Exhibit A

(Part 1 of 2)

Blue Shield
of California

Access+ HMO®

[redacted]

Blue Shield Combined Evidence of Coverage and Disclosure Form

Google Inc.

Effective Date: July 1, 2004

Visit us at mylifepath.com

[redacted] Group

Combined Evidence of Coverage and Disclosure Form

Google Inc.

Access+ HMO Plan 10 Premier

Effective Date: July 1, 2004

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan.

Please read this Evidence of Coverage and Disclosure Form carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your Plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact Blue Shield Member Services at the address or telephone number listed at the back of this booklet.

PLEASE NOTE

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health Plan at Blue Shield's Member Services telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

The Blue Shield Access+ HMO Health Plan

Member Bill of Rights

As a Blue Shield Access+ HMO Plan Member, you have the right to:

1. Receive considerate and courteous care, with respect for 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 Access+ HMO Health Plan, the Services we offer you, the Physicians and other practitioners available to care for you.
5. Select a Personal Physician and expect his/her team of health workers to provide or arrange for all the care that you need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive preventive health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Personal Physician.
12. Communicate with and receive information from Member Services in a language you can understand.
13. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
14. Obtain a referral from your Personal Physician for a second opinion.
15. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
16. Voice complaints or grievances about the Access+ HMO Health Plan or the care provided to you and present your grievance in person to Blue Shield if you choose to do so.
17. Participate in establishing Public Policy of the Blue Shield Access+ HMO, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.

The Blue Shield Access+ HMO Health Plan

Member Responsibilities

As a Blue Shield Access+ HMO Plan Member, you have the responsibility to:

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

Table of Contents

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the Definitions section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

Employee - (1) an individual engaged on a full-time basis in the conduct of the business of the Employer, whose normal work week is at least 24 hours, and whose duties in such employment are performed at the Employer's regular places of business; or (2) a sole proprietor or partner of a partnership engaged on a full-time basis, at least 24 hours per week, in the Employer's business and who is included as an Employee under a health care plan Contract of the Employer. However, an individual is ineligible for coverage who works part-time, temporary, or is employed on a substitute basis.

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the Eligibility section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each individual in the employ of the Employer on the effective date of this Contract who was a Subscriber of Blue Shield by virtue of the Employer's previous Contract on the date immediately preceding the effective date of this Contract, who lives and/or works in the Plan Service Area is eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the date of hire.

   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.

2. The date of eligibility of a former Employee, who has been re-employed, shall be determined as follows: The Employee's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:

   a. he has resumed active work within 6 months after such termination; or

   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights; or

   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Employee entering the employ of the Employer on the date he resumed work and shall be eligible on the date he completes the period of service specified in.A.1.b.

3. If any class of Employees is not eligible under A.1., and if an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Employer on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

2. For all Mental Health and substance abuse Services-

For all Mental Health and substance abuse Services Blue Shield of California has contracted with the Plan's Mental Health Services Administrator (MHSA). The MHSA should be contacted for questions about Mental Health and substance abuse Services, MHSA Participating Providers, or Mental Health and substance abuse Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

US Behavioral Health Plan California
3111 Camino Del Rio North, Suite 600
San Diego, CA 92108

The MHSA can answer many questions over the telephone.

Note: The MHSA has established a procedure for our Members to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the MHSA at the number listed above.

XII. GRIEVANCE PROCESS

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Members' grievances with Blue Shield of California.

For all Services other than Mental Health and substance abuse-

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

The Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this form from Member Services. The completed form should be submitted to Member Services at the address as noted on the last page this booklet. The Member may also submit the grievance online by visiting our web site at http://www.mylifepath.com.

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

For all Mental Health and substance abuse Services-

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

The Member may also initiate a grievance by submitting a letter or a completed "Grievance

Form". The Member may request this form from the MHSA's Member Services Department. If the Member wishes, the MHSA's Member Services staff will assist in completing the Grievance Form. Completed grievance forms must be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting http://www.mylifepath.com.

1-877-263-9952

US Behavioral Health Plan California
Attn: Customer Service
P. O. Box 880609
San Diego, CA 92168

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

NOTE: If your Employer's health Plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

For all Services-

EXTERNAL INDEPENDENT MEDICAL REVIEW

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

XIII. OTHER PROVISIONS

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health Plan, you should first telephone your health Plan **at the number provided on the last page of this booklet** and use your health Plan's grievance process before contacting the Department. Utiliz-

ing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to health or utilization of Benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

PUBLIC POLICY PARTICIPATION PROCEDURE

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a Plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the Plan's facilities to provide health care services to them, their families, and the public (Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Director, Consumer Affairs
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone Number: 1-415-229-5104

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Director, Consumer Affairs, at the above address, who will acknowledge receipt of your letter;

2. Your name, address, phone number, Subscriber number, and group number should be included with each communication;

3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter;

4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRE-

SERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Member Services Department at the number provided on the last page of this booklet, or by accessing Blue Shield of California's internet site located at http://www.mylifepath.com and printing a copy.

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

Correspondence Address:
Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

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

Email Address:
blueshieldca_privacy@blueshieldca.com

NON-ASSIGNABILITY

Benefits of this Plan are not assignable.

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

FACILITIES

The Plan has established a network of Physicians, Hospitals, Participating Hospice Agencies and Non-Physician Health Care Practitioners in your Personal Physician Service Area.

The Personal Physician(s) you and your Dependents select will provide telephone access 24 hours a day, seven days a week so that you can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the Plan network provide access to 24-hour emergency services. The list of the Hospitals, Physicians and Participating Hospice Agencies in your Personal Physician Service Area indicates the location and phone numbers of these providers. Contact Member Services at the number provided on the last page of this booklet for information on Plan Non-Physician Health Care Practitioners in your Personal Physician Service Area.

For Urgent Services when you are outside California or the United States, you simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, 7 days a week. We will identify the BlueCard provider closest to you. Urgent Services when you are outside the U.S. are available through the BlueCard Worldwide Network. For Urgent Services when you are within California, but outside of your Personal Physician Service Area, you should contact your Personal Physician or Blue Shield Member Services at the number listed on the last page of this booklet in accordance with Section IV., How to Use Your Health Plan. For Urgent Services when you are within your Personal Physician Service Area, contact your Personal Physician to obtain Urgent Services which must be provided or authorized by your Personal Physician just like all other non-emergency Services of the Plan.

INDEPENDENT CONTRACTORS

Plan Providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield of California conducts a process of credentialing and certification of all Physicians who participate in the Access+ HMO Network. However, in no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing Services, including any Physician, Hospital, or other provider or their employees.

PAYMENT OF PROVIDERS

Blue Shield generally contracts with groups of Physicians to provide Services to Members. A fixed, monthly fee is paid to the groups of Physi-

cians for each Member whose Personal Physician is in the group. This payment system, capitation, includes incentives to the groups of Physicians to manage all Services provided to Members in an appropriate manner consistent with the contract.

If you want to know more about this payment system, contact Member Services at the number listed on the last page of this booklet.

PLAN INTERPRETATION

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

ACCESS+ SATISFACTION

You may provide Blue Shield with feedback regarding the service you receive from Plan Physicians. Return the prepaid postcard available from Member Services to Blue Shield. If you are dissatisfied with the service provided during an office visit with a Plan Physician, you may request a refund of your office visit Copayment, as shown in the Summary of Benefits under Physician Services.

XIV. DEFINITIONS

Access+ Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the Access+ HMO Plan and for Mental Health and substance abuse Services, an MHSA Participating Provider.

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

Activities of Daily Living (ADL) — the self-care and mobility skills required for independence in normal everyday living. This does not include recreational or sports activities.

Allowed Charges — the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for non-Plan Providers.

Benefits (Covered Services) — those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Calendar Year — a period beginning 12:01 a.m., January 1 and ending 12:01 a.m., January 1 of the following year.

Close Relative — the spouse, child, brother, sister, or parent of a Subscriber or Dependent.

Copayment — the amount which a Member is required to pay for certain Benefits.

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

Covered Services (Benefits) — those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Custodial or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Physician); or care furnished to a Member who is mentally or physically disabled, and:

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Dental Care and Services — services or treatment on or to the teeth or gums whether or not

caused by accidental injury, including any appliance or device applied to the teeth or gums.

Dependent —

1. a Subscriber's legally married spouse who is not covered for Benefits as a Subscriber and is not legally separated from the Subscriber; or

2. a Subscriber's Domestic Partner, who is not covered for Benefits as a Subscriber; or

3. a Subscriber's (or Domestic Partner's) unmarried child (including any stepchild or child placed for adoption) who is: (a) less than 19 years of age; or (b) less than 25 years of age, if a full-time student and proof of student status is submitted to and received by Blue Shield. Full-time student means a Dependent must be enrolled in a college, university, vocational, or technical school for a minimum of 12 units as an undergraduate, or 6 units as a graduate student; and (c) not covered for Benefits as a Subscriber, and (d) primarily dependent upon the Subscriber (or Domestic Partner) for support and maintenance, or is dependent upon the Subscriber (or Domestic Partner) for medical support by reason of a court order;

and who has been enrolled and accepted by Blue Shield of California as a Dependent and has maintained membership under the terms of the contract.

4. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), and the Dependent child is Totally Disabled (Physically Handicapped or Mentally Retarded), Benefits for such Dependent will be continued upon the following conditions:

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

   b. the Subscriber (or Domestic Partner) submits to Blue Shield a Physician's written certification of Total Disability within 31 days from the date of the Employer's or Blue Shield's request; and

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

      (1) within 6 months after the month when the Dependent would otherwise have been terminated; and

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

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

1. Both partners are 18 years of age or older, and of the same or different sex;

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

3. The partners are (a) not currently married nor have had another domestic partner within the last 6 months, unless such former partner is deceased, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

4. Both partners are jointly responsible for each other's "basic living expenses" during the domestic partnership;

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

6. The domestic partnership is validated by the Blue Shield specific Affidavit of Do-

mestic Partnership. This affidavit must be completed, signed by both partners and submitted to Blue Shield with the Member's enrollment application;

7. In lieu of the Affidavit of Domestic Partnership, the Subscriber and domestic partner may submit a specific Declaration of Domestic Partnership that is filed with a governmental entity where filing of domestic partner arrangements is required by law. Blue Shield Underwriting may waive the required affidavit after review and acceptance of the Declaration of Domestic Partnership issued by a governmental entity.

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

Dues — the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

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

1. placing the Member's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

Employee — an individual who meets the eligibility requirements set forth in the Group Health Service Contract between Blue Shield of California and your employer.

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

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

Family — the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued by the Plan to the Contractholder that establishes the Services Members are entitled to receive from the Plan.

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

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

Hospital — either (1.), (2.), (3.) or (4.) below:

1. a licensed and accredited health facility which is primarily engaged in providing, for compensation from patients, medical, diagnostic, and surgical facilities for the care and treatment of sick and injured Members on an Inpatient basis, and which provides such facilities under the supervision of a staff of Physicians and 24 hour a day nursing service by registered nurses. A facility which is principally a rest home, nursing home or home for the aged is not included; or
2. a psychiatric Hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or
3. a licensed health facility operated primarily for the treatment of alcoholism and/or substance abuse accredited by the Joint Commission on Accreditation of Health Care Organizations; or
4. a "psychiatric health facility" as defined in Section 1250.2 of the Health and Safety Code.

Independent Practice Association (IPA) — a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members. For all Mental Health and substance abuse Services, this definition includes the Mental Health Services Administrator (MHSA).

Infertility — either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of Infertility, or (2) because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

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

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

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

1. The eligible Employee or Dependent meets all of the following requirements (a.), (b.), (c.) and (d.):
   a. The Employee or Dependent was covered under another employer health benefit plan at the time he was offered enrollment under this Plan;
   b. The Employee or Dependent certified, at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if he was covered under another employer health plan, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee;
   c. The Employee or Dependent has lost or will lose coverage under another

employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation or divorce; and

d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or

2. The employer offers multiple health benefit plans and the eligible employee elects this Plan during an open enrollment period; or

3. A court has ordered that coverage be provided for a spouse or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or

4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the employer stating that prior to declining coverage, he or the individual through whom he was covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or

5. For eligible Dependents who have lost or will lose their no share-of-cost Medi-Cal coverage and who request enrollment within 31 days after notification of this loss of coverage; or

6. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, birth, or placement for adoption.

Medical Group — an organization of Physicians who are generally located in the same facility and provide Benefits to Members. For all Mental Health and substance abuse Services, this definition includes the Mental Health Services Administrator (MHSA).

Medically Necessary —

1. Benefits are provided only for Services which are Medically Necessary.

2. services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are:

   a. consistent with Blue Shield Medical Policy; and,

   b. consistent with the symptoms or diagnosis; and,

   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and,

d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in 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 services which are not Medically Necessary include hospitalization:

   a. for diagnostic studies that could have been provided on an Outpatient basis;

   b. for medical observation or evaluation;

   c. for personal comfort;

   d. in a pain management center to treat or cure chronic pain; or

   e. for Inpatient rehabilitation that can be provided on an Outpatient basis.

4. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

Member — either a Subscriber or Dependent.

Mental Health Services — see definition for Psychiatric Care.

Mental Health Services Administrator (MHSA) — Blue Shield of California has contracted with the Plan's Mental Health Services Administrator (**MHSA**). The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care, and will underwrite and deliver Blue Shield's Mental Health and substance abuse Services through a unique network of MHSA Participating Providers.

Mentally Retarded — only those Members, not psychotic, who are so mentally retarded from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control, and care for their own welfare or for the welfare of others or for the welfare of the community.

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

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

Open Enrollment Period — that period of time set forth in the contract during which eligible individuals and their Dependents may transfer from another health benefit plan sponsored by the Employer to the Blue Shield Access+ HMO Plan.

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

Out of Area Follow-up Care — Out of area Services which are Medically Necessary in nature following an initial Emergency or Urgent service to stabilize the patient's condition.

Outpatient — an individual receiving services under the direction of a Plan Provider, but not as an Inpatient.

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

Partial Hospitalization/Day Treatment Program — a treatment program that may be free-standing or Hospital-based and provides

services at least 5 hours per day and at least 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Participating Hospice or Participating Hospice Agency — an entity which: 1) provides Hospice services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice Service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Personal Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a Personal Physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all Benefits to Members in accordance with the contract.

Personal Physician Service Area — that geographic area served by your Personal Physician's Medical Group or IPA.

Physical Handicap — a physical or mental impairment that results in anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Physical Therapy — treatment under the direction of a Physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, utilizing physical agents, such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

Plan — the Blue Shield Access+ HMO Health Plan and/or Blue Shield of California.

Plan Hospital — a Hospital licensed under applicable state law contracting specifically with Blue Shield to provide Benefits to Members under the Plan.

Plan Non-Physician Health Care Practitioner – a health care professional who is not a physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals or Blue Shield to provide covered Services to Members when referred by a Personal Physician. For all Mental Health and Substance Abuse Services, this definition includes Mental Health Services Administrator (MHSA) Participating Providers.

Plan Provider — a provider who has an agreement with Blue Shield to provide Plan Benefits to Members and an MHSA Participating Provider.

Plan Service Area — that geographic area served by the Plan.

Plan Specialist — a Physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide covered Services to Members either according to an authorized referral by a Personal Physician, or according to the Access+ Specialist program, or for OB/GYN Physician Services. For all Mental Health and substance abuse Services, this definition includes Mental Health Services Administrator (MHSA) Participating Providers.

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

Psychiatric Care (Mental Health Care Services) — psychoanalysis, psychotherapy, counseling, medical management, or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist, for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury or any other condition.

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

Rehabilitation — care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential. Rehabilitation Services will be provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

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

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

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

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

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

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

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

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

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

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

Subscriber — an individual who satisfies the eligibility requirements of the contract, and who is enrolled and accepted by the Plan as a Subscriber, and has maintained Plan membership in accord with this contract.

Total Disability —

1. 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.
2. in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Urgent Services — those covered Services (other than Emergency Services) which are medically necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an unforeseen illness, injury or medical condition with respect to which treatment can not reasonably be delayed until the Member returns to the Plan's service area.

This combined Evidence of Coverage and Disclosure Form should be retained for your future reference as a Member of the Blue Shield Access + HMO Plan.

Should you have any questions, please call the Blue Shield of California Member Services Department at the number provided on the last page of this booklet.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Blue Shield of California

PPO Plan

[redacted]

Blue Shield Combined Evidence of Coverage and Disclosure Form

Google Inc.

Group Number: 975686

Effective Date: July 1, 2004

Visit us at mylifepath.com

[redacted] Group

Combined Evidence of Coverage and Disclosure Form

Google Inc.

Preferred Provider Plan

Effective Date: July 1, 2004

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Blue Shield health Plan.

Please read this Evidence of Coverage and Disclosure Form carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your Plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

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

PLEASE NOTE

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

PART I. INTRODUCTION

This Blue Shield of California Health Plan will provide or arrange for the provision of Services to eligible Subscribers and Dependents of the Contractholder in accordance with the terms, conditions, limitations and exclusions of this Group Health Service Contract.

The Evidence of Coverage and Disclosure Form is included and made part of this Contract.

PART II. DEFINITIONS

In addition to the provisions contained in the Definitions section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

Employee - (1) an individual engaged on a full-time basis in the conduct of the business of the Employer, whose normal work week is at least 24 hours, and whose duties in such employment are performed at the Employer's regular places of business; or (2) a sole proprietor or partner of a partnership engaged on a full-time basis, at least 24 hours per week, in the Employer's business and who is included as an Employee under a health care plan Contract of the Employer. However, an individual is ineligible for coverage who works part-time, temporary, or is employed on a substitute basis.

PART III. ELIGIBILITY

A. Employee Eligibility, Waiting Periods and Open Enrollment

In addition to the provisions contained in the Eligibility section of the Evidence of Coverage and Disclosure Form, the following provisions apply to this Group Health Service Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:

   a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each individual in the employ of the Employer on the effective date of this Contract who was a Subscriber of Blue Shield by virtue of the Employer's previous Contract on the date immediately preceding the effective date of this Contract, shall be eligible on the effective date of this Contract.

   b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the date of hire.

   c. If associated Employers are added, the effective date of the amendment adding an associated Employer shall be treated as the effective date of this Contract for the purpose of determining the date of eligibility of the Employees of such Employer.

2. The date of eligibility of a former Employee, who has been re-employed, shall be determined as follows: The Employee's period of service prior to termination of employment shall be included in the determination of his date of eligibility, provided:

   a. he has resumed active work within 6 months after such termination; or

   b. if his previous employment was terminated due to entry into the Armed Forces, he has resumed active work within the time set by law for reinstatement of employment rights; or

   c. if termination was due to disability, he has resumed active work within one month after ceasing to be disabled;

   otherwise he shall be considered as an Employee entering the employ of the Employer on the date he resumed work and shall be eligible on the date he completes the period of service specified in.A.1.b.

3. If any class of Employees is not eligible under A.1., and if an Employee transfers from such ineligible class to an eligible class, he shall be considered as having entered the employ of the Employer on the date of such transfer. Service in an ineligible class shall not be included in the determination of the date of eligibility.

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since your Preferred Provider directory was published.

Your I.D. card has your Subscriber and group numbers on it. Be sure to include these numbers on all claims you submit to Blue Shield of California.

YOU MAY NEVER HAVE TO FILL OUT A CLAIM FORM...

Hospitals and Blue Shield of California Preferred Providers usually bill Blue Shield of California directly.

...But If You Do Need to Fill Out a Claim — It's Easy.

Send a copy of your itemized bill, along with a completed Blue Shield of California Subscriber's Statement of Claim form to the Blue Shield of California service center listed on the last page of this booklet.

You may call Blue Shield of California Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Blue Shield of California claim form.

Be sure to send in a claim for all covered Services even if you have not yet met your Calendar Year deductible. Blue Shield of California will keep track of the deductible for you. Blue Shield of California uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

Requests for payment from any source must be submitted to Blue Shield within 1 year after the month Services were provided. Blue Shield will notify you of its determination within 30 days after receipt of the claim.

DEFINITIONS

PLAN PROVIDER DEFINITIONS

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

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

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

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

Hospital —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.

2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code; or

4. a facility operated primarily for the treatment of alcoholism and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

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

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

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

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

Non-Participating/Non-Preferred Providers — any provider who has not contracted with Blue Shield to accept Blue Shield's payment, plus any applicable deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider. NOTE: This definition **does not apply** to Mental Health and substance abuse Services. For Non-Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Non-Participating Providers definition above.

Other Providers —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; certified nurse anesthetists; certified nurse midwives; licensed occupational therapists; certificated acupuncturists; inhalation and enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.

2. Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, hemodialysis and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

Participating Ambulatory Surgery Center — a licensed Ambulatory Surgery facility which has contracted with Blue Shield of California to provide surgical services on an Outpatient basis and accept reimbursement at negotiated rates.

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

Participating Hospice or Participating Hospice Agency – an entity which: 1) provides Hospice services to Terminally Ill Persons and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice Service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Participating Physician — a Physician or a Physician Member that has contracted with Blue Shield to furnish Services and to accept Blue Shield's payment, plus applicable deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Subscriber Copayment provision in this booklet.

Participating Provider — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, or a Home Health Care

and Home Infusion agency that has contracted with Blue Shield of California to furnish Services and to accept Blue Shield of California's payment, plus applicable deductibles and Copayments, as payment in full for covered Services, except as provided under the Payment and Subscriber Copayment provision in this booklet. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Participating Provider that is not a Preferred Provider.

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

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

Physician Member — a Doctor of Medicine who has enrolled with Blue Shield as a Physician Member.

Preferred Hospital — a Hospital under contract to Blue Shield which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by Blue Shield. NOTE: For Participating Providers for Mental Health and substance abuse Services, see the Mental Health Services Administrator (MHSA) Participating Providers definition above.

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

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

ALL OTHER DEFINITIONS

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

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

Activities of Daily Living (ADL) — the self-care and mobility skills required for independence in normal everyday living. This does not include recreational or sports activities.

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

Allowable Amount — the Blue Shield of California Allowance (as defined below) for the Service (or Services) rendered, or the provider's Billed Charge, whichever is less. The Blue Shield of California Allowance is:

1. the amount Blue Shield of California has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as Blue Shield's evaluation of the value of the Service(s) relative to the value of other Services, market considerations, and provider charge patterns; or

2. such other amount as the provider and Blue Shield of California have agreed will be accepted as payment for the Service(s) rendered; or

3. if an amount is not determined as described in either (1.) or (2.) above, the amount Blue Shield of California determines is appropriate considering the particular circumstances and the Services rendered.