RETA TRUST

Quality health plans.
Catholic values.

Benefit Booklet

Reta Plan

5124 Reta Trust PPO 1000 80/60

Group Number: WP0000120-M0045631

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blue california

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Claims Administered by Blue Shield of California

Welcome to the Reta Plan

The Reta Trust was established in 1976 by Roman Catholic dioceses and religious orders to provide health care coverage for clergy, religious members, and employees of Catholic employers and their eligible family members. The Catholic entities and employers who choose to participate in the Reta Trust are sometimes referred to as "Reta Trustors." The Reta Trust's mission is to enable Reta Trustors to offer affordable, quality health care coverage that respects the social and moral teachings of the Roman Catholic Church and that supports Catholic health care institutions. (More can be learned about the Reta Trust at www.retatrust.org.)

All of the coverage options that make up the Reta Plan provide benefits that are consistent with the Ethical and Religious Directives for Catholic Health Care Services (7th ed. 2025) ("Directives"). The Reta Plan only provides benefits that are consistent with these Directives. For your reference, the Directives can be found at the following webpage: https://www.usccb.org/resources/ethical-and-religious-directives-catholic-health-care-services-seventh-edition

Even if you are not Catholic, or if your personal beliefs are inconsistent with the Directives, the Reta Trust can only provide you with services that are consistent with the Directives. The Reta Trust has delineated those services within this Benefit Booklet. **There are no exceptions.** Catholic healthcare institutions are also bound by these Directives and will be unable to perform procedures or provide medicines or services that are contrary to the Directives. This Benefit Booklet may contain statements that you might interpret as inconsistent with the Directives; however, services that are contrary to the Directives are specifically excluded from coverage, as described within this Benefit Booklet.

The Reta Plan is **not** an insured health care plan. Blue Shield of California provides claims administration services for the Plan, but is not an insurer of the Plan or financially liable for the Plan's benefits. In that role, Blue Shield of California is the "Claims Administrator."

The Reta Trust is the "Plan Sponsor" and, as such, provides funding for benefit claims and retains exclusive and ultimate responsibility for its administration. The Reta Trust is also the Plan Administrator. In this Benefit Booklet, Plan participants and enrolled Dependents ("Members") are sometimes referred to as "you" and "your." The Reta Trust, as the Plan Administrator and the Plan Sponsor, is sometimes referred to in this Benefit Booklet as "we," "us," and "our." The covered services, cost sharing, exclusions and limitations that are specific to the coverage option in which you are enrolled are described in the schedule, called the "Schedule of Benefits," that is found at the end of the booklet. The Schedule of Benefits does not describe all the details of your benefits. For more information, on specific benefits, please refer to the "Your Benefits" section.

If you have questions that are not answered in this Benefit Booklet, contact the person associated with your employer who handles your healthcare benefits or call the Claims Administrator:

Blue Shield of California Customer Service
1-888-772-1076

Important: The Reta Plan is not a group health plan under which the benefits are insured by an insurance company. The benefits described in this Benefit Booklet or any amendments hereto are funded by the Reta Trust, which is responsible for their payment. Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Shield of California is an independent licensee of the Blue Cross Blue Shield Association.

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Introduction

Welcome! We are happy to have you as a Member of the Reta Trust PPO Plan (sometimes referred to in this Benefit Booklet as the "Plan"), a coverage option under the Reta 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 under the coverage option identified on the front cover. This Benefit Booklet is one of the documents under which the Reta Plan is governed. Another document under which the Reta Plan is governed is the Plan Constitution.

The Summary Plan Description for the Reta Plan is a separate document that contains important information in summary form about eligibility for coverage and when your coverage starts and ends. You should make sure you have a copy of the Summary Plan Description as well as this Benefit Booklet.

This Benefit Booklet tells you:

- 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
- About important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Benefit Booklet includes a *Schedule of Benefits* section that lists your Cost Share for Covered Services. Use the Schedule of Benefits 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 the 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:



Phone numbers and addresses

This table provides easy access to information
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 Participant's Employer.

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 Coverage Option

This coverage option 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, but you may incur higher out-of-pocket costs by receiving care from a Non-Participating Provider. 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 are here to help. The Claims Administrator's website and app are useful resources. Visit blueshieldca.com or use the Claims Administrator's mobile app 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.

The Claims Administrator's 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	Customer Service: 1-888-772-1076 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Prior authorization of radiological services, spine surgery, and interventional pain management services Prior authorization of oncology services	Evolent: (888) 642-2583 (888) 999-7713

If you are hearing impaired, you may contact Customer Service through the Claims Administrator's toll-free TTY number: 711.

Your 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 offered to 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 condition, mental health condition, or Substance Use Disorder 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 condition, mental health condition, or Substance Use Disorder 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 condition, mental health condition, or Substance Use Disorder 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.

	As a Member, you have the responsibility to:
13	Pay your Participant Contributions, (sometimes called "Premiums"), Copayments, Coinsurance, and charges for non-Covered Services in full and on time.
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 coverage option 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

The Claims Administrator has established a network of various types of "Participating Providers." These providers are called "Participating" because they have agreed to participate in the Claims Administrator's preferred provider organization program (PPO), which is called the Blue Shield Full PPO Network in California. Participating Providers have agreed to a rate they will accept as reimbursement for Covered Services.

The Blue Cross and Blue Shield Association, of which the Claims Administrator is a member, has a program (called the "BlueCard Program") which allows our Members to have the reciprocal use of participating providers contracted under another state's Blue Cross and/or Blue Shield Licensee (Host Blue). If you are outside of California and require medical care or treatment, you may use a local Host Blue provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard® Program.

Participating Providers have a contract with the Claims Administrator or the Host Blue 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, as well as charges for services above any maximum Benefit allowance. In the case of a Non-Participating Provider, the Plan is only obligated to pay the Allowable Amount. See the *Definitions* section for the definition of "Allowable Amount."

Some services will not be covered unless you receive them from a Participating Provider. See the *Schedule 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 former Participating Provider.



See the ***Inter-Plan Programs*** section for more information about receiving care through the BlueCard® Program. To find participating providers through the BlueCard® Program, visit ***bcbs.com***.



Visit ***blueshieldca.com*** or use the Claims Administrator's mobile app 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 or a Host Blue to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services.

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 blueshieldca.com or on the Claims Administrator's mobile app.

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.

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.

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 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, the Claims Administrator will approve your request and you will only be responsible for the Participating Provider Cost Share. You may also be responsible for what the Non-Participating Provider charges above the Allowable Amount because the Plan's payment responsibility with respect to a Non-Participating Provider is limited to the Allowable Amount, less the Cost Share you must pay.

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, visit blueshieldca.com or use the Claims Administrator's mobile app.

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 Health

Teladoc Health provides health consultations by phone or secure online video. Teladoc Health general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc Health mental health consultations are available for Members age 13 and older. Members under age 13 may obtain telebehavioral health services for Mental Health and Substance Use Disorders from a mental health professional. Teladoc Health is a supplemental service that is not intended to replace care from your Physician or mental health professional, or your relationship with your provider.

How to access Teladoc		
Teladoc Health service	***Ways to access***	***Availability***
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment
Mental health	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	7 a.m. to 9 p.m., 7 days a week by scheduled appointment only Consultations must be scheduled online and cannot be requested by phone

Telehealth behavioral health services

Online telehealth behavioral health services for Mental Health Conditions and Substance Use Disorders are available through the Claims Administrator. Telehealth behavioral 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.

NurseHelp 24/7SM

You can contact a registered nurse 24 hours a day, seven days a week through the NurseHelp 24/7SM program. Nurses are available to help you select appropriate care and answer questions about:

- Symptoms you are experiencing;
- Minor illnesses and injuries;
- Medical tests and medications;
- Chronic conditions; and
- Preventive care.

Call (877) 304-0504 or log in to your account at blueshieldca.com and use the chat feature to connect with a nurse. This service is free and confidential.

NurseHelp 24/7 SM is not meant to replace the advice and care you receive from your Physician or other health care professional.

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.

Visit blueshieldca.com to explore these resources.

Continuity of Care

The Plan uses Network providers to provide Plan benefits. Should a Network Provider contract terminate, Continuing Care Patients of the terminated provider have a right to elect to continue transitional care from the terminated provider under the same terms and conditions after the termination of the contract.

Transitional care may also be available if the Plan Sponsor terminates its contract with the Claims Administrator and contracts with a new third-party administrator (TPA) that does not include in its network the provider that is providing your care.

Transitional care may also be available if your Employer and the Plan Sponsor terminate your Employer's participation in the Plan and the provider that is providing your care is not included in a network under your Employer's new group health plan.

If you are a Continuing Care Patient and eligible for transitional care, you may receive care from the provider providing your care for up to 90 days from the date of receipt of notice of termination or until you are no longer a Continuing Care Patient, whichever is earlier.

A Continuing Care Patient is an individual who, with respect to a Network Provider:

a) Is undergoing a course of treatment for a serious and complex condition from the provider or facility; or

b) Is undergoing a course of institutional or inpatient care from the provider or facility; or

c) Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery; or

d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e) Is or was determined to be terminally ill (as determined under specified Medicare rules) and is receiving treatment for such illness from such provider or facility.

To request continuity of care with a former Participating Provider, visit blueshieldca.com and fill out the Continuity of Care Application. The Claims Administrator will confirm your eligibility and may review your request for Medical Necessity.

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

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

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 coverage option. 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***, visit 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.

Visit 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 and Surgical Benefits	• Non-emergency inpatient Hospital admissions • Surgery • Prescription Drugs administered by a Health Care Provider • Inpatient skilled nursing facility admissions • Non-emergency ambulance services • Hemophilia home infusion services • Routine patient care received while participating in a clinical trial • Hospice care • Home health care
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
Benefits for Mental Health Conditions and Substance Use Disorders	• Non-emergency inpatient Hospital admissions • Electroconvulsive therapy • Transcranial magnetic stimulation • Prescription Drugs administered by a Health Care Provider • Inpatient residential care facility admissions • Non-emergency ambulance services • Behavioral Health Treatment for pervasive developmental disorder or autism • Partial Hospitalization Program • Intensive Outpatient Program

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical condition, mental health condition, and substance use disorder requests	Within five business days, but not to exceed seven calendar days
Expedited medical condition, mental health condition, 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. A care management nurse associated with the Claims Administrator may contact you to see what assistance might be available to help you manage your health condition. You may also request care management support by calling 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 always retains the right to administer your Benefits according to the terms of this Benefit Booklet and the right 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 Reta Trust collects contributions from the Employers that participate in the Reta Trust. The Reta Trust 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 ***Schedule 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 *The Plan's Rights When Your Injury or Illness Was Caused by Someone Else (Third Parties)* 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.

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

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

If your coverage option has Family coverage, there is an individual Deductible within the Family Deductible. This means an individual family member can meet the individual Deductible before the entire Family meets the Family Deductible.

If your coverage option has individual coverage and you enroll a Dependent during the Calendar Year, you will have Family coverage. Any amount you have paid toward the Deductible for individual coverage will be applied to both the individual Deductible and the Family Deductible for the Calendar Year.

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

Credit for Deductible Under Prior Coverage Option

If you pay all or part of a Deductible for another coverage option under the Reta Plan for the Calendar Year in which you enroll in this coverage option, that part of the Deductible you paid will be applied to the Deductible for this coverage if:

- You were enrolled in a coverage option under the Reta Plan with a claims administrator other than Blue Shield of California during the same Calendar Year;
- This coverage option is replacing another coverage option under the Reta Plan administered by Blue Shield of California in which you were enrolled; or
- You were enrolled in another Blue Shield of California coverage option under the Reta Plan and you are transferring to this coverage option during open enrollment.

Copayment and Coinsurance

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

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

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

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Your Cost Share includes 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 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.

The Family Out-of-Pocket Maximum will be satisfied by the Member and all covered Dependents collectively.

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; and
- Charges over the Allowable Amount

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

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

Summary of Cost Share Principles

To recap, you are responsible for all costs for Covered Services until you reach any applicable Deductible. Once you reach any applicable Deductible, the Plan 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 Plan will pay 100% of the Allowable Amount for Covered Services. Exceptions are described above.

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.

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

See the *Inter-Plan Programs* section in the *Other important information about the Plan* section for more information on BlueCard® Program claims.

How to submit a claim

Type of claim	*What to submit*	*Where to submit it*	*Due date*
Medical services	• The Claims Administrator's 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 it receives 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 ***the Non-Participating Provider*** for making sure it 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

Each Employer establishes the rules for the eligibility for coverage under the Plan of its employees and their Dependents. To be eligible for coverage, you and your Dependents must meet all of your Employer's eligibility requirements and complete any waiting period established by your Employer.

Important information on the rules governing the eligibility of employees and their Dependents is found in the Summary Plan Description for the Reta Plan. More specific information can be obtained from your Employer.

Enrollment and effective dates of coverage

As the Participant, you can enroll in coverage for yourself and your eligible Dependents during your initial enrollment period established by your Employer, the annual open enrollment period, or if you qualify for a special enrollment period.

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 Employees 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.

Important information on the rules governing special enrollment periods for employees and Dependents is found in the Summary Plan Description for the Reta Plan. More specific information can be obtained from your Employer.

Plan changes

The Plan Sponsor has the right to change the Benefits and terms of this Plan to the fullest extent permitted by the law. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Participant Contributions; and
- Exclusions: Services and Treatments That Are Not Covered by the Plan.

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 provided by two or more plans

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's participation in the Reta Plan is terminated or discontinued ;
- The Participant cancels coverage; or
- The Claims Administrator cancels or rescinds the Member's 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 coverage* sections.

If your Employer's participation in the Plan is terminated or discontinued

Your Employer's participation in the Plan may be terminated or discontinued 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 Plan Sponsor cancels coverage

The Plan Sponsor can cancel coverage if you or your Dependent commits fraud or intentional misrepresentation of material fact.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

If the Plan Sponsor cancels or rescinds your coverage for fraud or intentional misrepresentation of material fact, the Plan Sponsor or Claims Administrator will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation, Rescission, or Nonrenewal. Rescission voids the coverage as if it never existed. Cancellation or rescission is effective on the date specified in the Notice of Cancellation, Rescission, or Nonrenewal and the Notice of End of Coverage.

Continuation of coverage

After your normal coverage under this Plan terminates, and depending on the circumstances, you may be able to elect to continue coverage under this Plan for a period of time from up to 18 months, up to 29 months, or up to 36 months pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, (COBRA).

The Summary Plan Description contains more information about the rights under COBRA that you and your Dependents have to continue coverage under the Plan after the normal termination of coverage, such as by reason of a reduction in hours worked, termination of employment, and loss of eligibility as a Dependent.

Please examine your options carefully before declining continuation of coverage.

Your Benefits

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

The Plan 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 may 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, through its Medical Management Programs, works with your provider to ensure that your care is provided effectively and safely 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: Services and Treatments That Are Not Covered by the Plan* section for more information about Benefit exclusions and limitations.



See the ***Schedule 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.

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 the air ambulance services from a Non-Participating Provider.

Bariatric surgery services

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

Behavioral Health Treatment

Benefits are provided for 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.

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 a per Member per Calendar Year visit maximum as shown on the *Schedule of Benefits*.

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

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 in this context includes services that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial. The *Schedule 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 monitors and those designed to help the visually impaired, and all related necessary supplies;
- Insulin pens, syringes, pumps and all related necessary supplies;
- Disposable hypodermic needles and syringes needed for administration of insulin and glucagon;
- 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. Insulin and glucagon may be covered under the Prescription Drug Benefits.

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 (magnetic resonance angiography) 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, including continuous blood glucose monitors, and all related necessary 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;
- Pasteurized donor human milk; 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;
- Adult eyewear;
- Video-assisted visual aids for diabetics;

- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes.

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;

- Wigs when necessary due to hair loss induced by chemotherapy or radiation therapy for treatment of cancer or other medical conditions;
- 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 services

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.

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 *Schedule 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. A list of Participating Hemophilia Home Infusion Providers is available at 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 time frame 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

A Participating Provider must get prior authorization from the Claims Administrator for all non-emergency Hospital admissions for inpatient care.

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.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of the cause of Infertility, including professional, Hospital, Ambulatory Surgery Center, and related services to

diagnose and treat the cause of Infertility, with the exception of what is excluded in the *Exclusions: Services and Treatments That Are Not Covered by the Plan* section.

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 that are an integral part of or 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 services

The Claims Administrator administers Mental Health Services and Substance Use Disorder Services for Members. See the *Inter-Plan Programs* section for an explanation of how Benefits are administered for BlueCard® 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 telehealth behavioral 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 that are at a minimum 20 hours per week;
- 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.

Natural Family Planning Services

Natural family planning services, including fertility awareness education, fertility diagnostic services, and restorative reproductive medicine, are covered by Network Providers and by providers affiliated with MyCatholicDoctor. For more information, visit Welcome Reta Trust Members – MyCatholicDoctor.

Outpatient prescription drugs

Benefits for outpatient prescription drugs and medicines are separately provided and administered by the Pharmacy Benefit Manager listed on the back of your Member ID card. See the Outpatient Prescription Drug Benefits section of the Schedule of Benefits found at the end of this booklet.

Coverage is provided for outpatient prescription drugs obtained from a pharmacy in the network administered by the Pharmacy Benefit Manager. No benefits are provided for drugs and medicines obtained from a Non-Participating Pharmacy. If you do not use the mail order service operated by the Pharmacy Benefit Manager, you must present a valid Member ID card at the time your prescription is dispensed.

The Pharmacy Benefit Manager uses a "formulary."

A formulary is a list of preferred drugs outlined by the Pharmacy Benefit Manager and elected by the Plan Sponsor. Your specific prescription benefit plan design may not cover certain medications, products, or categories regardless of their appearance on the Pharmacy Benefit Manager's Formulary document, as set forth in this Benefit Booklet. The formulary documents will outline drug-specific criteria for the preferred drugs listed such as prior authorization and/or step therapy requirements, quantity limits, age limits, and whether a drug is over-the-counter or specialty.

The drug formulary guidelines also allow you to obtain non-formulary prescription drugs (those not listed on the drug formulary for your condition) under some circumstances. For information on how to request a formulary exception, you or your Provider may contact the Pharmacy Benefit Manager at the telephone number on the back of your Member ID card. Prescriptions written by dentists are not eligible for a formulary exception.

Because the Pharmacy Benefit Manager is continually updating which prescription drugs are approved or not approved for coverage, you must contact the Pharmacy Benefit Manager by calling the tollfree customer service telephone number on your Member ID card or visit the Pharmacy Benefit Manager's website to verify whether a prescription drug is covered or not covered under the Plan.

The benefits under the Plan for outpatient prescription drugs are generic-based. This means that you will receive a generic drug unless:

- No generic drug equivalent exists;
- The prescribing Provider indicates "Dispense As Written" when a generic drug equivalent exists for the prescribed brand name drug; or
- You request a name brand drug when a generic equivalent drug is available, in which case you will be required to pay the difference in price.

See the *Exclusions: Services and Treatments That Are Not Covered by the Plan* section for the exclusions that may apply to a particular drug or medicine.

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 that must be administered by a Health Care Provider;
- 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. The Claims Administrator 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; and
- Elective newborn circumcision within 18 months of birth.

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 Plan only covers Preventive Health Services when you receive them from a 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; 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. Contraceptive interventions and services are not covered by the Plan. See the *Exclusions: Services and Treatments That Are Not Covered by the Plans* section for more information about the exclusion of contraceptive interventions and services from coverage.

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

Visit ***blueshieldca.com/preventive*** for more information about ***Preventive Health Services. Note, however, that contraceptive interventions and services are not covered by the Plan.***

Reconstructive Surgery

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by physical congenital defects, physical developmental abnormalities, physical trauma, infection, tumors, or disease to:
  - Improve function; or
  - Create a normal appearance to the extent possible;
- 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 any procedure that is directed at improving appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- Reconstructive Surgery when there is a more appropriate procedure that is not excluded from coverage; or
- Reconstructive Surgery intended 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 performed as a part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Provider.

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 *Schedule 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.

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 *Inter-Plan Programs* section for information on urgent care services through the BlueCard® Program.

Exclusions: Services and Treatments That Are Not Covered by the Plan

This section describes the general exclusions and limitations that apply to all your plan Benefits. ***If one or more exclusions apply to the service or supply, there is no coverage. This is true even if the service or supply is Medically Necessary.***

Services and Treatments That Are Not Covered by the Plan	
1	No coverage is provided for services or items that are not Medically Necessary. A Physician's or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or item does not, in itself, make it Medically Necessary.
2	No coverage is provided for routine physical examinations, immunizations, and vaccinations (however administered) for licensure, employment, travel, insurance, court order, parole, probation, or while incarcerated.
3	No coverage is provided for hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	No coverage is provided for routine foot care items and services that are not Medically Necessary, including, but not limited to, the following: • 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 that are covered under the *Diabetes Care services* section.
5	No coverage is provided for home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. For the purposes of this exclusion, "custodial care" means 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. For the purposes of this exclusion, "domiciliary care" means 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	No coverage is provided for Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.

Services and Treatments That Are Not Covered by the Plan	
7	No coverage is provided for 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. This exclusion does not apply to supplements provided through a Participating Hospice Agency. This exclusion does not apply to supplements provided at an inpatient mental health facility.
8	No coverage is provided for any services relating to the diagnosis or treatment of any emotional, social, or behavioral condition that is not a Mental Health Condition or a Substance Use Disorder or expressly provided under the *Behavioral Health Treatment* section.
9	No coverage is provided for hearing aids, hearing aid examinations for the appropriate type of hearing aid, hearing aid fitting, or hearing aid recheck appointments.
10	No coverage is provided for eye examinations or refractions, lenses and frames for eyeglasses, lens options, treatments, or contact lenses, except as listed under the *Prosthetic equipment and devices* section. No coverage is provided for video-assisted visual aids or video magnification equipment for any purpose. No coverage is provided for surgery to correct refractive error.
11	No coverage is provided for 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.
12	No coverage is provided for dental services and items for treatment of the teeth, gums, or associated periodontal structures. This exclusion applies to, but is 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 and services provided under the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections.
13	No coverage is provided for interventions, whether surgical, hormonal, or by way of genetic engineering, that aim not to restore, but only to alter or reshape, structures or tissues of the body form or function. This exclusion applies to cosmetic surgery. For the purposes of this exclusion, "cosmetic surgery" is any procedure that is directed at improving appearance

Services and Treatments That Are Not Covered by the Plan	
	and does not meaningfully promote the proper function of the body or prevent or treat illness or disease. This exclusion does not apply to Medically Necessary treatment of complications resulting from cosmetic surgery or other excluded treatment, such as infections or hemorrhages. This exclusion does not apply to Reconstructive Surgery, unless (1) the Reconstructive Surgery is intended to create a normal appearance and the surgery offers only a minimal change to appearance, or (2) there is a more appropriate procedure that is not excluded from coverage. "Reconstructive Surgery" is defined in the *Definitions* section. This exclusion does not apply to the removal or suppression of the function of one part of the body for the sake of the body as a whole if the following conditions are satisfied: (1) there is no other reasonable means of addressing the physical pathological condition, (2) the efficacy of the procedure is reasonably well-assured, and (3) the benefits expected from the procedure are proportionate to the burdens it imposes. These conditions are satisfied when the body part itself is diseased and presents a risk to the life or well-ordered functioning of the body as a whole. These conditions are also satisfied when a healthy body part presents a risk to the life or well-ordered functioning of the body as a whole because its present functioning contributes to a serious physical pathology in another part of the body.
14	No coverage is provided for any services, procedures, supplies, or devices associated with a treatment or procedure that is excluded from coverage.
15	No coverage is provided for any reproductive measure or technique of assisted conception that separates the unitive and procreative ends of the conjugal act or that substitutes for the conjugal act itself. Specific services that are covered by this exclusion include the harvesting or stimulation of the human ovum, in vitro fertilization, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, or services incident to or resulting from procedures for a surrogate mother. This exclusion applies to, but is not limited to, measures or techniques of assisted conception that involve the cryopreservation or destruction of human embryos (which include zygotes and blastocysts), or that involve the cryopreservation of human gametes, for the purpose of methods of infertility treatment that are excluded from coverage. This exclusion applies to, but is not limited to, measures or techniques of assisted conception that involve the post-mortem retrieval of human gametes.

Services and Treatments That Are Not Covered by the Plan	
	This exclusion applies to, but is not limited to, heterologous fertilization, which is any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouse. This exclusion applies to, but is not limited to, homologous artificial insemination and all techniques of fertilization (i.e., the use of the gametes of the two spouses joined in marriage) when it is used to achieve extracorporeal conception or when it involves the destruction or cryopreservation of human embryos. This exclusion does not apply to homologous artificial fertilization within marriage in situations in which the technique or measure utilized does not substitute for the conjugal act. This exclusion does not apply to services that help married couples conceive and do not separate the unitive and procreative ends of the conjugal act and does not substitute for the conjugal act itself. This exclusion does not apply to restorative reproductive medicine for the treatment of infertility. This exclusion does not apply to services and procedures to rule out the underlying medical causes of infertility.
16	No coverage is provided for abortion procedures. This exclusion applies to, but is not limited to, procured elective abortions. For the purposes of this exclusion, a "procured elective abortion" means the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth, whether chosen for its own sake or for a further end. This exclusion applies to any intervention, whether surgical or chemical, whose sole immediate effect is the destruction of a living human embryo or fetus or the removal of a living embryo or fetus from the uterus before viability, which includes the interval between conception and implantation of the embryo. This exclusion applies to removal of a living human fetus after viability with the sole intent for the removal to result in the death of the fetus. This exclusion applies, in the case of an extrauterine (e.g., ectopic) pregnancy, to any intervention which constitutes a procured elective abortion. For the purposes of this exclusion, the use of surgical and other measures, such as salpingostomy, salpingectomy, or methotrexate, in accord with accepted medical standards to address an extrauterine (e.g., ectopic) pregnancy does not constitute a procured elective abortion. This exclusion applies to prenatal diagnosis when undertaken with the intention of aborting an unborn child with a serious defect. This exclusion does not apply to operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious physical

Services and Treatments That Are Not Covered by the Plan	
	pathological condition of a pregnant woman when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child. This exclusion does not apply to Medically Necessary treatment for the treatment of the trauma of abortion or complications resulting from an abortion, such as infections or hemorrhages.
17	No coverage is provided for any contraceptive interventions that have the principal purpose, whether as an end or a means, to render procreation improbable. This exclusion does not apply, in the case of a sexual assault, to services and medications to prevent ovulation, sperm capacitation, or fertilization if, after appropriate testing, there is no evidence that conception has occurred already.
18	No coverage is provided for 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.
19	No coverage is provided for Preventive Health Services performed by a Non-Participating Provider.
20	No coverage is provided for 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.
21	No coverage is provided for services performed by your spouse, child, brother, sister, parent, or member of your household.
22	No coverage is provided for 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.
23	No coverage is provided for the following physical and occupational therapies: • 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.

Services and Treatments That Are Not Covered by the Plan	
	This exclusion does not apply to therapies provided at an inpatient mental health facility.
24	No coverage is provided for weight control programs, exercise programs, education, or nutritional counseling. This exclusion does not apply to nutritional counseling described in the *Diabetes care services* section or in the *Medical nutrition therapy* section. This exclusion does not apply to programs or counseling provided at an inpatient mental health facility.
25	No coverage is provided for drugs used or prescribed for the principal purpose of weight loss or weight control.
26	No coverage is provided for services or drugs that are Experimental or Investigational in nature.
27	No coverage is provided for services or items that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA). This exclusion applies to, but is not limited to, the following: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material.
28	No coverage is provided for the following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
29	No coverage is provided for Member convenience items or services, including, but not limited to, internet service, telephone service, telephones, televisions, guest trays, personal hygiene items, barber or salon services, air purifiers, or conditioners, and food delivery services. This exclusion does not apply to services and items provided at an inpatient mental health facility that are considered to be part of the costs of lodging.
30	No coverage is provided for disposable supplies for home use except as specifically described in the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections.

Services and Treatments That Are Not Covered by the Plan	
31	No coverage is provided for 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. If the Claims Administrator nevertheless provides payment for such services, the Plan will be entitled to establish a lien up to the amount paid by the Claims Administrator for the treatment of such injury or disease and obtain a recovery pursuant to that lien.
32	No coverage is provided for transportation services, except as specifically described in the *Ambulance services* section.
33	No coverage is provided for hospital care programs or services provided in a home setting (Hospital-at-home programs). This exclusion does not apply to services specifically described in the *Home health services* section.
34	The Claims Administrator does not administer the benefits for outpatient prescription drugs under the Reta Plan. Benefits for outpatient prescription drugs and medicines for Members covered by the Reta Plan are separately provided and administered by the Pharmacy Benefit Manager listed on the back of each Member's ID card. The Claims Administrator does administer benefits for prescribed drugs and medicines provided through a Participating Hospice Agency when the Member is receiving hospice services. The Claims Administrator does administer benefits for prescribed drugs and medicines specifically provided under the Home infusion and injectable medication services or the Hemophilia home infusion services sections.
35	No coverage is provided for Rehabilitative Services. This exclusion does not apply to services specifically described in the *Home health services*, *Hospice program services*, *Hospital services*, or *Rehabilitative and habilitative services* sections.
36	No coverage is provided for the following services provided by Non-Participating Providers: • Mammography; • Papanicolaou tests and other FDA-approved cervical cancer screening tests; • Family planning and consultation services; • Colorectal cancer screenings; or • Annual health appraisal exams.

Services and Treatments That Are Not Covered by the Plan	
37	No coverage is provided for speech therapy, speech correction, speech pathology, or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury, or illness. This exclusion does not apply to services specifically provided under the *Home health services*, *Hospice program services*, or *Rehabilitative and habilitative services* sections. This exclusion does not apply to services provided for the treatment of Mental Health or Substance Use Disorder Conditions.
38	No coverage is provided for any sterilization procedures, regardless of whether the induced sterility is intended to be permanent or temporary. This exclusion does not apply to procedures that induce sterility when their direct intended effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available. This exclusion does not apply to the removal of one part of the body or the suppression of its function for the sake of the body as a whole if the following conditions are satisfied: (1) there is no other reasonable means of addressing the physical pathological condition, (2) the efficacy of the procedure is reasonably well-assured, and (3) the benefits expected from the procedure are proportionate to the burdens it imposes. These conditions are satisfied when the body part itself is diseased and presents a risk to the life or well-ordered functioning of the body as a whole. These conditions are also satisfied when a healthy body part presents a risk to the life or well-ordered functioning of the body as a whole because its present or its functioning contributes to a serious physical pathology in another part of the body.
39	No coverage is provided for euthanasia or assisted suicide procedures. This exclusion does not apply, in the case of a patient in the terminal phase of an illness, to palliative measures, administered with the proper consent of the patient or surrogate, that induce a temporary or intermittent loss of consciousness and typical pain-management therapies have been ineffective, provided there is a plan of care is in place that addresses the degree and length of sedation. This exclusion does not apply, in the case of a dying person, to the administration of medicines directed toward alleviating or suppressing pain and other symptoms, even if the therapy may indirectly shorten the person's life so long as the dose is therapeutic and the intent is not to hasten death.
40	No coverage is provided for procedures or treatments that utilize tissue from an aborted fetus or cells harvested directly or indirectly (by way of a stem cell line) from a human embryo that was created or destroyed for the principal purpose of harvesting its cells.

Services and Treatments That Are Not Covered by the Plan	
41	No coverage is provided for interventions, whether surgical, hormonal, or by way of genetic engineering, that aim to transform the sexual characteristics of a human body into those of the opposite sex or to nullify the sexual characteristics of the human body. This exclusion applies to the removal of an organ in order to allow for its replacement with a simulation of the corresponding organ of the opposite sex; the removal of an organ because the absence of the organ is a characteristic of the opposite sex; and the reconfiguring of an organ in order to make the organ resemble as much as possible the corresponding organ of the opposite sex. This exclusion applies to drug or hormone therapy to induce or suppress changes to align an individual's primary or secondary sex characteristics with a gender identity that does not conform to the individual's biological sex, including the administration of puberty-suppressing hormones or masculinizing or feminizing hormones. This exclusion does not apply to health care services, such as counseling, intended to mitigate the suffering of those who suffer from gender incongruence or gender dysphoria, while also respecting the fundamental order of the human body.
42	No coverage is provided for treatment or procedures solely to increase or decrease height or to alter the rate of growth, including surgical procedures or devices to stimulate growth and the administration of growth hormones.
43	No coverage is provided for services for anyone in connection with a surrogacy arrangement, except for otherwise-covered services provided to a person covered by the Plan who is the surrogate. A "surrogacy arrangement" is an arrangement in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.
44	No coverage is provided for charges for services provided by a Non-Participating Provider that are in excess of the Allowable Amounts. This exclusion applies even if there was prior authorization from the Claims Administrator for treatment by the Non-Participating Provider.

Your Rights to Contest Adverse Benefit Determinations

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 Customer Service via telephone, mail, or by visiting the Claims Administrator's website at 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 180 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 30 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 60 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 Plan, 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 30 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.

Initial and Final Internal Appeals Are Mandatory If You Want to File a Lawsuit

A failure to complete the Initial Internal Appeal and Final Internal Appeal processes described above will ordinarily eliminate your right to bring a lawsuit on the denial of your Claim, unless the failure is excused by the court. The external review process is voluntary such that a failure to complete the external review process will not affect your right to bring a lawsuit against the Plan to recover benefits to which you claim you are entitled.

External Review

Standard External Review

If a final integral appeals determination involves medical judgment or a rescission of coverage and you are dissatisfied with it, you or 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. Instructions for submitting a request for external review will be outlined in the final internal appeal response letter.

The Independent Review Organization will provide a determination within 45 days after the Independent Review Organization receives the request for the external review. The determination of the Independent Review Organization will be limited to issues of medical judgment (medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) and issues of rescission of coverage.

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

Voluntary Appeal to the Reta Trust as Plan Administrator

As Plan Administrator, the Reta Trust has full power and authority to overturn a decision by the Claims Administrator if the Reta Trust determines that the decision of the Claims Administrator is contrary to the terms of the Plan.

Accordingly, if you have completed both the initial internal appeal and final internal appeal processes and you have received an adverse benefit determination from the Claims Administrator (Blue Shield of California), you may submit a request for reconsideration of the adverse benefit determination by way of a voluntary appeal to the Reta Trust as Plan Administrator. You may proceed with a voluntary appeal whether or not you have pursued the external review process. Furthermore, a designated representative, a provider, or an attorney may act on your behalf in a voluntary appeal.

A request for reconsideration as a voluntary appeal to the Plan Administrator should be submitted in writing to the following address:

Reta Trust
2121 California Street
Suite 350
Walnut Creek, CA 94596
Attn: Appeals

If you make a voluntary appeal to the Plan Administrator and the time period for filing a lawsuit has not already expired, then the time period for you to file a lawsuit is suspended during the time the voluntary appeal is pending, but not less than 90 days.

The Plan Administrator will have 90 days to decide your appeal, unless it determines that special circumstances require an extension of time. If an extension is required, the extension will be for no more than 90 days and the Plan Administrator will advise you of the need for the extension before the expiration of the initial 90-day period.

You may request a voluntary appeal at any time prior to the one-year deadline for filing a lawsuit discussed in the next section. If you do request a voluntary appeal and the time period for filing a lawsuit has not already expired, then the time period for you to file a lawsuit is suspended during the time the voluntary appeal is pending, but not less than 90 days.

Your Rights to File a Lawsuit; Your One-Year and Three-Year Deadlines

You have a right to bring a civil action (lawsuit) under Section 502(a) of ERISA to contest an adverse benefit determination. You may bring the lawsuit in either state or federal court, although if you file the lawsuit in state court, the Plan has the option to have it transferred to federal court.

No lawsuit or legal action of any kind related to a benefit decision, however, may be pursued by you, unless it is commenced within the **earlier** of the following dates:

- One year after the date of the Claims Administrator's final decision on the claim or other request for benefits, or
- Three years after the date of the provision of the service or services that are the subject of your claim.

If the Plan decides that an internal appeal to the Claims Administrator is untimely, then the Claims Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date for the purpose of the one-year deadline.

A request for an external review does **not** extend or suspend the time period for you to file a lawsuit.

If, however, you make a voluntary appeal to the Reta Trust as Plan Administrator and the time period for filing a lawsuit has not already expired, then the time period for you to file a lawsuit is suspended during the time the voluntary appeal is pending, but not less than 90 days. **This rule is designed to encourage the use of the voluntary appeal process if it has not already been used.**

You must exhaust the Plan's Internal Appeals procedures before filing a lawsuit or taking other legal action of any kind against the Plan. If you do not, you may lose your right to have the court make a decision on your claim, unless the court excuses your failure for some reason. This rule does not apply to an external review or a voluntary appeal to the Reta Trust as Plan Administrator. That is, you can still file a lawsuit even if you do not request an external review or a voluntary appeal.

Future Changes to Claims and Appeal Procedures

The Plan Administrator reserves the right to modify the claims and review policies, procedures, and time frames in this Benefit Booklet consistent with applicable law.

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).

The Plan's Rights When Your Injury or Illness Was Caused by Someone Else (Third Parties)

Rights to Subrogation and Reimbursement

The Plan has a right to subrogation and a right to reimbursement with respect to any amount you may or have a right to recover from someone you could or have sued. **What this means is that, 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, the Plan has a lead claim on any amount you recover from the third party.** These rights of the Plan can be enforced in a court of law.

References to "you" or "your" in this section shall include you, your estate in the event of your death, and your heirs and beneficiaries, unless otherwise stated.

The right to subrogation applies when the Plan has paid benefits on your behalf for an injury or illness for which any third party is or may be responsible. The right to subrogation means the Plan can be substituted for you and can succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits the Plan has paid that are related to the sickness or injury for which a third party is considered responsible.

The right to reimbursement is similar to subrogation. The right to reimbursement means that, if you receive or are entitled to receive a settlement, judgment, or other recovery from any third party as to whom it is alleged caused or is responsible for your illness or injury, you must use those proceeds from that settlement, judgment, or other recovery to fully return to the Plan 100% of the Plan benefits you receive from the Plan. The right of reimbursement shall apply to any benefits received from the Plan at any time until the rights are extinguished, resolved or waived in writing.

The Plan is not required to help you to pursue your claim for damages or personal injuries.

If you do not abide by the terms of this Section, the Plan may terminate Benefits to you and/or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan and you later are not covered by the Plan, the provisions of this Section continue to apply after you are no longer covered.

In the case of your death, the Plan's rights to subrogation and reimbursement shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

The provisions of this Section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

The Claims Administrator is the Plan's delegate for the enforcement of its rights to subrogation and to reimbursement.

The Plan Administrator, as well as its agents and administrators administering the provisions of this Section, has the authority necessary to enforce compliance with the provisions of this Section. This authority includes the discretionary authority (1) to construe and enforce the terms of the Plan's subrogation and reimbursement rights, (2) to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan, and (3) to provide or exchange medical payment information with the responsible third party, your legal representatives, an insurer, the insurer's or responsible third party's legal representative, or other third party.

Who Are "Third Parties" Who May Be Responsible for Your Illness or Injury?

The following persons and entities are considered "third parties" for purposes of the Plan's rights of subrogation and reimbursement:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the illness, injury, or damages.
- An employer in a workers' compensation case or other matter alleging workplace liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to an sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

Your Enrollment in the Plan Means You Have Agreed the Terms of this Section

By enrolling in the Plan, you are bound by the terms in this Benefit Booklet, including this Section. Those terms include your obligation to cooperate with the Plan and the Claims Administrator in protecting the Plan's legal and equitable rights to subrogation and/or reimbursement in a timely manner, including, but not limited to:

  - You are obligated to notify the Claims Administrator, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.

- You are obligated to provide any relevant information requested by the Claims Administrator.
- You are obligated to sign and/or deliver such documents as the Plan or its their agents reasonably request to secure the subrogation and reimbursement claim.
- You are obligated to respond to requests for information about any accident or injuries.
- You are obligated to make court appearances if requested by the Claims Administrator or the Plan.
- You are obligated to obtain the Plan's consent or the Plan's agent's consent before releasing any party from liability or payment of medical expenses.
- You are obligated to comply with the terms of this Section.
- You agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy – including no- fault benefits, PIP benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury.
- By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, and, through your enrollment in the Plan, you agree to this assignment voluntarily.

Your failure to cooperate as provided above would be a breach of contract, In such event, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan or its agents.

The Plan Has a Lien on Your Claims and Recoveries

The Plan's rights to reimbursement and subrogation create what is called an "equitable lien by agreement" in favor of the Plan. This equitable lien by agreement attaches to your legal rights to sue the third parties who are legally liable or responsible for the injury or illness, as well as any amounts you actually recover.

The amount of the equitable lien by agreement is the total amount of the benefits paid by the Plan for medical services for the treatment of the injury or illness for which the third party is responsible and legally liable. Benefits paid by the Plan also include benefits advanced.

If you receive any payment from any party because of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and /or your representative are obligated to hold those funds in trust for the benefit of the Plan, either in a separate bank account in your name or in your representative's trust account.

The Plan's equitable lien by agreement is a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan's equitable lien by agreement is a first priority right on your recoveries that you receive from the third party.

The Plan's equitable lien by arrangement is superior to any and all claims, debts, or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, which assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's equitable lien by agreement attaches to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs, and beneficiaries, no matter how those proceeds are captioned or characterized. For this purpose, recoveries include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages.

The Plan may assign its rights to enforce its equitable lien by agreement, as well as its other rights.

Legal Actions by the Plan

The Plan may, at its option, take necessary and appropriate action to enforce its rights under this Section. In particular, the Plan may file a lawsuit against you and others to recover the full amount of medical benefits you received for the illness or injury out of any settlement, judgment or other recovery from any third party considered responsible. The Plan may also file suit in your name to recover the benefits paid (which would not obligate the Plan in any way to pay you part of any recovery the Plan might obtain except as provided by law).

The Plan may also file a lawsuit against your legal representatives if your legal representatives receive settlement or judgment proceeds on your behalf. Your legal representatives may be liable to the Plan for what the law calls "equitable relief" if they disburse settlement or judgment proceeds that they receive on your behalf without paying to the Plan the amount of recovery to which it is entitled.

In the case of your death giving rise to any wrongful death or survival claim, the Plan may file a lawsuit against your estate, the personal representative of your estate, and your heirs or beneficiaries.

Amount of the Plan's Lien

The amount of the Plan's lien is 100% of the Plan benefits you received from the Plan.

In addition, if the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

No amount of associated costs, including attorneys' fees, shall be deducted from the amount of the Plan's lien and what the Plan is entitled to recover without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal

representatives obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized.

Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages.

No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

The Plan's rights to recovery are not reduced due to your own negligence.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

What To Do If You Make a Claim or File a Lawsuit Against a Third Party

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to the following address:

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

For the Plan to determine the existence of any rights the Plan may have and to satisfy those rights, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay the Plan directly.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, this Section will apply your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator will be subject to the Plan's lien and other rights to the same extent as if you had asserted the claim against the third party.

You Must Not Settle Your Claim with the Third Parties Without the Plan's Approval

You may not agree to waive, release, or reduce the Plan's rights under this Section without the Plan's prior written consent. You may not accept any settlement that does not fully reimburse the Plan for what it has paid out in medical benefits for the illness or injury for which the third party is responsible, without the Plan's written consent.

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

So that the rights the Plan may have be satisfied, you must complete and send all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay the Plan directly. You may not agree to waive, release, or reduce the Plan's rights under this provision without the Plan's prior written consent.

If you are entitled to Medicare, Medicare law may apply with respect to services covered by Medicare.

If any third party causes or is alleged to have caused you to suffer an illness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who suffers an illness or injury caused or alleged to have been cause by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's illness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

In the case of your death, the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

In the case of your death giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

The Plan Administrator and the Claims Administrator any other authorized agents administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge their duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights, and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Other important information about the 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.

Inter-Plan Programs

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Programs and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Services outside of the Claims Administrator's geographic service area (California), the claims for those services may be processed through one of these Inter-Plan Programs 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 do not contract with the Host Blue. The Claims Administrator's payment practices for both kinds of providers are described below.

Emergency Services

Members who experience an Emergency Medical Condition 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 the Claims Administrator's geographic service area (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 is set forth in the Benefit Booklet. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with participating healthcare providers, including direct payment to the provider.

The BlueCard® Program enables you to obtain Covered Services within the BlueCard® Service Area, 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 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 provider. Sometimes, it is an estimated price that considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also consider 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 some 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, your liability for any Covered Services would then be calculated 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 Services* section for information on emergency admission notification.

Non-participating providers outside of the Claims Administrator's geographic service area

When Covered Services are provided outside of the Claims Administrator's geographic service area (California) and within the BlueCard® Service Area by non-participating providers, the amount a Member pays for such services will be based on either the Host Blue's non-participating healthcare 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, the Member 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 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.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Claims Administrator pays claims for covered Emergency Services based on the Allowable Amount as defined in this Benefit Booklet.

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 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.

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 amounts paid by the Claims Administrator as payment in full. You may be liable to the Participating Provider for the difference, if any, between the amounts paid by the Claims Administrator and the reasonable value recovered for those services.

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 Employee 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 Employees.
- 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, the Claims Administrator 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

In the exercise of its fiduciary responsibility and authority to make benefit determinations, 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 Plan. 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. By enrolling in this Plan, each Member agrees that any provider or entity can disclose to the Claims Administrator such information that is reasonably needed by the Claims Administrator. Members must also 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 Plan.
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.
Claims Administrator	The claims payor designated by the Plan Administrator 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 or the Host Blue 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; or (3) amounts paid by governmental or private payors for the Services. 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 Plan.
Deductible	The Calendar Year amount you must pay for specific Covered Services before the Claims Administrator pays for Covered Services pursuant to the Plan. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not count toward the Calendar Year Deductible.

Dependent	The rules for eligibility of a spouse as a Dependent are established by your Employer. Natural and adopted children of an eligible Employee may be enrolled as Dependents up to age 26. The rules for eligibility of other categories of children, such as foster children and stepchildren, are established by your Employer. No spouse or child who is determined to be eligible as an Employee may be enrolled as a Dependent. **Other important information about the eligibility of spouses and children as Dependents is set forth in the Summary Plan Description for the Reta Plan.**
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; and • 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.

Employee	An individual who meets the eligibility requirements established by the Employer.
Employer	Refers to an employer that provides group health plan coverage for its employees through the Reta Trust. The Reta Trust is also an "employer" for certain purposes of the Employee Retirement Income Security Act of 1974, as amended (ERISA), by virtue of its status as a group or association of employers acting indirectly for its constituent employers in their interest in relation to an employee benefit plan. The Reta Trust collects contributions from its constituent employers and 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 shall be considered experimental or investigational if, as determined by Claims Administrator, at least one of the following elements is met: • Requires 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; or • Is 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, but nevertheless is authorized by law or by a government agency for use; or • Is not approved or recognized in accordance with accepted professional medical standards, but nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or • Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable, or where the consensus amongst experts in recognized published medical literature is that further studies or experience are necessary to determine effectiveness and net health benefit in treatment of the illness, injury, or condition at issue, but nevertheless are authorized by law or by a government agency for use.
Family	The Participant and all enrolled Dependents.

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; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • 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; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law; • Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • 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	May be either of the following: • 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 after a year of regular sexual relations without contraception.
Intensive Outpatient Program	An outpatient treatment program for Mental Health Conditions or Substance Use Disorder Conditions that provides structure, monitoring, and medical or psychological intervention at least three hours per day, three times per week.
Inter-Plan Program	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 Employee 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.
Medically Necessary *and Medical Necessity*	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, meet all of the following requirements: • 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 has 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 as either a Participant or a Dependent. Use of "you" in this document refers to the Member.
Mental Health Condition	Mental health disorders that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Non-Participating or Non-Participating Provider	Any provider who does not participate in this plan's network and does not contract with the Claims Administrator or a Host Blue 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. A Non-Participating Provider is 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 Plan's Pharmacy Network. These pharmacies are not contracted to provide services to the Plan's 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; • Psychological Testing; and • Behavioral Health Treatment. 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, and Out-of-Area Follow-up Care that are provided outside the BlueCard® Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services that are provided outside the BlueCard® 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 *Schedule of Benefits* section. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not count toward 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 that are at a minimum 20 hours per week.
Participant	An Employee who has been accepted for enrollment by his or her Employer and enrolled in the Plan by the Claims Administrator and who has maintained enrollment in accordance with this plan.
Participant Contribution (Premiums)	Amounts the Employer 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 the Host Blue 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 group health plan coverage described in this Benefit Booklet that is a constituent part of the Reta Plan and, if the context requires, the Reta Plan.
Plan Administrator	The Reta Trust.

Plan Sponsor	The Reta Trust.
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	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.
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.
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 under state law 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 specialties designated by the Claims Administrator.
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	Substance Use disorders that fall under the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Total Disability (Totally Disabled)	In the case of an Employee, or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity. 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.
Urgent Services	Those Covered Services rendered outside of the BlueCard® 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 BlueCard® Service Area.

Notices about your plan

Notice about the Administrative Services under this Plan:

Reta Trust is the Plan Sponsor and Plan Administrator. 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 coverage* sections. The Plan Sponsor 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 has 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 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 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 Customer Service or by visiting 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

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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, age, disability, or sex, 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, the Claims Administrator's 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, kwiji' 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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Schedule of Benefits

Reta Trust
Effective July 1, 2026
PPO Plan

Coverage Option: 5124 Reta Trust PPO 1000 80/60

This Schedule of Benefits shows your share of the cost of Covered Services under this coverage option. This Schedule of Benefits is part of the Benefit Booklet,[1] but does not describe all of the details of your Benefits.

For more information on specific Benefits, please refer to the applicable Benefit in the "Benefits and Cost Sharing" section. For Services and supplies that are excluded from coverage, see the section of the Benefit Booklet entitled "Exclusions: Services and Treatments That Are Not Covered by the Plan." Additional exclusions that apply only to a particular Service are listed in the description of that benefit in the "Benefits and Cost Sharing" section of the Benefit Booklet.

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 blueshieldca.com. If you do use a Non-Participating Provider, any charges above the Allowable Amount do not count towards your Out-of-Pocket Maximum and are your responsibility for payment to the provider. This extra out-of-pocket expense can be significant.

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$1,000
	Family coverage	$1,000: individual $2,000: Family

Calendar Year Out-of-Pocket Maximum[5]

A Calendar Year Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year when using Participating Providers. Any exceptions are listed in the Notes section at the end of this Schedule of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$5,000	$10,000
Family coverage	$5,000: individual $10,000: Family	$10,000: individual $20,000: Family

No Annual or Lifetime Dollar Limit

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

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Benefits[6]	Your Share After Satisfying the Deductible			
	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		40%	✔
Physician services				
Primary care office visit	$25/visit		40%	✔
Specialist care office visit	$40/visit		40%	✔
Office visit for allergy serum injection	$25/visit		40%	✔
Physician home visit	$25/visit		40%	✔
Physician or surgeon services in an Outpatient Facility	20%	✔	40%	✔
Physician or surgeon services in an inpatient facility	20%	✔	40%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$25/visit		40%	✔
Acupuncture services *Up to 12 visits per Member, per Calendar Year.*	$40/visit		40%	✔
Chiropractic services *Up to 24 visits per Member, per Calendar Year.*	$40/visit		40%	✔
Teladoc Health consultation	$25/consult		Not covered	
Podiatric services	$40/visit		40%	✔
Medical nutrition therapy, not related to diabetes	20%	✔	40%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	$0	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	**CYD[2] applies**	**When using a Non-Participating Provider[4]**	**CYD[2] applies**
For all other pregnancy and maternity care Covered Services, please refer to the applicable Benefit sections in this Summary of Benefits.				
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.*	$200/visit plus 20%		$200/visit plus 20%	
Emergency room Physician services	20%		20%	
Urgent care center services	$75/visit		$75/visit	
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	$0		40%	✔
Outpatient Department of a Hospital: surgery	20%	✔	40%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	40%	✔
Inpatient facility services				
Hospital services and stay (including for pregnancy and maternity care)	20%	✔	40%	✔
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	20%	✔	Not covered	
• Physician inpatient services	20%	✔	Not covered	
Bariatric surgery services				
Inpatient facility services	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient Facility services	20%	✔	40%	✔
Physician services	20%	✔	40%	✔
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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, and respiratory therapy.				
Office location	$40/visit		40%	✔
Outpatient Department of a Hospital	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Speech Therapy services				
Office location	$40/visit		40%	✔
Outpatient Department of a Hospital	20%	✔	40%	✔
Durable medical equipment (DME)				
DME	20%	✔	40%	✔
Breast pump	$0		40%	✔
Orthotic equipment and devices	20%	✔	40%	✔
Prosthetic equipment and devices	20%	✔	40%	✔
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.*	20%	✔	40%	✔
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%	✔	40%	✔
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	40%	✔
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	20%	✔	40%	✔
Hospital-based SNF	20%	✔	40%	✔
Hospice program services				
Pre-Hospice consultation	20%	✔	40%	✔
Routine home care	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
24-hour continuous home care	20%	✔	40%	✔
Short-term inpatient care for pain and symptom management	20%	✔	40%	✔
Inpatient respite care	20%	✔	40%	✔
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	40%	✔
• Self-management training	$25/visit		40%	✔
• Medical nutrition therapy	$25/visit		40%	✔
Dialysis services	20%	✔	40%	✔
PKU product formulas and special food products	20%	✔	40%	✔
Allergy serum billed separately from an office visit	20%	✔	40%	✔
Wigs	20%	✔	40%	✔

Mental Health and Substance Use Disorder Benefits	Your Share After Satisfying the Deductible			
	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	$25/visit		40%	✔
Teladoc Health mental health	$25/consult		Not covered	
Intensive outpatient care	20%	✔	40%	✔
Behavioral Health Treatment in an office setting	20%	✔	40%	✔
Behavioral Health Treatment in home or other non-institutional setting	20%	✔	40%	✔
Office-based opioid treatment	20%	✔	40%	✔
Partial Hospitalization Program	20%	✔	40%	✔
Psychological Testing	20%	✔	40%	✔
Inpatient services				
Physician inpatient services	20%	✔	40%	✔
Hospital services	20%	✔	40%	✔

Mental Health and Substance Use Disorder Benefits	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Residential Care	20%	✔	40%	✔

Prior Authorization

Please review the Benefit Booklet concerning Benefits that require prior authorization. Some examples of frequently-utilized Benefits that require prior authorization are as follows:

- Advanced imaging services
- Non-emergency inpatient facility admissions
- Intensive outpatient mental health services
- Surgery
- Hospice care
- Home health care
- Non-emergency ambulance services
- Prescription drugs administered by a Health Care Provider

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, a coverage option under the Reta Trust Group Medical. Please review the Benefit Booklet for more details of coverage outlined in this Schedule 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 Schedule 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 Plan 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 Plan 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 has a combined Participating Provider and Non-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:

- Your obligation to pay Coinsurance is calculated based on the Allowable Amount or Benefit maximum, whichever is less.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members at negotiated rates. 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 additional 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.
- **IMPORTANT: 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 Calendar Year 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 Plan will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

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 Calendar Year 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.

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

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 with 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.

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Schedule of Benefits

Reta Trust
Effective July 1, 2026
PPO Plan

Coverage Option: 5124 Reta Trust PPO 1000 80/60

This Schedule of Benefits shows your share of the cost of Covered Services under this coverage option. This Schedule of Benefits is part of the Benefit Booklet,[1] but does not describe all of the details of your Benefits.

For more information on specific Benefits, please refer to the applicable Benefit in the "Benefits and Cost Sharing" section. For Services and supplies that are excluded from coverage, see the section of the Benefit Booklet entitled "Exclusions: Services and Treatments That Are Not Covered by the Plan." Additional exclusions that apply only to a particular Service are listed in the description of that benefit in the "Benefits and Cost Sharing" section of the Benefit Booklet.

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 blueshieldca.com. If you do use a Non-Participating Provider, any charges above the Allowable Amount do not count towards your Out-of-Pocket Maximum and are your responsibility for payment to the provider. This extra out-of-pocket expense can be significant.

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$1,000
	Family coverage	$1,000: individual $2,000: Family

Calendar Year Out-of-Pocket Maximum[5]

A Calendar Year Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year when using Participating Providers. Any exceptions are listed in the Notes section at the end of this Schedule of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$5,000	$10,000
Family coverage	$5,000: individual $10,000: Family	$10,000: individual $20,000: Family

No Annual or Lifetime Dollar Limit

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

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

Benefits[6]	Your Share After Satisfying the Deductible			
	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		40%	✔
Physician services				
Primary care office visit	$25/visit		40%	✔
Specialist care office visit	$40/visit		40%	✔
Office visit for allergy serum injection	$25/visit		40%	✔
Physician home visit	$25/visit		40%	✔
Physician or surgeon services in an Outpatient Facility	20%	✔	40%	✔
Physician or surgeon services in an inpatient facility	20%	✔	40%	✔
Other professional services				
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$25/visit		40%	✔
Acupuncture services *Up to 12 visits per Member, per Calendar Year.*	$40/visit		40%	✔
Chiropractic services *Up to 24 visits per Member, per Calendar Year.*	$40/visit		40%	✔
Teladoc Health consultation	$25/consult		Not covered	
Podiatric services	$40/visit		40%	✔
Medical nutrition therapy, not related to diabetes	20%	✔	40%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal *For all other pregnancy and maternity care Covered Services, please refer to the applicable Benefit sections in this Summary of Benefits.*	$0	✔	40%	✔
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.*	$200/visit plus 20%		$200/visit plus 20%	
Emergency room Physician services	20%		20%	

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Urgent care center services	$75/visit		$75/visit	
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient Facility services				
Ambulatory Surgery Center	$0		40%	✔
Outpatient Department of a Hospital: surgery	20%	✔	40%	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	40%	✔
Inpatient facility services				
Hospital services and stay (including for pregnancy and maternity care)	20%	✔	40%	✔
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	20%	✔	Not covered	
• Physician inpatient services	20%	✔	Not covered	
Bariatric surgery services				
Inpatient facility services	20%	✔	40%	✔
Outpatient Facility services	20%	✔	40%	✔
Physician services	20%	✔	40%	✔
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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
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	20%	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	$0	✔	40%	✔
• Outpatient Department of a Hospital	20%	✔	40%	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	$40/visit		40%	✔
Outpatient Department of a Hospital	20%	✔	40%	✔
Speech Therapy services				
Office location	$40/visit		40%	✔
Outpatient Department of a Hospital	20%	✔	40%	✔
Durable medical equipment (DME)				
DME	20%	✔	40%	✔
Breast pump	$0		40%	✔
Orthotic equipment and devices	20%	✔	40%	✔
Prosthetic equipment and devices	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
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.*	20%	✔	40%	✔
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	20%	✔	40%	✔
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	40%	✔
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	20%	✔	40%	✔
Hospital-based SNF	20%	✔	40%	✔
Hospice program services				
Pre-Hospice consultation	20%	✔	40%	✔
Routine home care	20%	✔	40%	✔
24-hour continuous home care	20%	✔	40%	✔
Short-term inpatient care for pain and symptom management	20%	✔	40%	✔
Inpatient respite care	20%	✔	40%	✔
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%	✔	40%	✔
• Self-management training	$25/visit		40%	✔
• Medical nutrition therapy	$25/visit		40%	✔
Dialysis services	20%	✔	40%	✔
PKU product formulas and special food products	20%	✔	40%	✔
Allergy serum billed separately from an office visit	20%	✔	40%	✔

Benefits[6]	Your Share After Satisfying the Deductible			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Wigs	20%	✔	40%	✔

Mental Health and Substance Use Disorder Benefits	Your Share After Satisfying the Deductible			
	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	$25/visit		40%	✔
Teladoc Health mental health	$25/consult		Not covered	
Intensive outpatient care	20%	✔	40%	✔
Behavioral Health Treatment in an office setting	20%	✔	40%	✔
Behavioral Health Treatment in home or other non-institutional setting	20%	✔	40%	✔
Office-based opioid treatment	20%	✔	40%	✔
Partial Hospitalization Program	20%	✔	40%	✔
Psychological Testing	20%	✔	40%	✔
Inpatient services				
Physician inpatient services	20%	✔	40%	✔
Hospital services	20%	✔	40%	✔
Residential Care	20%	✔	40%	✔

Prior Authorization

Please review the Benefit Booklet concerning Benefits that require prior authorization. Some examples of frequently-utilized Benefits that require prior authorization are as follows:

- Advanced imaging services
- Non-emergency inpatient facility admissions
- Intensive outpatient mental health services
- Surgery
- Hospice care
- Home health care
- Non-emergency ambulance services
- Prescription drugs administered by a Health Care Provider

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, a coverage option under the Reta Trust Group Medical. Please review the Benefit Booklet for more details of coverage outlined in this Schedule 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 Schedule of Benefits.

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2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Plan 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 Plan 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 has a combined Participating Provider and Non-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.

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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:

- Your obligation to pay Coinsurance is calculated based on the Allowable Amount or Benefit maximum, whichever is less.

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4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members at negotiated rates. 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 additional 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.
- **IMPORTANT: 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**.

Notes

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

Calendar Year Out-of-Pocket Maximum explained. The Calendar Year 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 Plan will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

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 Calendar Year 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.

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

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 with 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.

Plans may be modified to ensure compliance with Federal requirements.

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