Brown v. Google, Inc. et al Doc. 32 Att. 2

Exhibit A

(Part 2 of 2)

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Benefits (Services) — those Services which a Person is entitled to receive pursuant to the Group Health Service Contract.

Billed Charges — the amount actually charged for covered Services except the amount which exceeds that normally charged other patients for the same Service.

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

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

Close Relative — the spouse, children, brothers, sisters or parents of a covered Person.

Copayment — the amount that a Person is required to pay for certain Services after meeting any applicable deductible.

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

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. Title XVIII of the Social Security Act, e.g., Medicare.
3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored or funded program of medical care.

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

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

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 Domestic 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 Person 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) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Employee — an individual who meets the eligibility requirements set forth in the Group 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.

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

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

Family — the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued by the Plan to the contractholder that establishes the Services that Subscribers and Dependents 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 items such as wheelchairs, Hospital beds, respirators, and other items that Blue Shield of California determines are Home Medical Equipment.

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

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 shall not be considered a Late Enrollee if any of the following paragraphs (1.), (2.), (3.), (4.), (5.) or (6.) is applicable:

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):

   a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and

   b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and

   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation 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, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, as well as a 6 month Pre-existing Condition exclusion, 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.

Mental Health Services — see definition of 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 separate network of MHSA Participating Providers.

Mentally Retarded (or Mental Retardation) — only those Persons, 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.

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

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

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

Partial Hospitalization/Day Treatment Program — a treatment program that may be freestanding 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.

Person — either a Subscriber or Dependent.

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 Medicine — services including but not limited to physical medicine evaluations and management, office visits, patient training, and treatment utilizing physical agents, such as ultrasound, heat and massage, rendered by a Doctor of Medicine, registered physical therapist, or certified occupational therapist to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Blue Shield PPO Plan and/or Blue Shield of California.

Pre-existing Condition — an illness, injury or condition (including Total Disability) which existed during the 6 months prior to the enrollment date of coverage if, during that time, any medical advice, diagnosis, care or treatment was recommended or received from a licensed health practitioner.

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

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

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

Rehabilitation or Rehabilitative Care — care furnished primarily to an Inpatient to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation or Rehabilitative Care services consist of the combined use of medical, social, educational,

occupational/vocational treatment modalities and are provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders **(other than a primary substance use disorder or developmental disorder)**, that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

   (a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;

   (b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes medically necessary healthcare services and medically necessary supplies furnished incident to those services.

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

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

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

2. Used in place of normal food products, such as grocery store foods, used by the general population.

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

Subacute Care — skilled nursing or skilled 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 an Employee, who has been enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Blue Shield of California coverage under the group contract.

Total Disability (or Totally Disabled) —

1. in the case of an Employee or Person 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.

ELIGIBILITY

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

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer's next open enrollment period and shall be subject to a six-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

Newborn infants of the Subscriber will be eligible immediately after birth for the first 31 days. Children placed for adoption will be eligible immediately upon the date the Subscriber or spouse has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield prior to 31 days from the date of birth or placement for adoption of such Dependent.

You may add newly acquired Dependents and yourself to the Plan by submitting a written application on forms furnished by Blue Shield of California within 31 days from the date of acquisition of the Dependent:

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

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

If a husband and wife are both eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are Physically Handicapped or Mentally Retarded, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of Mental Retardation or Physical Handicap within 31 days of the request for information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the Employee 6 months later and annually thereafter.

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

EFFECTIVE DATE OF COVERAGE

Your coverage will become effective at 12:01 a.m. Pacific Time on the eligibility date established by your Employer. You become eligible when you submit a written application on the form furnished by Blue Shield, and completed health statement when required by your Employer, within 31 days of that date. If you enroll during the initial enrollment period, you will become eligible on your eligibility date.

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

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date of request for enrollment or at the Employer's next open enrollment period and shall be subject to a six-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

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

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

1. For marriage, the effective date will be the first day of the first month following receipt of your request for enrollment;

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

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

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

Any individual who becomes eligible at a time other than during the annual open enrollment (e.g., newborn, child placed for adoption, new spouse, newly hired or newly transferred employees) must complete an enrollment form within 31 days of becoming eligible.

To receive credit for your prior Creditable Coverage, submit to Blue Shield a certificate from your prior employer, insurer, or health plan which shows the period of time you were covered under the prior Creditable Coverage. If you are unable to obtain the certificate, you should contact Blue Shield of California's Customer Service area for assistance.

This Plan's Pre-existing Condition exclusion does not apply to:

1. pregnancy Benefits;

2. newborns or children placed for adoption who had prior Creditable Coverage within 30 days of the birth, or placement for adoption, who enrolled in this Plan within 63 days of that prior Creditable Coverage (exclusive of any waiting period).

EXCLUSION FOR DUPLICATE COVERAGE

In the event that you are covered under this Plan and are also entitled to benefits under any of the conditions listed below, Blue Shield's liability for services (including room and board) provided for the treatment of any one illness or injury will be reduced by the amount of benefits paid, or the reasonable value or the amount of Blue Shield's fee-for-service payment to the provider, whichever is less, of the services or supplies provided without any cost to you, because of your entitlement to such other benefits. This exclusion is applicable to benefits received from any of the following sources:

1. Benefits provided under Title XVIII of the Social Security Act (commonly known as Medicare). If a covered Person receives services for which he is entitled to benefits under Medicare and those services are also covered under this Plan, the Benefits of this Plan will be provided less the amount paid under Medicare. Any deductible or Copayment requirement of this Plan will be waived when Medicare is primary and the provider of services has accepted Medicare assignment. This exclusion for Medicare does not apply when the Employer is subject to the Medicare Secondary Payer laws and the Employer maintains:

   a. an employer group health plan that covers Persons entitled to Medicare solely because of end-stage renal disease and active Employees or spouses entitled to Medicare by reason of age; and/or

   b. a large group health plan as defined under the Medicare Secondary Payer laws that covers Persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to an individual who becomes eligible for Medicare benefits prior to age 65, but who had not enrolled under Medicare on the date that he received notice from Blue Shield of California of eligibility for such enrollment.

2. Any services, including room and board, provided by any other Federal or State governmental agency, or by any Municipality, County or other political subdivision except that this exclusion does not apply to the Medi-Cal program, or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code or for reasonable costs of services provided to the Person at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the Person is not on active duty.

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS REVIEW

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

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

Customer Service can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Subscribers and Dependents to request an expedited decision. A Person, Physician, or representative of a Person may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Person, or when the Person is experiencing severe pain. Blue Shield shall make a decision and notify the Person 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 our Customer Service Department at the number provided on the last page of this booklet.

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 network Providers, or Mental Health and substance abuse Benefits. You may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952

U.S. 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 Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. The MHSA shall make a decision and notify the Subscriber 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.

GRIEVANCE PROCESS

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

For all Services other than Mental Health and substance abuse

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

The Subscriber may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from Customer Service. The completed form should be submitted to Customer Service at the address as noted on the last page of this booklet. The Subscriber 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 Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

For all Mental Health and substance abuse Services

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

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

1-877-263-9952

U.S. 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 Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

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

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 grievance 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 submit a grievance to 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 Customer Service. 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

Blue Shield
of California

PPO Plan

[redacted]

Blue Shield Combined Evidence of Coverage and Disclosure Form

Google Inc.

Group Number: 975687

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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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.

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.

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 Hospice Program Services. For Participating Providers for Hospice Program Services, see the 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.

Preferred Provider — a Physician Member, a Preferred Hospital, or a Participating Provider.

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.

Benefits (Services) — those Services which a Person is entitled to receive pursuant to the Group Health Service Contract.

Billed Charges — the amount actually charged for covered Services except the amount which exceeds that normally charged other patients for the same Service.

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

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

Close Relative — the spouse, children, brothers, sisters, or parents of a covered Person.

Copayment — the amount that a Person is required to pay for certain Services after meeting any applicable deductible.

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

Creditable Coverage —

1. Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. Title XVIII of the Social Security Act, e.g., Medicare.

3. The Medicaid/Medi-Cal program pursuant to Title XIX of the Social Security Act.

4. Any other publicly sponsored or funded program of medical care.

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

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

2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

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 Domestic 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 Person 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) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Employee — an individual who meets the eligibility requirements set forth in the Group 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.

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

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

Family — the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued by the Plan to the contractholder that establishes the Services that Subscribers and Dependents 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 items such as wheelchairs, Hospital beds, respirators, and other items that Blue Shield of California determines are Home Medical Equipment.

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

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.

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

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
   a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and
   b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation 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, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, as well as a 6 month Preexisting Condition exclusion, 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.

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.

Mental Health Services — see definition of Psychiatric Care.

Mentally Retarded (or Mental Retardation) — only those Persons, 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.

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

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

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

Partial Hospitalization/Day Treatment Program — a treatment program that may be freestanding 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.

Person — either a Subscriber or Dependent.

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 Medicine — services including but not limited to physical medicine evaluations and management, office visits, patient training, and treatment utilizing physical agents, such as ultrasound, heat and massage, rendered by a Doctor of Medicine, registered physical therapist, or certified occupational therapist to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan — the Blue Shield PPO Plan and/or Blue Shield of California.

Pre-existing Condition — an illness, injury or condition (including Total Disability) which existed during the 6 months prior to the enrollment date of coverage if, during that time, any medical advice, diagnosis, care or treatment was recommended or received from a licensed health practitioner.

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

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

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

Rehabilitation or Rehabilitative Care — care furnished primarily to an Inpatient to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation or Rehabilitative Care services consist of the combined use of medical, social, educational,

occupational/vocational treatment modalities and are provided for as long as continued treatment is Medically Necessary pursuant to the treatment plan.

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders **(other than a primary substance use disorder or developmental disorder),** that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

(a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community: and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;

(b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes medically necessary healthcare services and medically necessary supplies furnished incident to those services.

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

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

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

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

Subacute Care — skilled nursing or skilled 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 an Employee, who has been enrolled and accepted by Blue Shield of California as a Subscriber, and has maintained Blue Shield of California coverage under the group contract.

Total Disability (or Totally Disabled) —

1. in the case of an Employee or Person otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the in-

dividual'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.

ELIGIBILITY

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

When you decline coverage for yourself or your Dependents during the initial enrollment period and later request enrollment, you and your Dependents will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer's next open enrollment period and shall be subject to a 6-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

Newborn infants of the Subscriber will be eligible immediately after birth for the first 31 days. Children placed for adoption will be eligible immediately upon the date the Subscriber or spouse has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by Blue Shield prior to 31 days from the date of birth or placement for adoption of such Dependent.

You may add newly acquired Dependents and yourself to the Plan by submitting a written application on forms furnished by Blue Shield of California within 31 days from the date of acquisition of the Dependent:

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

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

If a husband and wife are both eligible to be Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are Physically Handicapped or Mentally Retarded, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician's written certification of Mental Retardation or Physical Handicap within 31 days of the request for information by the Employer or by Blue Shield. Proof of continuing disability and dependency must be

submitted by the Employee 6 months later and annually thereafter.

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

EFFECTIVE DATE OF COVERAGE

Your coverage will become effective at 12:01 a.m. Pacific Time on the eligibility date established by your Employer. You become eligible when you submit a written application on the form furnished by Blue Shield, and completed health statement when required by your Employer, within 31 days of that date. If you enroll during the initial enrollment period, you will become eligible on your eligibility date.

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

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date of request for enrollment or at the Employer's next open enrollment period and shall be subject to a six-month Pre-Existing Condition exclusion. Blue Shield will not consider applications for earlier effective dates.

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

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

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

1. For marriage, the effective date will be the first day of the first month following receipt of your request for enrollment;

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

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

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

Any individual who becomes eligible at a time other than during the annual open enrollment (e.g., newborn, child placed for adoption, new spouse, newly hired or newly transferred employ-

Secondary Payer laws and the Employer maintains:

a. an employer group health plan that covers Persons entitled to Medicare solely because of end-stage renal disease and active Employees or spouses entitled to Medicare by reason of age; and/or

b. a large group health plan as defined under the Medicare Secondary Payer laws that covers Persons entitled to Medicare by reason of disability.

This paragraph shall also apply to an individual who becomes eligible for Medicare benefits prior to age 65, but who had not enrolled under Medicare on the date that he received notice from Blue Shield of California of eligibility for such enrollment.

2. Any services, including room and board, provided by any other Federal or State governmental agency, or by any Municipality, County or other political subdivision except that this exclusion does not apply to the Medi-Cal program, or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code or for reasonable costs of services provided to the Person at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the Person is not on active duty.

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS REVIEW

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

REDUCTIONS

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

The covered Person is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such covered Person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agree to fully cooperate with Blue Shield to execute any forms or documents needed to assist them in exercising their equitable right to restitution or other available remedies; and

3. Provide Blue Shield with a lien, in the amount of reasonable costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

A covered Person's failure to comply with 1 through 3, above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

When a Person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the

of California ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Person must be a Subscriber who has been accepted by the Employer and enrolled by Blue Shield of California and who has maintained enrollment under the terms of this Plan.

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

If the Person receives Services from a Non-Preferred Provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the Non-Preferred Provider. The Person or the provider of Service may not request that the payment be made directly to the provider of Service.

SERVICES FOR EMERGENCY CARE

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

PLAN INTERPRETATION

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

CUSTOMER SERVICE

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

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

Customer Service can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Subscribers and Dependents to request an expedited decision. A Person, Physician, or representative of a Person may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Person, or when the Person is experiencing severe pain. Blue Shield shall make a decision and notify the Person 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 our Customer Service Department at the number provided on the last page of this booklet.

GRIEVANCE PROCESS

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

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

The Subscriber may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from Customer Service. The completed form should be submitted to Customer Service at the address as noted on the last page of this booklet. The Subscriber 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 Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

External Independent Medical Review

If your grievance 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 submit a grievance to 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 Customer Service. 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 Customer Service.

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. Utilizing 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 reasons of 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 established 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 Persons who rely on the Plan's facilities to provide health care Services to them, their families, and the public (California Health and Safety Code, §1369).

At least one third of the Board of Directors of Blue Shield of California 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: 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 PRESERVING 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 Customer Service 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: