status, death of the SFHSS Member, termination of employment, or reduction in the number of hours of employment;
  - In the case of coverage offered through an HMO, loss of coverage because the eligible SFHSS Member or Dependent no longer resides,

lives, or works in the service area (whether or not within the choice of the individual), and if the previous HMO coverage was group coverage, no other benefit package is available to the SFHSS Member or Dependent;
    - Termination of the employer health plan or contributions to SFHSS Member or Dependent coverage;
    - Exhaustion of COBRA group continuation coverage; or
- The SFHSS Member or Dependent is eligible for coverage under a Medicaid (e.g. Healthy Families Program or Medi-Cal) premium assistance program, provided that enrollment is within 60 days of the notice of eligibility for these premium assistance programs;
- A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered SFHSS Member's health benefit Plan. The health Plan shall enroll a Dependent child effective the first day of the month following presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party or the employer, as described in Section 3751.5 and 3766 of the Family Code; or
- An eligible SFHSS Member acquires a Dependent through marriage, establishment of domestic partnership, birth, or placement for adoption. Applies to both the SFHSS Member and the Dependent.

Out-of-area services

Overview

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Services outside of California, the claims for those services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Claims Administrator's payment practices for both kinds of providers are described below and in the *Introduction* section of this Benefit Booklet.

See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard® Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard® Service Area. When you receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what we agreed to in the Benefit Booklet. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard® Program enables you to obtain Covered Services outside of California, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this Benefit Booklet.

The Claims Administrator calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this Benefit Booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard® Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Claims Administrator used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods,

including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard® providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at bcbs.com and select "Find a Doctor."

Prior authorization may be required for non-emergency services. Please see the *Medical Management Programs* section for additional information on prior authorization and the *Emergency Benefits* section for information on emergency admission notification.

Non-participating providers outside of California

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

If you do not see a participating provider through the BlueCard® Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Claims Administrator for reimbursement. The Claims Administrator will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services as listed in the Summary of Benefits. .

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please see the *Medical Management Programs* section for additional information on emergency admission notification.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global® Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global® Core is unlike the BlueCard® Program available within the BlueCard® Service Area in certain ways. For instance, although Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care

from provider outside the BlueCard® Service Area, you will typically have to pay the providers and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global® Core claim

When you pay directly for services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Accolade Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to Covered Services from providers that participate in a Claims Administrator Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes, and Shared Savings arrangements.

From the Find A Doctor search page, click on the hyperlink "Providers outside of CA" under the Accessing Care Outside CA descriptor. National Doctor and Hospital Finder at www.bcbs.com/find-a-doctor, Blue Distinction Center Finder at www.bcbs.com/blue-distinction or by calling (800) 810-BLUE.

BlueCard® Program- Member Benefits of Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

Limitation for duplicate coverage

Medicare

This Plan will provide Benefits before Medicare when:

- You are eligible for Medicare due to age, if the Participant is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Participant is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws); or
- You are eligible for Medicare solely due to end-stage renal disease during the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare.

This Plan will provide Benefits after Medicare when:

- You are eligible for Medicare due to age, if the Participant is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare due to disability, if the Participant is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws);
- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

When this Plan provides Benefits after Medicare, your combined Benefits from Medicare and this Plan may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You do not have to pay any Plan Deductibles, Copayments, or Coinsurance.

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, the Claims Administrator will pay the reasonable value or the Allowable Amount for Covered Services you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, the Claims Administrator will pay the reasonable value or the Allowable Amount for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and this Plan will equal but not be more than what the Claims Administrator would pay if you were not eligible for Benefits under that coverage. The Claims Administrator will provide Benefits based on the reasonable value or the Allowable Amount.

Exception for other coverage

A Participating Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this Plan.

If you recover from a third party the reasonable value of Covered Services received from a Participating Provider, the Participating Provider is not required to accept the fees paid by the Claims Administrator as payment in full. You may be liable to the Participating Provider for the difference, if any, between the fees paid by the Claims Administrator and the reasonable value recovered for those services.

Reductions – third-party liability

If your injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no Benefits will be payable or paid under the Plan unless you agree in writing, in a form satisfactory to the plan, to do all of the following:

- Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;
- Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from your own uninsured or underinsured motorist coverage;
- Execute a lien in favor of the Plan for the full amount of Benefits paid by the plan;
- Ensure that any Recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the plan;
- Periodically respond to information requests regarding the claim against the third party, and notify the plan, in writing, within 10 days after any Recovery has been obtained;
- Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If you fail to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the plan, through deductions from future benefit payments to the you or others enrolled through you in the plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the you or on your behalf, and without regard to whether you have been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in your name, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on your behalf, such as an attorney-client trust account.

You shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, you shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

Your acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys' fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys' fees and costs incurred in connection with the claims against the third party.

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If you receive services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from you the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when you receive payment or reimbursement for medical expenses.

Coordination of benefits, continued

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable expenses. The coordination of benefits rules also determine which group health plan is primary and prevent delays in benefit payments. The Claims Administrator determines the order of benefit payments between two group health plans, as follows:

- When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering you as an SFHSS Member will provide its benefits before the plan covering you as a Dependent.
- Coverage for Dependent children:
    - When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
    - When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.
    - When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:
        - The plan of the custodial parent;
        - The plan of the stepparent; then

        - The plan of the non-custodial parent.
    - If the above rules do not apply, the plan which has covered you for the longer period of time is the primary plan. There may be exceptions for laid-off or retired SFHSS Members.
    - When the Claims Administrator is the primary plan, Benefits will be provided without considering the other group health plan. When the Claims Administrator is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.
    - Anytime the Claims Administrator makes payments over the amount they should have paid as the primary or secondary plan, the Claims Administrator reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

These coordination of benefits rules do not apply to the programs included in the *Limitation for Duplicate Coverage* section.

General provisions

Independent contractors

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

Assignment

The Benefits of this plan, including payment of claims, may not be assigned without the written consent of the Claims Administrator. Participating Providers are paid directly by the Claims Administrator. When you receive Covered Services from a Non-Participating Provider, the Claims Administrator, at its sole discretion, may make payment to the Participant or directly to the Non-Participating Provider. If the Claims Administrator pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between the Claims Administrator and the Non-Participating Provider. The Participant must make sure the Non-Participating Provider receives the full billed amount, whether or not the Claims Administrator makes payment to the Non-Participating Provider.

Plan interpretation

The Claims Administrator shall have the power and authority to construe and interpret the provisions of this plan, to determine the Benefits of this plan, and to determine eligibility to receive Benefits under the Contract. The Claims Administrator shall exercise this authority for the benefit of all Members entitled to receive Benefits under this plan.

Access to information

The Claims Administrator may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this plan and the Contract. By enrolling in this health plan, each

Member agrees that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. Members also agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in the Member's possession. Failure to assist the Claims Administrator 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 the Claims Administrator will be maintained as confidential and will not be disclosed without the Member's consent, except as otherwise permitted or required by law.

Right of recovery

Whenever payment on a claim is made in error, the Claims Administrator has the right to recover such payment from the Participant or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, the Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Participant (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant's coverage, or payments made on fraudulent claims.

Definitions

Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Adverse Benefit Determination	A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for Benefits that is: • based on a determination of a Participant's or Dependent's eligibility to participate in the Plan; • resulting from the application of any utilization review; or • a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
Allowable Amount	Unless otherwise stated in this booklet, the lower of either the Claims Administrator's Agreed Amount, or the Claims Administrator's Reasonable Amount.
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • Is a licensed facility accredited by an ambulatory surgery center accrediting body; and • Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital.
Behavioral Health Treatment (BHT)	Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. BHT includes applied behavior analysis and evidence-based intervention programs.
Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year.

Care Coordination	Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
Care Coordinator	An individual within a provider organization who facilitates Care Coordination for patients.
Care Coordinator Fee	A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
Claims Administrator	The claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.
Claims Administrator's Agreed Amount	The amount agreed upon by the Claims Administrator and the provider or, if there is no agreement, the provider's billed charges.
Claims Administrator's Reasonable Amount	The amount determined by the Claims Administrator to be the fair value of the Services. In its discretion, the Claims Administrator may determine fair value based upon a variety of data or methods that the Claims Administrator determines to be appropriate based on the type of Service and the particular circumstances. The Claims Administrator's determination of fair value typically may include use of one or more of the following factors: (1) the amounts paid by the Claims Administrator to providers who have agreements with the Claims Administrator; (2) studies, surveys or third-party compilations of amounts charged by providers for the Services; (3) amounts paid by governmental or private payors for the Services; or (4) amounts dictated by federal law. In addition, if the Services were rendered outside of California, the Claims Administrator may determine fair value based upon the amounts paid by the local Blue Cross and/or Blue Shield plan for the Services. If the Claims Administrator has not made a determination of the fair value of the Services, then the Claims Administrator's Reasonable Amount will be the provider's billed charges.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for

	brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Deductible	The Calendar Year amount you must pay for specific Covered Services before the Claims Administrator pays for Covered Services pursuant to the Contract.
Dependent	The spouse, Domestic Partner, or child of an eligible SFHSS Member, who is determined to be eligible and who is not independently covered as an eligible SFHSS Member or Participant. • A spouse who is legally married to the Participant and who is not legally separated from the Participant. • A Domestic Partner to the Participant who meets the definition of Domestic Partner as defined in this Benefit Booklet. • A child who is the child of, adopted by, or in legal guardianship of the Participant, spouse, or Domestic Partner, and who is not covered as a Participant. A child includes any stepchild, child placed for adoption, or any other child for whom the Participant, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Participant, spouse, or Domestic Partner), unless the Participant, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
Domestic Partner	An individual who is personally related to the Participant by a domestic partnership that meets all the following requirements: • Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

	• The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;
	• The partners are:
	  o not currently married to someone else or a member of another domestic partnership, and
	  o not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
	• Both partners are capable of consenting to the domestic partnership; and
	• If required under your Plan Sponsor's eligibility requirements, provide a declaration of domestic partnership.
	
	The domestic partnership is deemed created on the date when both partners meet the above requirements.

Emergency Medical Condition	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.
Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or

	eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the Plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or an inpatient or outpatient stay.
Employer (Contractholder)	Is San Francisco Health Service System (SFHSS) and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for Benefits under the Plan.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that 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 that 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 that 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 Participant and all enrolled Dependents.
Former Participating Provider	A Former Participating Provider is a provider of services to the Member under any of the following conditions: • A provider who is no longer available to you as a Participating Provider, but at the time of the provider's contract termination with the Claims Administrator, you were receiving Covered Services from that provider for

	one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section. • A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with the Claims Administrator became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section. • A provider who is a Participating Provider with the Claims Administrator but no longer available to you as a Participating Provider because: o The Employer has terminated its contract with the Claims Administrator; and o The Employer currently contracts with a new health plan (insurer) that does not include the Claims Administrator Participating Provider in its network; and o At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Massage therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist;

	• Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Registered dietician; • Registered nurse; • Registered respiratory therapist; • Speech and language pathologist.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia. A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with the Claims Administrator to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria: • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.
Independent Review Organization	An entity that conducts independent external reviews of Adverse Benefit Determinations.
Infertility	• A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or

	• The inability to conceive a pregnancy or to carry a pregnancy to a live birth.
Intensive Outpatient Program	An outpatient treatment program for Mental Health Conditions or Substance Use Disorder Conditions that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.
Inter-Plan Arrangements	The Claims Administrator's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Late Enrollee	An eligible SFHSS Member or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the date a written request for coverage is made or at the Employer's next open enrollment period.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that 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 Claims Administrator, are: • Consistent with the Claims Administrator's medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a 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 admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. The Claims Administrator reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.
Member	An individual who is enrolled and maintains coverage in the plan pursuant to the Plan Document as either a Participant or a Dependent. Use of "you" in this document refers to the Member.
Mental Health Condition	Mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.
Non-invasive	Relating to a procedure that does not break the skin or physically enter the body.
Non-Participating (Non-Participating Provider)	Any provider who does not participate in this plan's network and does not contract with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services. Also referred to as an out-of-network provider. Certain services of this plan are not covered or benefits are reduced if the service is provided by a Non-Participating Provider.
Non-Participating Pharmacy	A pharmacy that does not participate in the Claims Administrator Pharmacy Network. These pharmacies are not contracted to provide services to the Claims Administrator Members.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy;

	• Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.
Participant	An SFHSS Member who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment in accordance with this plan.
Participant Contribution (Dues)	Amounts the Plan Sponsor may require Participants to contribute toward the cost of coverage under the Plan.
Participating Hospice or Participating Hospice Agency	An entity that has either contracted with the Claims Administrator or has received prior approval from the Claims Administrator to provide Hospice service Benefits.

Participating (Participating Provider)	A provider who participates in this Plan's network and contracts with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan	the Blue Shield of CA PPO 20 Benefit Plan for eligible SFHSS Members.
Plan Administrator	Is San Francisco Health Service System (SFHSS).
Plan Document	The document adopted by the Plan Sponsor that establishes the services that Participants and Dependents are entitled to receive under the Plan.
Plan Service Area	A geographical area designated by the Plan within which a plan shall provide health care services.
Plan Sponsor	Is San Francisco Health Service System (SFHSS).
Plan Year	The 12-month consecutive period established by the Employer.
Preventive Health Services	Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the *Preventive Health Services* section.
Primary Care Physician (PCP)	A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician.
Provider Incentive	An additional amount of compensation paid to a Health Care Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.
Reasonable and Customary	In California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Claims Administrator to be the reasonable and customary value for the services rendered by a Non-Participating 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, or (3) if applicable, the amount determined under federal law. Outside of California: The lower of (1) the provider's billed charge, or, (2) if applicable, the amount determined under federal law.

	Where required under federal law, the Reasonable and Customary Amount used for purposes of determining your Cost Share may be based on the Plan's "qualifying payment amount," which may differ from the amount the Claims Administrator pays the Non-Participating Provider or facility for Covered Services.
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: • Improve function; or • Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures.
Serious Emotional Disturbances of a Child	A minor under the age of 18 years who has 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. The child must 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: • As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: o Self-care; o School functioning; o Family relationships; o Ability to function in the community; and o Either 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; • The child displays one of the following: o Psychotic features; o Risk of suicide; or o Risk of violence due to a mental disorder; • The child meets special education eligibility requirements under Chapter 26.5 (starting with

	Section 7570) of Division 7 of Title 1 of the Government Code.
Severe Mental Illnesses	Conditions with the following diagnoses: • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic depressive illness) • Major depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism • Anorexia nervosa • Bulimia nervosa
SFHSS Member	An individual who meets the eligibility requirements set forth in the Plan Document between the Claims Administrator and the Employer, and the SFHSS Member Rules.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and • Other designated as appropriate.
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 that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Substance Use Disorder Condition	Drug or alcohol abuse or dependence.
Substance Use Disorder Services	Services provided to treat a Substance Use Disorder Condition.
Total Disability (Totally Disabled)	In the case of a Participant, or Member otherwise eligible for coverage as a Participant, 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. 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.
Value-Based Program	An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.
Urgent Services	Those Covered Services rendered outside of the Plan Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Plan Service Area.

Notices about your plan

Notice about this Administrative Services Only plan: The Plan Document is on file with your Employer and a copy will be furnished upon request.

San Francisco Health Service System (SFHSS) is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this Plan. You do not have the right to receive the Benefits of this Plan after coverage ends, except as specifically provided under the *Continuity of Care* and *Continuation of group coverage* sections. The Claims Administrator may change Benefits during the term of coverage as specifically stated in this Benefit Booklet. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary. The Claims Administrator reserves the right to review all claims to determine if a service or supply is 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.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your Plan 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 enroll. Call your prospective doctor or clinic, or contact Accolade Customer Service to ensure that you can obtain the health care services you need.

Notice about Participating Providers: The Claims Administrator contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual agreement may include incentives to manage all services for Members in an appropriate manner consistent with the Plan. To learn more about this payment system, contact Accolade Customer Service.

Notice about confidentiality of personal and health information: The Claims Administrator protects the confidentiality/privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. The Claims Administrator will not disclose this information without authorization, except as permitted by law.

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

The Claims Administrator's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling Accolade Customer Service or by visiting member.accolade.com or blueshieldca.com.

Members who are concerned that the Claims Administrator may have violated their privacy rights, or who disagree with a decision the Claims Administrator made about access to their individually-identifiable personal information, may contact the Claims Administrator at:

Blue Shield of California Privacy Office
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

blue of california

Outpatient Prescription Drug Benefit

San Francisco Health Service System Fund (CCSF)
Effective January 1, 2024
PPO

Enhanced Rx $10/25/50 with $0 Pharmacy Deductible Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for covered Drugs under the outpatient prescription Drug Benefit. The Claims Administrator pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] or Non-Participating[3] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$0

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs[6]				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs (mostly preferred Generic Drugs and some Brand Drugs)	$10/prescription		50% plus $10/prescription	
Tier 2 Drugs (mostly preferred Brand Drugs and some Generic Drugs)	$25/prescription		50% plus $25/prescription	
Tier 3 Drugs (non-preferred Generic and non-preferred Brand Drugs)	$50/prescription		50% plus $50/prescription	
Tier 4 Drugs (Specialty and high-cost Drugs)	$50/prescription		50% plus $50/prescription	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs (mostly preferred Generic Drugs and some Brand Drugs)	$20/prescription		Not covered	

Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[3]	CYPD[1] applies
Tier 2 Drugs (mostly preferred Brand Drugs and some Generic Drugs)	$50/prescription		Not covered	
Tier 3 Drugs (non-preferred Generic and non-preferred Brand Drugs)	$100/prescription		Not covered	
Tier 4 Drugs (high-cost Drugs)	$100/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by the Claims Administrator before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This 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 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 do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to the Claims Administrator for the Brand Drug and its Generic Drug equivalent plus the Tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment for a 30-day supply or less from the mail service pharmacy.

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6 Extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy:

You also have an option to receive up to a 90-day supply of prescription Drugs at any retail network pharmacy, when you take maintenance Drugs for an ongoing condition. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed. Specialty Drugs may only be dispensed up to a 30-day supply. You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug, for each 30-day supply dispensed. Visit blueshieldca.com for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

Benefit designs may be modified to ensure compliance with Federal requirements.
Pb071323;083123;090823

Prescription Drug Benefits

Benefits are available for outpatient prescription Drugs as described in this supplement. This Prescription Drug Benefit is separate from the medical Plan coverage. The Medical Plan Deductible and the Coordination of Benefits provisions do not apply to this Outpatient Prescription Drug Rider. However, the Calendar Year Out-of-Pocket Maximum, general provisions and exclusions of the Plan Document apply.

Outpatient prescription Drugs are self-administered Drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies that are prescribed and are not provided for use on an inpatient basis. Drugs also include diabetic testing supplies and self-applied continuous blood glucose monitoring supplies. Glucose monitors, including self-applied continuous blood glucose monitoring supplies are also covered under the Durable medical section of your Benefit Booklet.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from a Participating Pharmacy, except as noted below. Drugs, items, and services that are not covered under this Benefit are listed in the *Exclusions and limitations* section.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization to be covered. The prior authorization process is described in the *Prior authorization/exception request process/step therapy* section. You or your Physician may request prior authorization from the Claims Administrator.

Outpatient Drug Formulary

The Claims Administrator's Drug Formulary is a list of FDA-approved preferred Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs.

The Claims Administrator's Formulary is established and maintained by the Claims Administrator's Pharmacy and Therapeutics (P&T) Committee. This committee consists of Physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year.

Your Physician or Health Care Provider might prescribe a Drug even though it is not included in the Claims Administrator Formulary.

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

Formulary Drug tiers	
Drug Tier	***Description***
Tier 1	• Most Generic Drugs or low cost preferred Brand Drugs
Tier 2	• Non-preferred Generic Drugs • Preferred Brand Drugs • Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
Tier 3	• Non-preferred Brand Drugs • Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost • Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	• Drugs that are biologics, and Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than $600 (net of rebates) for a one-month supply

Contact Accolade Customer Service or visit ***member.accolade.com*** or ***blueshieldca.com/pharmacy***, for more information on the ***Drug Formulary*** or to request a printed copy of the Formulary.

Obtaining outpatient prescription Drugs at a Participating Pharmacy

You must present a Claims Administrator ID Card at a Participating Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. See the *Obtaining Specialty Drugs from a Network Specialty Pharmacy* section for more information.

Contact Accolade Customer Service or visit ***member.accolade.com*** or to locate a *retail Participating Pharmacy*.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted

rate is less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum.

Contraceptive Drugs and devices obtained from a Participating Pharmacy are covered without a Copayment or Coinsurance, except for Brands that have a Generic equivalent. If your Physician or Health Care Provider determines that the covered Generic Drug therapeutic equivalent is medically inadvisable, the Brand contraceptive will be covered without a Copayment or Coinsurance upon submission of an exception request. If there is no Generic Drug therapeutic equivalent available, you will receive the Brand contraceptive without a Copayment or Coinsurance.

If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance.

If you select a Brand Drug when a Generic Drug equivalent is available, you pay the difference in cost, plus your Tier 1 Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent, plus the Tier 1 Copayment or Coinsurance. For example, you select Brand Drug A when there is an equivalent Generic Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300 and the contracted rate for Generic Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the Tier 1 Copayment or Coinsurance. This difference in cost does not apply to your Calendar Year Pharmacy Deductible or your Out-of-Pocket Maximum responsibility.

If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you can request an exception to paying the difference in cost between the Brand Drug and Generic Drug equivalent through the Claims Administrator prior authorization process. The request is reviewed for Medical Necessity.

See the *Prior authorization/exception request/step therapy process* section for more information on the approval process and exception requests. If the request is approved, you pay only the applicable tier Copayment or Coinsurance.

The Claims Administrator created a Patient Review and Coordination (PRC) program to help reduce harmful prescription drug misuse and the potential for abuse. Examples of harmful misuse include obtaining an excessive number of prescription medications or obtaining very high doses of prescription opioids from multiple providers or pharmacies within a 90-day period. If the Claims Administrator determines a Member is using prescription drugs in a potentially harmful, abusive manner, the Claims Administrator may, subject to certain exemptions and upon 90 days' advance notice, restrict a Member to obtaining all non-emergent outpatient prescriptions drugs at a single pharmacy home. This restriction applies for a 12-month period and may be renewed. The pharmacy home, a single Participating Pharmacy, will be assigned by the Claims Administrator or a Member may request to select a pharmacy home. The Claims Administrator may also require prior authorization for all opioid medications if sufficient medical justification for their use has not been provided. Members that disagree with their enrollment in the PRC program can file an appeal or submit a grievance to the Claims Administrator as described in the *Grievance process* section of your Benefit Booklet. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Accolade Customer Service at the number listed on their Identification Card.

Obtaining extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy

You also have an option to receive up to a 90-day supply of prescription Drugs at any retail network pharmacy when you take maintenance Drugs for an ongoing condition. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed.

You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug, for each 30-day supply dispensed.

Visit blueshieldca.com for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

Obtaining outpatient prescription Drugs at a Non-Participating Pharmacy

When you receive Drugs from a Non-Participating Pharmacy, you must pay for the prescription in full and then submit a claim for reimbursement to:

Blue Shield of California
P.O. Box 52136
Phoenix, AZ 85072-2136

The Claims Administrator will reimburse you as shown on the Summary of Benefits, based on the price you paid for the Drugs.

Claim forms may be obtained by calling Accolade Customer Service or visiting member.accolade.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining outpatient prescription Drugs from the mail service pharmacy

You have an option to receive prescription Drugs from the mail service pharmacy when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of the Drug, which may save you money. You may enroll in this program online, by phone, or by mail. Once enrolled, please allow up to 14 days to receive the Drug. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the mail service pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the mail service pharmacy.

You must pay the applicable Copayment or Coinsurance listed in the *Summary of Benefits* for each prescription Drug.

Call Accolade Customer Service or visit member.accolade.com or blueshieldca.com for additional information about how to get prescription Drugs from the mail service pharmacy.

Obtaining Specialty Drugs from a Network Specialty Pharmacy

Specialty Drugs are Drugs that require coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy, and that are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs generally have a higher cost.

Specialty Drugs are only available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, at your request, will transfer the Specialty Drug to an associated retail store for pickup.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA.

To be covered, most Specialty Drugs require prior authorization by the Claims Administrator, as described in the *Prior authorization/exception request/step therapy process* section.

Call Accolade Customer Service or visit member.accolade.com or blueshieldca.com for a complete list of Specialty Drugs or to select a Network Specialty Pharmacy.

Prior authorization/exception request/step therapy process

Some Drugs and Drug quantities require approval based on Medical Necessity before they are eligible for coverage under this Benefit. This process is prior authorization.

The following Drugs require prior authorization:

- Some Formulary Drugs, compounded medications, and most Specialty Drugs; and
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy.

You pay the Tier 3 Copayment or Coinsurance for covered compounded medications.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to the Claims Administrator. Once the Claims Administrator receives all required supporting information, the Claims Administrator will provide prior authorization approval or denial within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug or to request that a Brand contraceptive Drug with a Generic equivalent be covered without a Cost Share, you, your representative, your Physician, or your Health Care Provider may submit an exception request to the Claims Administrator. You can submit an exception request by calling Customer Service. Once all required supporting information is received, the Claims Administrator will approve or deny the exception request, based on Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

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

If the Claims Administrator denies a request for prior authorization or an exception request, you, your representative, your Physician, or your Health Care Provider can file a grievance with the Claims Administrator. See the *Grievance process* section of your Benefit Booklet for information on filing a grievance.

Limitation on quantity of Drugs that may be obtained per prescription or refill

Except as otherwise stated in this section, you may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

The Claims Administrator has a short cycle Specialty Drug program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for the initial prescription. This program allows you to receive a 15-day supply of the Specialty Drug to help determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save money if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You, your Physician, or your Health Care Provider may choose a full 30-day supply for the first fill.

If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug.

Call Accolade Customer Service or visit ***member.accolade.com*** or ***blueshieldca.com/pharmacy*** for a list of *Specialty Drugs* in the *short cycle Specialty Drug program*.

You may receive up to a 90-day supply of Drugs at any retail network pharmacy or from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will dispense that amount and you are responsible for the applicable Copayment or Coinsurance listed in the *Summary of Benefits* section. Refill authorizations cannot be combined to reach a 90-day supply.

Select over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.

You may receive up to a 12-month supply of contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

Exclusions and limitations

This section describes the exclusions and limitations that apply to this Outpatient prescription Drug Benefit. You may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Benefit Booklet to determine if the plan covers Drugs under that Benefit.

	Outpatient prescription Drug exclusions and limitations
1	Any Drug you receive while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of your Benefit Booklet.
2	Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital services* and *Skilled Nursing Facility (SNF) services* sections of your Benefit Booklet.
3	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.
4	Drugs that are Experimental or Investigational in nature.
5	Medical devices or supplies, except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Durable medical equipment* section of your Benefit Booklet.
6	Blood or blood products. See the *Hospital services* section of your Benefit Booklet.
7	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.
8	Medical food, dietary, or nutritional products. See the *Home health services, Home infusion and injectable medication services, PKU formulas and special food products* sections of your Benefit Booklet.
9	Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home health services, Home infusion and injectable medication services, Hospice program services,* or *Family Planning* sections of your Benefit Booklet.

Outpatient prescription Drug exclusions and limitations

10	Appetite suppressants or Drugs for body weight reduction. This exclusion does not apply to Medically Necessary Drugs for the treatment of morbid obesity when prior authorized.
11	Compounded medications which do not meet all of the following requirements: • A compounded medication includes at least one Drug; • There are no FDA-approved, commercially available, medically appropriate alternatives; • The compounded medication is self administered; and • Medical literature supports its use for the requested diagnosis.
12	Replacement of lost, stolen or destroyed Drugs.
13	If you are enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the *Hospice program services* section of your Benefit Booklet.
14	Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to antibiotics prescribed to treat infection, Drugs prescribed to treat pain, or Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
15	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list. This exclusion does not apply to SFHSS Members enrolled in the Blue Shield of California PPO Out-of-Area Plan, who current do not reside within the United States or United States Territories.
16	Immunizations and vaccinations solely for the purpose of travel.
17	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.
18	Prescription Drugs that are repackaged by an entity other than the original manufacturer.

Definitions

Anticancer Medications	Drugs used to kill or slow the growth of cancerous cells.
Brand Drugs ("Brand")	Drugs that are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer.
Calendar Year Pharmacy Deductible	The amount a Member pays each Calendar Year before the Claims Administrator pays for covered Drugs under the outpatient prescription Drug Benefit.
Drugs	Drugs include the following: • FDA-approved medications that require a prescription either by California or Federal law; • Insulin; • Pen delivery systems for the administration of insulin, as Medically Necessary; • Self-applied continuous blood glucose monitoring supplies, including the following: o Sensors, o Transmitters, and o Receivers; • Diabetic testing supplies including the following: o Lancets, o Lancet puncture devices, o Blood and urine testing strips, and o Test tablets; • Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B; • Contraceptive drugs and devices, including the following: o Diaphragms, o Cervical caps, o Contraceptive rings, o Contraceptive patches, o Oral contraceptives, o Emergency contraceptives, and o OTC contraceptive products; • Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers.
Formulary	A list of preferred Generic and Brand Drugs maintained by the Claims Administrator's Pharmacy & Therapeutics Committee. It is designed to assist Physicians in prescribing Drugs that are

	Medically Necessary and cost-effective. The Formulary is updated periodically.
Generic Drugs ("Generic")	Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs.
Network Specialty Pharmacy	Select Participating Pharmacies contracted by the Claims Administrator to provide covered Specialty Drugs.
Non-Participating Pharmacy	A pharmacy that does not participate in the Claims Administrator Pharmacy Network. These pharmacies are not contracted to provide services to the Claims Administrator Members.
Participating Pharmacy	A pharmacy that has contracted with the Claims Administrator to provide covered Drugs at certain rates. A Participating Pharmacy participates in the Claims Administrator Pharmacy Network.
Specialty Drugs	Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy and are available exclusively at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high-cost.

Please be sure to retain this document. It is not a Contract but is a part of your Benefit Booklet.

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

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

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

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

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

Language access services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiijį' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。
無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ): សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل بالاتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

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