



**SYMBOLIC DISPLAYS**  
**12/01/2019**  
**Platinum Full PPO 0/10 OffEx**



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December 18, 2019

GROUP NAME: **SYMBOLIC DISPLAYS**

GROUP NUMBER: **W0051076-M0016488**

Thank you for continuing your Blue Shield of California coverage.

The enclosed Contract replaces any that have previously been issued. In order to complete the enrollment process, it is necessary for you to sign and return the original application page to us as soon as possible.

Please sign the first application page and return it by fax to (209) 367-6433 or by email at [Small.Group@blueshieldca.com](mailto:Small.Group@blueshieldca.com). The accompanying Contract is for your records.

We appreciate your trust and look forward to a continuing relationship.

**Contract Processing**  
**Lodi Product Services**  
P.O. Box 3008  
Lodi, CA 95241

An independent member of the Blue Shield Association



**APPLICATION IS HEREBY MADE TO**  
**Blue Shield of California**  
**(California Physicians' Service)**

FOR A GROUP HEALTH SERVICE CONTRACT

**BY:     SYMBOLIC DISPLAYS**  
**1917 ST ANDREW PLACE EAST**  
**SANTA ANA, CA 92705**

This Contract, number **W0051076-M0016488**, shall be effective **December 1, 2019**. It has been read and approved, and the terms and conditions are accepted by the Contractholder.

The Contractholder, on behalf of itself and its Subscribers, hereby expressly acknowledges its understanding that this agreement constitutes a Contract solely between the Contractholder and Blue Shield of California (hereafter referred to as "the Plan"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting the Plan to use the Blue Shield Service Mark in the State of California, and that the Plan is not contracting as the agent of the Association. The Contractholder further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Plan and that neither the Association nor any person, entity, or organization affiliated with the Association, shall be held accountable or liable to the Contractholder or its Subscribers for any of the Plan's obligations to the Contractholder created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this agreement.

**The Contractholder shall sign, date, and return this original application page to Blue Shield of California by fax to (209) 367-6433.** The Contract shall be retained by the Contractholder. Payment of Premiums and acceptance of Blue Shield's performance hereunder by the Contractholder shall be deemed to constitute the Contractholder's acceptance of the terms hereof, whether or not this agreement is signed by the Contractholder.

The Contractholder is responsible for communicating any changes to Benefits as set forth in Part IX., Contractholder Responsibility for Distribution and Notification Requirements. Please see this section for important timelines for distribution of information.


It is agreed that this application supersedes any previous application for this Contract.

Dated at \_\_\_\_\_ (City, State)  
this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_  
(Legal Name of Contractholder)

By \_\_\_\_\_  
Title \_\_\_\_\_

**PLEASE SIGN, DATE AND FAX THE ORIGINAL APPLICATION PAGE**  
**TO BLUE SHIELD OF CALIFORNIA AT: (209) 367-6433**  
**or mail to Blue Shield of California,**  
**P.O. Box 629014, El Dorado Hills, CA 95762.**

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield of California at the address provided on page GC-1.

blue  of california





**601 12<sup>th</sup> Street  
Oakland, CA 94607  
(510) 607-2000**

## **GROUP HEALTH SERVICE CONTRACT**

### **Full PPO Off Exchange**

between

### **SYMBOLIC DISPLAYS** *("Contractholder")*

and

California Physicians' Service  
dba Blue Shield of California  
a not-for-profit corporation

In consideration of the applications and the timely payment of Premiums, Blue Shield agrees to provide Benefits of this Contract to covered Employees and their covered Dependents.

This Contract shall be effective as of **December 1, 2019**, for a term of 12 months, subject to the provisions entitled, "Changes: Entire Contract".

A handwritten signature in black ink, appearing to read "Steve Shue", with a long horizontal flourish extending to the right.

**VICE PRESIDENT AND GENERAL MANAGER  
SMALL BUSINESS MARKET**

Group Number: **W0051076-M0016488**

Original Effective Date: **September 1, 2012**





## MONTHLY DUES/PREMIUMS SCHEDULE

Refer to PART V. of this Contract for additional information pertaining to the payment of Dues/Premiums.

The Employer will pay to Blue Shield the following monthly Premiums:

<b>SYMBOLIC DISPLAYS W0051076-M0016488</b> <b>Dues - Subscriber / Member Rates</b> <b>Region 18</b>							
Age Category	Premiums	Age Category	Premiums	Age Category	Premiums	Age Category	Premiums
0-14	\$374.57	27-27	\$513.14	40-40	\$625.76	53-53	\$998.86
15-15	\$407.87	28-28	\$532.24	41-41	\$637.51	54-54	\$1,045.37
16-16	\$420.60	29-29	\$547.90	42-42	\$648.77	55-55	\$1,091.89
17-17	\$433.33	30-30	\$555.74	43-43	\$664.44	56-56	\$1,142.32
18-18	\$447.04	31-31	\$567.49	44-44	\$684.02	57-57	\$1,193.25
19-19	\$460.75	32-32	\$579.24	45-45	\$707.04	58-58	\$1,247.60
20-20	\$474.95	33-33	\$586.59	46-46	\$734.46	59-59	\$1,274.53
21-21	\$489.64	34-34	\$594.42	47-47	\$765.30	60-60	\$1,328.87
22-22	\$489.64	35-35	\$598.34	48-48	\$800.56	61-61	\$1,375.88
23-23	\$489.64	36-36	\$602.25	49-49	\$835.32	62-62	\$1,406.73
24-24	\$489.64	37-37	\$606.17	50-50	\$874.49	63-63	\$1,445.41
25-25	\$491.60	38-38	\$610.09	51-51	\$913.17	64-plus	\$1,468.91
26-26	\$501.39	39-39	\$617.92	52-52	\$955.77		

## HEALTH DUES/PREMIUMS

An Employee's Premiums will automatically increase the first day of the plan year following the plan year in which an age change that moves the Employee into the next higher age category occurs. Dependent age changes will similarly affect the portion of the premium attributed to them, if any. The Premiums set forth above do not include coverage for dental (other than pediatric dental benefits), vision (other than pediatric vision benefits), or life insurance when applicable.

The Employer must be located in, and the Employee and all Dependents must live, reside, or work in, the Service Area to be eligible for this health plan.

## IMPORTANT

No person has the right to receive the Benefits of this Contract for services or supplies furnished following termination of coverage, except as specifically provided in the Group Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage. Benefits of this Contract are available only for services and supplies as included in the applicable sections of the Evidence of Coverage, furnished during the term the Contract is in effect and while the individual claiming Benefits is actually covered by this Contract. Benefits may be modified during the term of this Contract under the applicable section in Part V. Premiums, Part VIII. General Provisions, D. Changes: Entire Contract, or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Contract.

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## PART I. INTRODUCTION

Blue Shield of California (“Blue Shield”) 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 (“Contract”).

The EOC 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, the following provisions apply to this Contract:

**Employee** - (1) an individual engaged in the conduct of the business of the Employer and whose duties in such employment are performed at the Employer’s regular places of business. This individual is a permanent employee and works a normal workweek of an average of 30 hours per week over the course of a month. At the option of the Employer and elected prior to issuance of the Contract, an Employee may also include a permanent employee who works at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. An individual who works on a part-time, temporary, or substitute basis is not included in this definition (e.g., short-term employment).

Or (2), a sole proprietor or partner of a partnership engaged on a full-time basis, and who is included as an employee under a health benefit plan of the Employer. A sole proprietor or partner works an average of at least 30 hours per week over the course of a month in the Employer’s business; however, if elected by the Employer prior to issuance of the Contract, the definition will also include a sole proprietor or partner who works at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter.

### **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, the following provisions apply to this Contract:

1. The date of eligibility of Employees who enroll during the initial enrollment period shall be determined as follows:
  - a. Inasmuch as this Contract replaces a Contract between Blue Shield and the Employer, each individual in the employ of the Employer on the effective date of this Contract who was a Subscriber of Blue Shield by virtue of the Employer's previous Contract on the date immediately preceding the effective date of this Contract, who lives and/or works in the Plan Service Area is eligible on the effective date of this Contract.
  - b. Each individual, except as provided in paragraph a. above, shall be eligible to enroll on the first of the month following the completion of any applicable waiting period established by the Employer.
  - 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. However, there will be no waiting periods as prohibited by The Military & Veterans Code; 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.
4. The Employer agrees to offer health Benefits coverage to all eligible Employees during the initial enrollment period and distribute information as set forth in Part IX., Contractholder Responsibility for Distribution and Notification Requirements. In addition, the Employer agrees to get the Employee's signed acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of the Employee's later decision to elect coverage, an exclusion from coverage for a period of 12 months, or at the Employer's next Open Enrollment Period, whichever is earlier, unless the Employee meets the criteria for a Special Enrollment Period as defined in the Evidence of Coverage. Blue Shield will not consider applications for earlier effective dates.
5. An Employee may transfer enrollment for himself or his Dependent(s) from another group health plan sponsored by the Employer to the health Plan covered by this Contract only during the Open Enrollment Period in November of each year. The effective date of Benefits for such Employee and Dependent(s) shall be the first day of each subsequent December. Submission of evidence of acceptability is not required when application is made during this Open Enrollment Period.
6. The Employer shall timely report any additions or terminations of Employees or Dependents so that retroactive Premiums adjustments are avoided and claims are not paid for ineligible individuals. However, if the Employer determines that it has made an administrative error in the processing of eligibility for an Employee or Dependent, Blue Shield will accept the retroactive changes subject to the following limitations:

### PART III. ELIGIBILITY

- a. Blue Shield will accept enrollment of the Employee or Dependent retroactively for a maximum of 30 days, as long as Premiums are paid by the Employer for the entire retroactive enrollment period. If an Employee or Dependent is retroactively enrolled pursuant to this, and the Employee or Dependent received covered health care services during that retroactive period, Blue Shield will reimburse the Employee for payments made for Covered Services received in accordance with the rules of the EOC, minus the Member's Copayments or Coinsurance as stated in the EOC;
  - b. Blue Shield will accept termination/disenrollment of the Employee or Dependent retroactive for a maximum of 30 days and will refund appropriate Premiums paid for the retroactive termination period. In such case, Blue Shield reserves the right to request refund from the Employee for any payments made for services rendered during the retroactive termination period. In making a request for retroactive termination or disenrollment, Contractholder shall comply with all applicable state and federal law, including, but not limited to, the Patient Protection & Affordable Care Act and any related regulations.
7. The Employer agrees to comply with the requirements of Section 2708 of the Patient Protection & Affordable Care Act (Section 2708), which prohibits an employer from imposing a prohibited waiting period. "Waiting period" means a period that is required to pass before an otherwise eligible Employee will be able to enroll in coverage under the Group Contract. Specifically, Employer agrees:
- a. Any conditions of eligibility or waiting periods imposed on the eligible Employee will comply with the requirements of Section 2708 and California state law and any rules and regulations implementing those requirements.
  - b. Employer will notify Blue Shield if Employer imposes a waiting period on an eligible Employee that would exceed the time-period permitted by Section 2708.
  - c. The Employer must ensure that any orientation period that may be imposed by the Employer prior to the start of the waiting period is consistent with federal regulations. The Employer will notify Blue Shield of the Employee's eligibility for coverage after the orientation period.
  - d. Employer will notify Blue Shield if any changes are made regarding these representations.
  - e. Employer will hold Blue Shield harmless for any violation of the requirements of Section 2708 or California state law.

#### **B. Associated Employers**

Employees of the following listed Employers associated with the Employer as subsidiaries or affiliates are eligible for Benefits in accord with this Contract. For the purposes of this Contract only, service with any associated Employers shall be considered service with the Employer. The Employer may act for and on behalf of any associated Employers in all matters pertaining to this Contract, and every act done by, agreement made with, or notice given to the Employer shall bind all associated Employers.

(list of associated Employers)

NONE

list of associated Employers

## **PART III. ELIGIBILITY**

### **C. Termination of Benefits**

In addition to the provisions contained in the Termination of Benefits section of the EOC, the following provisions apply to this Contract:

1. The Benefits of a Subscriber shall cease on the first day of the month following the month in which the Subscriber retires, is pensioned, leaves voluntarily, or is dismissed from the employ of the Contractholder or otherwise ceases to be a member of a class eligible for coverage, unless a different date on which the Subscriber no longer meets the requirements for eligibility has been agreed to between Blue Shield and the Contractholder, except that:
  - a. if the Subscriber ceases active work because of a disability due to illness or bodily injury, or because of an approved leave of absence or temporary layoff, payment of Premiums for that Subscriber shall continue coverage in force in accordance with the Employer's policy regarding such coverage; or,
  - b. if the Employer is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of Premiums for that Subscriber shall keep coverage in force for the duration(s) prescribed by the Acts. The Employer is solely responsible for notifying Employees of the availability and duration of family leaves.
2. With respect to a newborn child or a child placed for adoption, coverage will cease on the 31<sup>st</sup> day at 11:59 p.m. Pacific Time following the Dependent's effective date of coverage, except that coverage shall not cease if a written or electronic application for the addition of the Dependent is submitted to and received by Blue Shield within 60 days following the date of birth or placement for adoption.

### **D. Employer Eligibility/Participation Requirements and Contribution Requirements**

1. The Employer will be eligible for this Contract if the Employer is an eligible Employer as herein defined and meets the following requirements set forth in subsections 2. and 3. below:
  - a. The Employer must have at least one eligible Employee.
  - b. The Employer agrees to offer health Benefits to 100% of its eligible Employees. Those Employees who waive coverage on the grounds that they have other group coverage are not counted as eligible Employees.
  - c. The Employer agrees to pay the required Premiums.
  - d. The Employer agrees to inform the eligible Employees and Dependents of the availability of coverage and distribute information as set forth in Part IX., Contractholder Responsibility for Distribution and Notification Requirements. In addition, the Employer agrees to inform the eligible Employees and Dependents that those not electing coverage must wait for a period of up to 12 months if they later decide to elect coverage. If the Employee or Dependent initially declines coverage, the Employer agrees to submit a written certification declining coverage signed by the Employee and Employer.
  - e. For Employers offering an HMO Plan, Employees and Dependents who are covered by this Contract work or reside in the Service Area of the Plan.
  - f. The Employer agrees that small business plans offered by Blue Shield of California cannot be paired or integrated with an employer-sponsored health reimbursement arrangement (HRA). However, Employer may offer the following HRAs:
    - (a) A retiree HRA (covering only retirees).
    - (b) An excerpted benefits HRA (an HRA that has a limited purpose and reimburses only certain benefits recognized as "HIPAA-excerpted benefits," such as limited scope vision benefits or dental benefits).
2. The Employer must meet the following participation requirements:
  - a. The Employer must enroll 100% of the eligible Employees if the Employer contribution is 100%.

### **PART III. ELIGIBILITY**

- b. If the Employer contribution is not 100%, the Employer must enroll at least 65% of the total eligible Employees. This includes those enrolled under Blue Shield of California or any of its affiliated companies small group plan, excluding those who have certified that they are declining coverage because they are covered under another employer's health benefit plan or have coverage through a government program; and

The size of the Employer is determined annually. If after this Contract is issued the Employer does not meet the participation requirements, this Contract shall continue until the Contract anniversary following the date the Employer no longer meets the participation requirements.

Participation requirements are waived for Employers new to Blue Shield enrolling during the period of November 15 through December 15 with an effective date of January 1. On and after the first Contract anniversary, the Employer must meet the participation requirements as set forth in this section 2.

- 3. The Employer must meet the following contribution requirements:
  - a. The Employer must contribute either (1) a defined contribution of a minimum \$100 per Employee (or the cost of the total Employee Premiums, whichever is less), or (2) a minimum of 50% of the Employee Premiums, and
  - b. Payroll deductions are required.
- 4. The Group Health Service Contract will renew, in accordance with the Renewal of Group Health Service Contract section of the Evidence of Coverage, if the Employer meets and continues to meet all of the eligibility, participation, and contribution requirements set forth in subsections 1., 2., and 3. above.
- 5. If the Employer does not meet all of the eligibility, participation, and contribution requirements of subsections 1., 2., and 3. above, this Contract can be cancelled at the Contract anniversary following the date the Employer does not meet all of the eligibility, participation, and contribution requirements.

Cancellation for non-payment of Premiums or for fraud, misrepresentation, or omissions is subject to the requirements set forth in Part VII. B. and C.

## **PART IV. GROUP RENEWAL PROVISIONS**

### **A. Advance Notification of Blue Shield's Intent to Renew the Group Health Service Contract**

The Employer shall be notified by Blue Shield of its intent to renew this Group Health Service Contract at least 60 days prior to the proposed effective date of the renewal. However, this renewal advance notification is distinct from, and does not alter the notification periods specified in Part V. Premiums, Paragraph D., or in Part VIII. General Provisions, Paragraph D. Changes: Entire Contract.

### **B. Renewal of the Group Health Service Contract**

Blue Shield will renew this Contract at the option of the Contractholder except in the following instances:

1. Contractholder violates a material contract provision relating to group contributions or group participation requirements as specified under Part III. D;
2. Contractholder fails to pay the required Premiums as specified under Part V. Premiums;
3. Contractholder commits fraud or other intentional misrepresentation of material fact;
4. Contractholder relocates outside of California;
5. Blue Shield ceases to offer a plan type purchased by the Contractholder;
6. Blue Shield ceases to offer health benefit plans in the state (withdrawal of all products).
7. Contractholder is an association and association membership ceases.



## **PART V. PREMIUMS**

### **A. Premiums**

The monthly Premiums for the Subscriber and any Dependents are shown on the Monthly Dues/Premiums Schedule page.

### **B. When And Where Payable**

1. The first month's Premiums must be paid to Blue Shield by the effective date of this Contract and subsequent Premiums shall be prepaid in full by the same date of each succeeding month. No Member will be covered under this Contract until the first month's Premiums payment has been received by Blue Shield.
2. Premiums for Employees and/or Dependents who become eligible on a date other than the bill date are waived for the month during which eligibility for covered Benefits is attained. Premiums for Employees and/or Dependents whose eligibility for covered Benefits terminates on a date other than the bill date are due in full for the month during which eligibility is terminated.
3. All Premiums are payable by the Employer to Blue Shield of California. The payment of any Premiums shall not maintain the Benefits under this Contract in force beyond the date immediately preceding the next transmittal date except as otherwise provided in Part V. F.

### **C. The terms of this Contract or the Premiums payable therefor may be changed from time to time as set forth in Part VIII., D. Changes: Entire Contract.**

### **D. The Employer shall remit to Blue Shield the amount specified in Part V. A. ("the Premiums"). If a Federal, State or any other taxing or licensing authority imposes upon Blue Shield any tax or fee on account of any of the Employer's health benefit plans that is not included in the Premiums, whether such tax or fee is based on Premiums, gross receipts, enrollment or any other basis, Blue Shield may amend the Contract to increase the Premiums by an amount sufficient to cover any such tax or fee rounded to the nearest cent. This amendment shall be effective as of the date stated in the notice, which shall not be earlier than the date of the imposition of such tax or fee, by mailing a postage prepaid notice of the amendment to the Employer at its address of record with Blue Shield at least 60 days before the effective date of the amendment. In the case of Federal excise taxes, Blue Shield may also amend the Premiums to include any increased Federal income taxes to Blue Shield associated with such Federal excise taxes.**

### **E. If benefit amounts are changed due to a change in the terms of this Contract or if a tax or fee is levied under Part V. D., the Premiums charge therefore may be made, or the Premiums credit therefore may be given, as of the effective date of such change.**

### **F. A grace period of 30 days to pay all delinquent Premiums and avoid cancellation will be granted for the payment of Premiums accruing other than those due on the effective date of this Contract, during which period this Contract shall continue in force, but the Employer shall be liable to Blue Shield for the payment of all Premiums accruing during the period the Contract continues in force during the grace period. Cancellation for non-payment of Premiums shall be in accordance with PART VII.B.**

## **PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)**

### **Out-of-Area Services**

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as Inter-Plan Arrangements. Whenever a Member accesses Covered Services outside of California, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to Blue Shield for payment in accordance with the Blue Cross Blue Shield Association rules and procedures then in effect. The Inter-Plan Arrangements available to Members under this agreement are described generally below.

When Members access Covered Services outside of California, within the BlueCard Service Area, they may obtain care from participating health care providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement with the Host Blue (non-participating providers). Blue Shield's payment practices in both instances are described below.

### **BlueCard® Program**

The BlueCard® Program is an Inter-Plan Arrangement. Under this arrangement, when Members access Covered Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for fulfilling our contractual obligations. However, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating health care providers.

The financial terms of the BlueCard Program are described generally below.

### **Liability Calculation Method Per Claim**

Calculation of Member liability on claims for Covered Services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to Blue Shield by the Host Blue. The negotiated price may represent one of the following:

- (i) an actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced, or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- (iii) an average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual price, estimated price, or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., a prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by Blue Shield in determining the Employer's Premiums.

### **Return of Overpayments**

Under the BlueCard Program, recoveries of overpayments from a Host Blue or its participating and non-participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied

## **PART VI. INTER-PLAN ARRANGEMENTS (BLUECARD® PROGRAM AND OTHERS)**

in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed along on a claim-by-claim basis from a Host Blue to Blue Shield, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to your account as a percentage of the recovery.

### **Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees**

In some instances, federal or state laws or regulations may impose a surcharge, tax, or other fee that applies to insured accounts. If applicable, Blue Shield will include any such surcharge, tax, or other fee in determining Employer's Premiums.

### **Non-Participating Providers Outside of California**

When Covered Services, other than Emergency Services, are received from non-participating providers outside of California, but within the BlueCard Service Area, the amount(s) a Member pays for such services will generally be based on the Host Blue's non-participating provider local payment, the Allowable Amount Blue Shield pays a Non-Participating provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating provider bills and the payment Blue Shield will make for the Covered Services as set forth in this paragraph.

Claims for covered Emergency Services are paid based on the Allowable Amount as defined in the EOC.

### **Blue Shield Global Core**

If Members are outside the BlueCard Service Area, they may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area. Although Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue plan. As such, when Members receive care from providers outside the BlueCard Service Area, Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services. Details for Blue Shield Global Core claim submission are provided in the *Inter-Plan Arrangements* section of the EOC.

## **PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD**

### **A. Cancellation Without Cause**

The Employer may cancel this Contract at any time by written notice delivered or mailed to Blue Shield, effective on receipt or on such later date as specified in the notice.

### **B. Cancellation for Non-Payment of Dues/Premiums**

Blue Shield may cancel this Contract for non-payment of Premiums. If Premiums are not received when due, coverage will end 30 days after the date for which Premiums are due. The Employer will be liable for all Premiums accrued while this Contract continues in force including those accrued during the 30-day grace period. In such case, a Notice Confirming Termination of Coverage will be mailed to the Employer by Blue Shield. A new application for coverage will be required by the Employer and a new Contract will be issued only upon demonstration that the Employer meets all underwriting requirements at the time of application.

### **C. Cancellation/Rescission for Fraud, Intentional Misrepresentations of Material Fact**

Blue Shield may cancel or rescind this Contract within 24 months following issuance for fraud or intentional misrepresentation of material fact by the Employer; or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. Fraud or intentional misrepresentations of material fact on an application may, at the discretion of Blue Shield, result in the cancellation or rescission of this Contract. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice prior to any rescission.

### **D. Grace Period**

The Employer shall be entitled to a grace period of 30 days for payment of Premiums, as described in PART V.F. hereof. If during a Premiums grace period written notice is given by the Employer to Blue Shield that the Contract or (subject to the consent of Blue Shield) any part of the Contract is to be discontinued before the expiration date of the grace period, the Contract or such part shall be discontinued as of the date specified by the Employer or the date of receipt of such written notice by Blue Shield, whichever is the later date. The Employer shall be liable to Blue Shield for the full month's payment of Premiums if discontinuance of coverage occurs on or after the 15<sup>th</sup> of the month. If discontinuance of coverage occurs prior to the 15<sup>th</sup> of the month then Premium payment will be waived and refunded to the Employer.

### **E. Payment or Refund of Dues/Premiums Upon Cancellation**

In the event of cancellation, the Employer shall promptly pay any earned Premiums which have not previously been paid. Blue Shield shall within 30 days of cancellation (1) return to the Employer the amount of prepaid Premiums, if any, that Blue Shield determines have not been earned as of the effective date of cancellation, and (2) provide Benefits of the Plan for services incurred during the time coverage was in effect up to and including the effective date of cancellation.

### **F. Termination of Benefits**

No Benefits shall be provided for services rendered after the effective date of cancellation, except as specifically provided in the Group Continuation of Coverage and Extension of Benefits sections of the Evidence of Coverage.

In the event this Contract is cancelled for any reason, including but not limited to for non-payment of Premiums, no further Benefits will be provided after cancellation unless the Member is a registered Inpatient or is undergoing treatment for an ongoing condition and obtains an extension of Benefits in accordance with the Extension of Benefits section of the Evidence of Coverage.

### **G. Employer to Provide Subscribers with Notice Confirming Termination of Coverage**

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's Notice Confirming Termination of Coverage to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

## **PART VII. CANCELLATION/REINSTATEMENT/GRACE PERIOD**

## **PART VIII. GENERAL PROVISIONS**

In addition to the provisions contained in the EOC, the following provisions apply to this Contract:

### **A. Choice of Providers**

A Member may select any Hospital or Physician to provide Covered Services hereunder, including providers outside of California. Benefits differ depending on whether a Participating Provider or a Non-Participating Provider is selected. It is to the Member's advantage to select Participating Providers whenever possible. A Participating Provider Directory is available to all Members by calling Blue Shield or on the website at [www.blueshieldca.com](http://www.blueshieldca.com).

In the event that a Participating Provider is not able to perform, breaches its contract to furnish services, or terminates its contract with Blue Shield, which would result in materially and adversely impacting the Employer, Blue Shield will advise the Employer in writing, within a reasonable period of time.

### **B. Use of Masculine Pronoun**

Whenever a masculine pronoun is used in this Contract, it shall include the feminine gender unless the context clearly indicates otherwise.

### **C. Workers' Compensation**

This Contract is not in lieu of, and shall not affect, any requirements for coverage by Workers' Compensation Insurance.

### **D. Changes: Entire Contract**

This Contract, including appendices, attachments, or other documents incorporated by reference constitutes the entire agreement between the parties, and any statement made by the Employer or by any Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty.

The terms of this Contract, the Premiums payable therefor, and the benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment and annual Out-of-Pocket Maximum amounts, may be changed from time to time. Blue Shield will provide at least 60 days' written notice of any such change, and these changes shall not become effective until at least 60 days after written notice of such change is delivered or mailed to the Employer's last address as shown on the records of Blue Shield. Benefits for services furnished on or after the effective date of any Benefit modification shall be provided based on the modification. No change in this Contract shall be valid unless approved by an executive officer of Blue Shield and a written endorsement is issued. No other representative has authority to change this Contract or to waive any of its provisions.

Notice of changes in Benefits, and any documents that may be delivered to the Employer or the Employer's representative for the purpose of informing Members of the details of their coverage under this Contract, will be distributed by the Employer or his representative as set forth in Part IX., Contractholder Responsibility for Distribution and Notification Requirements.

### **E. Statutory Requirements**

This Contract is subject to the requirements of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Contract by reason of the Act or Regulations shall bind Blue Shield whether or not such provision is actually included in this Contract. In addition, this Contract is subject to applicable state and federal statutes and regulations, which may include the Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act ("HIPAA"), the Patient Protection and Affordable Care Act ("PPACA"), and applicable Centers for Medicare and Medicaid Services ("CMS") requirements. Any provision required to be in this Contract by reason of such state and federal statutes shall bind the Group and Blue Shield whether or not such provision is actually included in this Contract.

### **F. Legal Process**

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

## **PART VIII. GENERAL PROVISIONS**

### **G. Time of Commencement or Termination**

Wherever this Contract provides for a date of commencement or termination of any part or all of this Contract, commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

### **H. Records and Information to be Furnished**

The Employer shall furnish Blue Shield with such information as Blue Shield may require to enable it to administer this Plan, to determine the Premiums and to enable it to perform this Contract. CMS specifically requires Blue Shield to obtain the following information: Social Security numbers for Subscribers and dependents over forty-five (45) years of age, Subscriber employment status, Employer identification number and Employer size. Failure to provide any such information required by this Section may result in immediate Cancellation of this Contract.

### **I. Inquiries and Complaints**

Inquiries concerning any problems that may develop in the administration of this Contract should be directed to Blue Shield at the address or telephone number indicated on page GC-1 of this Contract. (See also the Customer Service section of the EOC.)

### **J. Confidentiality**

The Contractholder shall comply with all applicable state and federal laws regarding the privacy and confidentiality of the personal and health information of Subscribers and Dependents. The Contractholder shall not require the Blue Shield to release the personal and health information of individual Subscribers or Dependents without written authorization from the Subscriber, unless permitted by law. No information may be disclosed by either party in violation of Cal. Civ. Code §§ 56, et seq. At the request of the Contractholder, Blue Shield may provide aggregate, encrypted, or encoded data regarding Subscribers and Dependents to the Contractholder, unless such data would explicitly or implicitly identify specific Subscribers or Dependents. To the extent the Contractholder receives, maintains, or transmits personal or health information of Subscribers or Dependents electronically, the Contractholder shall comply with all state and federal laws relating to the protection of such information including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) provisions on security and confidentiality.

### **K. ERISA Plan Administrator**

If the Contractholder's Plan is governed by ERISA (29 USC Sections 1001, et seq.), it is understood that Blue Shield is not the plan administrator for the purposes of ERISA. The plan administrator is the Contractholder.

## **PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS**

The Contractholder has various distribution of notices and Member materials and other notification requirements under this Contract. Some of the major Contractholder distribution and notification requirements are summarized below; however, this is a summary only and is not to be construed as an all-inclusive list.

### **A. Obtaining Declinations or Waivers of Coverage**

All eligible Employees will be offered health benefits coverage during the initial and subsequent enrollment periods. If an Employee elects to decline or waive coverage, the Employer is responsible for obtaining the Employee's signed acknowledgment of receipt of an explicit written notice in bold type specifying that failure to elect coverage during the Open Enrollment Period permits Blue Shield to impose an exclusion from coverage for a period of 12 months or at the Employer's next Open Enrollment Period, whichever is earlier, if the Employee later decides to elect coverage.

### **B. Distribution of Summary of Benefits and Coverage (SBC)**

A summary of benefits and coverage (SBC) will be issued by Blue Shield for all eligible Employees and Dependents. The Employer is solely responsible for the timely distribution of a complete SBC for each benefit plan offered. The Employer will distribute the SBCs free of charge to Members and prospective Members as required by applicable federal law and regulations.

The Employer shall distribute the SBCs in a manner which complies with applicable federal law and regulations. If the Employer does not distribute paper SBCs, then the Employer will ensure that any alternative or electronic distribution method used complies with applicable federal requirements.

If a material modification is made to the Employer's group health plan that impacts the SBC, other than at the time of renewal, then notice of the material change, as provided by Blue Shield, will be distributed by the Employer to the Subscriber and any Dependents no later than sixty (60) days prior to the date on which the modification will become effective. The notice shall be distributed in a manner that complies with applicable federal requirements.

In the event that the Employer fails to distribute SBCs to Members or prospective Members as required herein, Blue Shield will, after notice to the Employer, distribute SBCs as necessary to comply with applicable federal statutes and regulations. In such case, the Employer agrees to reimburse Blue Shield for the reasonable costs incurred by Blue Shield to generate and distribute the SBCs.

### **C. Distribution of Member ID Cards and EOC Booklets**

#### **1. Member ID Cards**

Member identification cards will be issued by Blue Shield for all Subscribers and will either be sent to the Contractholder for distribution to the Subscribers, or sent directly to the Subscribers, depending on the Contractholder's instructions.

#### **2. Evidence of Coverage Booklets**

An Evidence of Coverage (EOC) which summarizes the Benefits of this Contract and how to obtain Covered Services will be issued by Blue Shield for all Subscribers. Blue Shield will send the EOC to the Contractholder, and, the Contractholder is responsible for distributing the EOC to Subscribers whether in printed, hardcopy or electronic form.

EOCs will be provided to the Contractholder in electronic form (such as by Compact Disk (CD) or posted on Blue Shield's employer website) or in paper hard copy form. If Contractholder receives the EOC in electronic form, Contractholder is not authorized to modify or alter in any way the text or the formatting of the electronic EOC file. Blue Shield assumes no responsibility for any changes in text or formatting that may occur in the EOC after it is provided to Contractholder. If Contractholder receives the EOC in hard copy form, Contractholder will notify Subscribers that printed hard copies of the EOC are available and will promptly distribute to Subscribers.



## **PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS**

Contractholder may ensure electronic distribution of the EOC to Subscribers by one of the following methods: (1) by posting the EOC in a read-only format on an intranet site which is accessed by Employees of Contractholder; (2) by emailing the EOC directly to Subscribers; or (3) by providing Subscribers with Blue Shield's instructions for accessing the EOC from the Blue Shield website.

If Contractholder posts the electronic EOC on its intranet site, it shall do so in such a way so as to permit Employees of Contractholder to download and print a complete and accurate copy of the EOC. Contractholder will notify Employees enrolled with Blue Shield that the EOC for their plan is available to review, download and print from Contractholder's intranet site, and will provide Subscribers with reasonable and appropriate instructions by which to access and print the document from its intranet site.

Contractholder will provide a hard copy of the EOC to an Employee upon request. If Blue Shield receives an inquiry from an Employee of the Contractholder regarding obtaining a copy of the EOC, Blue Shield will refer that individual to Contractholder's human resources benefits staff with instructions that a copy of the EOC is available from Contractholder on request.

In the event Blue Shield reasonably concludes that Contractholder is either using the electronic EOC in a matter not permitted by this Agreement or is not providing Subscribers with access to the EOC in accordance herewith, then Blue Shield will print copies of the EOC, and Contractholder will cooperate with Blue Shield to ensure that printed copies of the EOC are timely provided to all Employees of Contractholder enrolled with Blue Shield. Contractholder agrees to reimburse Blue Shield for the reasonable cost of printing and delivering the EOC documents.

### **D. Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal**

Upon receipt of a Notice of Cancellation for Nonpayment of Premiums and Grace Period or a Notice of Cancellation, Rescission or Nonrenewal from the Plan, the Employer shall promptly send any such Notice to each subscriber in a manner which complies with applicable law.

### **E. Notification of Cancellation to Subscribers**

If this Contract is rescinded, or cancelled by either party, the Employer shall notify the Subscribers. If rescinded or cancelled by Blue Shield, the Employer shall promptly mail a copy of Blue Shield's notice of the rescission or cancellation to each Subscriber and provide Blue Shield proof of such mailing and the date thereof.

### **F. Notification of COBRA and Cal-COBRA Coverage Option and Other COBRA/Cal-COBRA Notices**

The following provisions are applicable only when the Contractholder is subject to Title X. of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). See the Continuation of Group Coverage and Extension of Benefits sections of the Evidence of Coverage for additional information.

#### **1. COBRA**

Blue Shield is not the plan administrator or plan sponsor, as those terms are defined by ERISA, for any purpose, including but not limited to COBRA, and has no responsibility for the Contractholder's COBRA administration obligations

To the extent required by COBRA, and upon timely receipt of Premiums and proper enrollment forms, Blue Shield will continue the group coverage to qualified beneficiaries after the period that their coverage would normally terminate under the Contract.

Blue Shield will not be responsible for determining whether a Subscriber or Dependent is eligible to receive continuation coverage; such determination is based on the requirements of COBRA and the procedures established by the Contractholder or its COBRA administrator.

## **PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS**

If the Contractholder or any Subscriber or Dependent fails to meet its obligations under the Contract and COBRA, Blue Shield shall not be liable for any claims of the Subscriber or Dependent after his/her termination of coverage, except as expressly provided in other applicable provisions of the Contract.

The Contractholder is solely responsible for all aspects of the administration of Title X. of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any amendments with respect to the group health coverage provided by this Contract. The obligations of the Contractholder, in the event that federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Contractholder, are as set forth below:

- a. Contractholder or its COBRA administrator will complete and timely provide all notices and enrollment forms to all eligible Subscribers and Dependents (including the initial notice of COBRA rights) required under COBRA.
- b. Contractholder or its COBRA administrator will establish procedures to verify eligibility for COBRA coverage and receive COBRA election forms from Qualified Beneficiaries.
- c. The Contractholder will notify its COBRA administrator (or the Plan administrator if the Contractholder does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, or of the Subscriber's Medicare entitlement, or the Employer's (Contractholder's) filing for reorganization under Title XI, United States Code.
- d. Contractholder or its COBRA administrator will establish a determination date upon which applicable COBRA rates may be annually changed and determine the applicable premium amount for qualified COBRA beneficiaries in accordance with its Contract with Blue Shield, adding the 2% administrative fee permitted by COBRA.
- e. Contractholder or its COBRA administrator will bill and collect premiums from COBRA Qualified Beneficiaries, and provide timely notification of nonpayment of COBRA continuation coverage premiums, per the terms of the Contract and the COBRA law.
- f. Contractholder or its COBRA administrator will remit premiums to Blue Shield on behalf of the COBRA qualified beneficiary until Blue Shield receives notice from the Contractholder that such beneficiary is no longer entitled to COBRA coverage.
- g. Contractholder or its COBRA administrator will provide notification of continuation of coverage rights to the extent required by COBRA or any other federal or state laws as applicable, on termination of COBRA coverage. The Contractholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end.
- h. Contractholder or its COBRA administrator will inform eligible Subscribers and Dependents of changes in the COBRA law as they occur, including an explanation of the impact of these changes upon COBRA coverage.
- i. The Contractholder agrees to assume responsibility for any and all COBRA violations resulting from the failure of the Contractholder or its COBRA administrator to perform its COBRA administration responsibilities.

### **2. Cal-COBRA**

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing within 30 days when the Contractholder becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

## **PART IX. CONTRACTHOLDER RESPONSIBILITY FOR DISTRIBUTION AND NOTIFICATION REQUIREMENTS**

Contractholders subject to the California Continuation Benefits Replacement Act (Cal-COBRA) are responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction in hours of employment within 30 days of the Qualifying Event.

## **EVIDENCE OF COVERAGE**

An EOC booklet and any applicable Supplements will be issued by Blue Shield for all Subscribers covered under this Group Health Service Contract. The following pages contain the exact provisions of this EOC and any applicable Supplements and are included as part of this Contract.

# Platinum Full PPO 0/10 OffEx

## **Evidence of Coverage**

Group

An independent member of the Blue Shield Association



# Blue Shield of California

## Evidence of Coverage

### Platinum Full PPO 0/10 OffEx

#### PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

**Packaged Plan:** This health plan is part of a package that consists of a health plan and a dental plan which is offered at a package rate. This Evidence of Coverage describes the Benefits of the health plan as part of the package.

**This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.**

**Notice About This Group Health Plan:** Blue Shield makes this health plan available to Employees through a contract with the Employer. The Group Health Service Contract (Contract) includes the terms in this Evidence of Coverage, as well as other terms. A copy of the Contract is available upon request. A Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage. The Summary of Benefits sets forth the Member's share-of-cost for Covered Services under the benefit Plan.

Please read this Evidence of Coverage carefully and completely to understand which services are Covered Services, and the limitations and exclusions that apply to the Plan. Pay particular attention to those sections of the Evidence of Coverage that apply to any special health care needs.

Blue Shield provides a matrix summarizing key elements of this Blue Shield health Plan at the time of enrollment. This matrix allows individuals to compare the health plans available to them. The Evidence of Coverage is available for review prior to enrollment in the Plan.

For questions about this Plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this Evidence of Coverage.

**Notice About Plan Benefits:** No Member has the right to receive Benefits for services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Continuation of Group Coverage provision in this Evidence of Coverage.

Benefits are available only for services and supplies furnished during the term this health plan is in effect and while the individual claiming Benefits is actually covered by this group Contract.

Benefits may be modified during the term as specifically provided under the terms of this Evidence of Coverage, the group Contract or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

**Notice About Reproductive Health Services:** 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 provided on the back page of this Evidence of Coverage to ensure that you can obtain the health care services that you need.

**Notice About Contracted Providers:** Blue Shield contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. To learn more about this payment system, contact Customer Service.

**Notice About Health Information Exchange Participation:** Blue Shield participates in the Manifest MedEx Health Information Exchange ("HIE") making its Members' health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

Manifest MedEx respects Members' right to privacy and follows applicable state and federal privacy laws. Manifest MedEx uses advanced security systems and modern data encryption techniques to protect Members' privacy and the security of their personal information. The Manifest MedEx notice of privacy practices is posted on its website at [www.manifestmedex.org](http://www.manifestmedex.org).

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx, should fill out the online form at [www.manifestmedex.org/opt-out](http://www.manifestmedex.org/opt-out) or call Manifest MedEx at (888) 510-7142.



# Blue Shield of California

## Subscriber Bill of Rights

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As a Blue Shield Subscriber, you have the right to:

- 1) Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
- 2) Receive information about all health services available to you, including a clear explanation of how to obtain them.
- 3) Receive information about your rights and responsibilities.
- 4) Receive information about your health plan, the services we offer you, the Physicians and other practitioners available to care for you.
- 5) Have reasonable access to appropriate medical services.
- 6) Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
- 7) A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- 8) Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- 9) Receive preventive health services.
- 10) Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
- 11) Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
- 12) Communicate with and receive information from Customer Service in a language you can understand.
- 13) Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
- 14) Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
- 15) Voice complaints or grievances about the health plan or the care provided to you.
- 16) Participate in establishing Public Policy of the Blue Shield health plan, as outlined in your Evidence of Coverage.

# Blue Shield of California

## Subscriber Responsibilities

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As a Blue Shield Subscriber, you have the responsibility to:

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

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Summary of Benefits

Group Plan  
PPO Benefit Plan

Platinum Full PPO 0/10 OffEx

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California benefit Plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).<sup>1</sup> Please read both documents carefully for details.

Provider Network:

Full PPO Network

This benefit Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)<sup>2</sup>

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

When using a Participating <sup>3</sup> or Non-Participating <sup>4</sup> Provider		
Calendar Year medical Deductible	Individual coverage	\$0
	Family coverage	\$0: individual
		\$0: Family

Calendar Year Out-of-Pocket Maximum<sup>5</sup>

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

No Lifetime Benefit Maximum

Under this benefit Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

	When using a Participating Provider <sup>3</sup>	When using any combination of Participating <sup>3</sup> or Non-Participating <sup>4</sup> Providers
Individual coverage	\$3,600	\$7,200
Family coverage	\$3,600: individual	\$7,200: individual
	\$7,200: Family	\$14,400: Family

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Preventive Health Services<sup>7</sup></b>	\$0		Not covered	
California Prenatal Screening Program	\$0		\$0	
<b>Physician services</b>				
Primary care office visit	\$10/visit		40%	
Specialist care office visit	\$25/visit		40%	
Physician home visit	\$10/visit		40%	
Physician or surgeon services in an Outpatient Facility	10%		40%	
Physician or surgeon services in an inpatient facility	10%		40%	
<b>Other professional services</b>				
Other practitioner office visit	\$10/visit		40%	
<i>Includes nurse practitioners, physician assistants, and therapists.</i>				
Acupuncture services	\$25/visit		40%	
Chiropractic services	50%		50%	
<i>Up to 12 visits per Member, per Calendar Year.</i>				
Teladoc consultation	\$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	10%		Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	\$25/visit		40%	
<b>Pregnancy and maternity care<sup>7</sup></b>				
Physician office visits: prenatal and initial postnatal	\$0		40%	
Physician services for pregnancy termination	10%		40%	

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Emergency services</b>				
Emergency room services	\$100/visit plus 10%		\$100/visit plus 10%	
<i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i>				
Emergency room Physician services	10%		10%	
<b>Urgent care center services</b>	\$10/visit		40%	
<b>Ambulance services</b>	10%		10%	
<i>This payment is for emergency or authorized transport.</i>				
<b>Outpatient Facility services</b>				
Ambulatory Surgery Center	10%		40% up to \$350/day plus 100% of additional charges	
Outpatient department of a Hospital: surgery	\$100/surgery plus 10%		40% up to \$350/day plus 100% of additional charges	
Outpatient department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%		40% up to \$350/day plus 100% of additional charges	
<b>Inpatient facility services</b>				
Hospital services and stay	10%		40% up to \$2000/day plus 100% of additional charges	

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<p>Transplant services</p> <p><i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i></p> <ul style="list-style-type: none"> <li>Special transplant facility inpatient services 10%</li> <li>Physician inpatient services 10%</li> </ul>			<p>Not covered</p> <p>Not covered</p>	
<p><b>Bariatric surgery services, designated California counties</b></p> <p><i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and Outpatient Physician services payments apply.</i></p> <p>Inpatient facility services 10%</p> <p>Outpatient Facility services \$100/surgery plus 10%</p> <p>Physician services 10%</p>			<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>	
<p><b>Diagnostic x-ray, imaging, pathology, and laboratory services</b></p> <p><i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i></p> <p>Laboratory services</p> <p><i>Includes diagnostic Papanicolaou (Pap) test.</i></p> <ul style="list-style-type: none"> <li>Laboratory center \$10/visit</li> <li>Outpatient department of a Hospital 10%</li> </ul>			<p>40%</p> <p>40% up to \$350/day plus 100% of additional charges</p>	



## Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<p>X-ray and imaging services</p> <p><i>Includes diagnostic mammography.</i></p> <ul style="list-style-type: none"> <li>Outpatient radiology center</li> <li>Outpatient department of a Hospital</li> </ul> <p>Other outpatient diagnostic testing</p> <p><i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i></p> <ul style="list-style-type: none"> <li>Office location</li> <li>Outpatient department of a Hospital</li> </ul> <p>Radiological and nuclear imaging services</p> <ul style="list-style-type: none"> <li>Outpatient radiology center</li> <li>Outpatient department of a Hospital</li> </ul>	<p>\$25/visit</p> <p>\$75/visit</p> <p>\$25/visit</p> <p>\$75/visit</p> <p>10%</p> <p>\$100/visit plus 10%</p>		<p>40%</p> <p>40% up to \$350/day plus 100% of additional charges</p> <p>40%</p> <p>40% up to \$350/day plus 100% of additional charges</p> <p>40%</p> <p>40% up to \$350/day plus 100% of additional charges</p>	
<b>Rehabilitative and Habilitative Services</b>				
<p><i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.</i></p> <p>Office location</p> <p>Outpatient department of a Hospital</p>	<p>10%</p> <p>10%</p>		<p>40%</p> <p>40% up to \$350/day plus 100% of additional charges</p>	

Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Durable medical equipment (DME)</b>				
DME	50%		Not covered	
Breast pump	\$0		Not covered	
Orthotic equipment and devices	10%		Not covered	
Prosthetic equipment and devices	10%		Not covered	
<b>Home health services</b>				
<i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period, except hemophilia and home infusion nursing visits.</i>				
Home health agency services	10%		Not covered	
<i>Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>				
Home visits by an infusion nurse	10%		Not covered	
Home health medical supplies	10%		Not covered	
Home infusion agency services	10%		Not covered	
Hemophilia home infusion services	10%		Not covered	
<i>Includes blood factor products.</i>				
<b>Skilled Nursing Facility (SNF) services</b>				
<i>Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i>				
Freestanding SNF	10%		10%	
Hospital-based SNF	10%		40% up to \$2000/day plus 100% of additional charges	

## Benefits<sup>6</sup>

## Your payment

	When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Hospice program services</b>  <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>	\$0		Not covered	
<b>Other services and supplies</b>  Diabetes care services <ul style="list-style-type: none"> <li>Devices, equipment, and supplies</li> <li>Self-management training</li> </ul> Dialysis services  PKU product formulas and Special Food Products  Allergy serum billed separately from an office visit	50%  \$0  10%  10%  10%		Not covered  40%  40% up to \$350/day plus 100% of additional charges  10%  40%	

## Mental Health and Substance Use Disorder Benefits

## Your payment

<i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).</i>	When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a MHSA Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Outpatient services</b>  Office visit, including Physician office visit  Other outpatient services, including intensive outpatient care, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment  Partial Hospitalization Program  Psychological Testing	\$10/visit  10%  10%  10%		40%  40%  40% up to \$350/day plus 100% of additional charges  40%	

## Mental Health and Substance Use Disorder Benefits

## Your payment

Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Services Administrator (MHSA).		When using a MHSA Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a MHSA Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<b>Inpatient services</b>					
Physician inpatient services		10%		40%	
Hospital services		10%		40% up to \$2000/day plus 100% of additional charges	
Residential Care		10%		40% up to \$2000/day plus 100% of additional charges	

## Prescription Drug Benefits<sup>8,9</sup>

## Your payment

Pharmacy	Network:	Rx	Ultra	When using a Participating Pharmacy <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Pharmacy <sup>4</sup>	CYD <sup>2</sup> applies
<b>Drug Formulary: Standard Formulary</b>							
<b>Retail pharmacy prescription Drugs</b>							
Per prescription, up to a 30-day supply.							
Tier 1 Drugs				\$5/prescription		Not covered	
Tier 2 Drugs				\$30/prescription		Not covered	
Tier 3 Drugs				\$50/prescription		Not covered	
Tier 4 Drugs (excluding Specialty Drugs)				30% up to \$250/prescription		Not covered	
Contraceptive Drugs and devices				\$0		Not covered	
<b>Mail service pharmacy prescription Drugs</b>							
Per prescription, up to a 90-day supply.							
Tier 1 Drugs				\$10/prescription		Not covered	
Tier 2 Drugs				\$60/prescription		Not covered	
Tier 3 Drugs				\$100/prescription		Not covered	
Tier 4 Drugs (excluding Specialty Drugs)				30% up to \$500/prescription		Not covered	

## Prescription Drug Benefits<sup>8,9</sup>

## Your payment

<b>Pharmacy Drug Formulary:</b> Standard Formulary	<b>Network:</b> Rx Ultra	<b>When using a Participating Pharmacy<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>	<b>When using a Non-Participating Pharmacy<sup>4</sup></b>	<b>CYD<sup>2</sup> applies</b>
Contraceptive Drugs and devices		\$0		Not covered	
<b>Specialty Drugs</b>  <i>Per prescription. Specialty Drugs are covered at tier 4 and only when dispensed by a Network Specialty Pharmacy.</i>		30% up to \$250/prescription		Not covered	
<b>Oral Anticancer Drugs</b>  <i>Per prescription, up to a 30-day supply.</i>		30% up to \$200/prescription		Not covered	

## Pediatric Benefits

## Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>		<b>When using a Participating Dentist<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>	<b>When using a Non-Participating Dentist<sup>4</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Pediatric dental<sup>10</sup></b>					
Diagnostic and preventive services					
• Oral exam		\$0		20%	
• Preventive – cleaning		\$0		20%	
• Preventive – x-ray		\$0		20%	
• Sealants per tooth		\$0		20%	
• Topical fluoride application		\$0		20%	
• Space maintainers - fixed		\$0		20%	
Basic services					
• Restorative procedures		20%		30%	
• Periodontal maintenance		20%		30%	
Major services					
• Oral surgery		50%		50%	
• Endodontics		50%		50%	
• Periodontics (other than maintenance)		50%		50%	
• Crowns and casts		50%		50%	

## Pediatric Benefits

## Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	<b>When using a Participating Dentist<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>	<b>When using a Non-Participating Dentist<sup>4</sup></b>	<b>CYD<sup>2</sup> applies</b>
<ul style="list-style-type: none"> <li>Prosthodontics</li> </ul>	50%		50%	
Orthodontics (Medically Necessary)	50%		50%	

## Pediatric Benefits

## Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>	<b>When using a Non-Participating Provider<sup>4</sup></b>	<b>CYD<sup>2</sup> applies</b>
<b>Pediatric vision<sup>11</sup></b>				
Comprehensive eye examination				
<i>One exam per Calendar Year.</i>				
<ul style="list-style-type: none"> <li>Ophthalmologic visit</li> </ul>	\$0		All charges above \$30	
<ul style="list-style-type: none"> <li>Optometric visit</li> </ul>	\$0		All charges above \$30	
Eyewear/materials				
<i>One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.</i>				
<ul style="list-style-type: none"> <li>Contact lenses</li> </ul>				
Non-elective (Medically Necessary) - hard or soft	\$0		All charges above \$225	
<i>Up to two pairs per eye per Calendar Year.</i>				
Elective (cosmetic/convenience)				
Standard and non-standard, hard	\$0		All charges above \$75	
<i>Up to a 3 month supply for each eye per Calendar Year based on lenses selected.</i>				
Standard and non-standard, soft	\$0		All charges above \$75	
<i>Up to a 6 month supply for each eye per Calendar Year based on lenses selected.</i>				

## Pediatric Benefits

## Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>		When using a Participating Provider <sup>3</sup>	CYD <sup>2</sup> applies	When using a Non-Participating Provider <sup>4</sup>	CYD <sup>2</sup> applies
<ul style="list-style-type: none"> <li>Eyeglass frames</li> </ul>					
Collection frames		\$0		All charges above \$40	
Non-collection frames		All charges above \$150		All charges above \$40	
<ul style="list-style-type: none"> <li>Eyeglass lenses</li> </ul>					
<i>Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.</i>					
Single vision		\$0		All charges above \$25	
Lined bifocal		\$0		All charges above \$35	
Lined trifocal		\$0		All charges above \$45	
Lenticular		\$0		All charges above \$45	
Optional eyeglass lenses and treatments					
<ul style="list-style-type: none"> <li>Ultraviolet protective coating (standard only)</li> </ul>		\$0		Not covered	
<ul style="list-style-type: none"> <li>Polycarbonate lenses</li> </ul>		\$0		Not covered	
<ul style="list-style-type: none"> <li>Standard progressive lenses</li> </ul>		\$55		Not covered	
<ul style="list-style-type: none"> <li>Premium progressive lenses</li> </ul>		\$95		Not covered	
<ul style="list-style-type: none"> <li>Anti-reflective lens coating (standard only)</li> </ul>		\$35		Not covered	
<ul style="list-style-type: none"> <li>Photochromic - glass lenses</li> </ul>		\$25		Not covered	
<ul style="list-style-type: none"> <li>Photochromic - plastic lenses</li> </ul>		\$25		Not covered	
<ul style="list-style-type: none"> <li>High index lenses</li> </ul>		\$30		Not covered	
<ul style="list-style-type: none"> <li>Polarized lenses</li> </ul>		\$45		Not covered	
Low vision testing and equipment					
<ul style="list-style-type: none"> <li>Comprehensive low vision exam</li> </ul>		35%		Not covered	
Once every 5 Calendar Years.					

## Pediatric Benefits

## Your payment

<i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i>	<b>When using a Participating Provider<sup>3</sup></b>	<b>CYD<sup>2</sup> applies</b>	<b>When using a Non-Participating Provider<sup>4</sup></b>	<b>CYD<sup>2</sup> applies</b>
<ul style="list-style-type: none"> <li>Low vision devices</li> </ul> <p><i>One aid per Calendar Year.</i></p>	35%		Not covered	
Diabetes management referral	\$0		Not covered	

## Prior Authorization

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

- Radiological and nuclear imaging services
- Mental health services, except outpatient office visits, electroconvulsive therapy, and Psychological Testing
- Inpatient facility services
- Hospice program services
- Home health services from Non-Participating Providers
- Some prescription Drugs (see [blueshieldca.com/pharmacy](https://blueshieldca.com/pharmacy))
- Pediatric vision non-elective contact lenses and low vision testing and equipment

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

## Notes

### 1 Evidence of Coverage (EOC):

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

Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

### 2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

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

### 3 Using Participating Providers:



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

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

#### 4 Using Non-Participating Providers:

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

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

"Allowable Amount" is defined in the EOC. In addition:

- Any Coinsurance is determined from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar (\$) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.

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

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- dialysis center Benefits: dialysis services from a Non-Participating Provider
- Benefit maximum: charges for services after any Benefit limit is reached

Essential health benefits count towards the OOPM.

This benefit Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

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

#### 6 Separate Member Payments When Multiple Covered Services are Received:

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

**7 Preventive Health Services:**

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

**8 Outpatient Prescription Drug Coverage:**

**Medicare Part D-creditable coverage-**

This benefit Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this benefit plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

**9 Outpatient Prescription Drug Coverage:**

Brand Drug coverage when a Generic Drug is available. If you, the Physician, or Health Care Provider, select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum.

Request for Medical Necessity Review. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Member payment.

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

**10 Pediatric Dental Coverage:**

Pediatric dental benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

**11 Pediatric Vision Coverage:**

Pediatric vision benefits are provided through Blue Shield's Vision Plan Administrator (VPA).

Covered Services from Non-Participating Providers. There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

Coverage for frames. If frames are selected that are more expensive than the Allowable Amount established for frames under this Benefit, you pay the difference between the Allowable Amount and the provider's charge.

"Collection frames" are covered with no Member payment from Participating Providers. Retail chain Participating Providers do not usually display the frames as "collection," but a comparable selection of frames is maintained.

"Non-collection frames" are covered up to an Allowable Amount of \$150; however, if the Participating Provider uses:

## Notes

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- wholesale pricing, then the Allowable Amount will be up to \$99.06.
- warehouse pricing, then the Allowable Amount will be up to \$103.64.

Participating Providers using wholesale pricing are identified in the provider directory.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

PENDING REGULATORY APPROVAL

## Introduction to the Blue Shield of California Health Plan

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This Blue Shield of California (Blue Shield) Evidence of Coverage describes the health care coverage that is provided under the Group Health Service Contract between Blue Shield and the Contractholder (Employer). A Summary of Benefits is provided with, and is incorporated as part of, this Evidence of Coverage.

Please read both this Evidence of Coverage and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about Member responsibilities, such as payment of Copayments, Coinsurance and Deductibles and obtaining prior authorization for certain services (see the *Benefits Management Program* section).

Capitalized terms in this Evidence of Coverage have special meaning. Please see the *Definitions* section to understand these terms. Please contact Blue Shield with questions about Benefits. Contact information can be found on the last page of this Evidence of Coverage.

## How to Use This Health Plan

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

### Choice of Providers

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This Blue Shield health plan is designed for Members to obtain services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members may choose to seek services from Non-Participating Providers for most services. Covered Services obtained from Non-Participating Providers will usually result in a higher share of cost for the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider.

Please be aware that a provider's status as a Participating Provider or an MHSA Participating

Provider may change. It is the Member's obligation to verify whether the provider chosen is a Participating Provider or an MHSA Participating Provider prior to obtaining coverage.

Call Customer Service or visit [www.blueshieldca.com](http://www.blueshieldca.com) to determine whether a provider is a Participating Provider. Call the MHSA to determine if a provider is an MHSA Participating Provider. See the sections below and the Summary of Benefits for more details. See the *Out-of-Area Services* section for services outside of California.

### Blue Shield Participating Providers

Blue Shield Participating Providers include primary care Physicians, specialists, Hospitals, and Alternate Care Services Providers that have a contractual relationship with Blue Shield to provide services to Members of this Plan. Participating Providers are listed in the Participating Provider directory.

Participating Providers agree to accept Blue Shield's payment, plus the Member's payment of any applicable Deductibles, Copayments, Coinsurance or amounts in excess of specified Benefit maximums as payment-in-full for Covered Services, except as provided under the *Exception for Other Coverage* and the *Reductions - Third Party Liability* sections. This is not true of Non-Participating Providers.

If a Member receives services from a Non-Participating Provider, Blue Shield's payment for that service may be substantially less than the amount billed. The Subscriber is responsible for the difference between the amount Blue Shield pays and the amount billed by the Non-Participating Provider.

If a Member receives services at a facility that is a Participating Provider, Blue Shield's payment for Covered Services provided by a health professional at the Participating Provider facility will be paid at the Participating Provider level of Benefits, whether the health professional is a Participating Provider or Non-Participating Provider. The Member's share of cost will not exceed the Copayment or Coinsurance due to a

Participating Provider under similar circumstances.

Some services are covered only if rendered by a Participating Provider. In these instances, using a Non-Participating Provider could result in a higher share of cost to the Member or no payment by Blue Shield for the services received.

Payment for Emergency Services rendered by a Physician or Hospital that is not a Participating Provider will be based on Blue Shield's Allowable Amount and will be paid at the Participating level of Benefits. The Member is responsible for notifying Blue Shield within 24 hours, or as soon as reasonably possible following medical stabilization of the emergency condition.

The Member should contact Member Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Provider or MHSA Non-Participating Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Provider level.

Please call Customer Service or visit [www.blueshieldca.com](http://www.blueshieldca.com) to determine whether a provider is a Participating Provider.

### **MHSA Participating Providers**

For Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, Blue Shield has contracted with a Mental Health Service 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 Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

MHSA Participating Providers are those providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services to Members of

this Plan. A Blue Shield Participating Provider may not be an MHSA Participating Provider. It is the Member's responsibility to ensure that the provider selected for Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services is an MHSA Participating Provider. MHSA Participating Providers are identified in the Blue Shield Behavioral Health Provider Directory. Additionally, Members may contact the MHSA directly by calling 1-877-263-9952.

If a Member receives services at a facility that is an MHSA Participating Provider, MHSA's payment for Mental Health and Substance Use Disorder Services provided by a health professional at the MHSA Participating Provider facility will be paid at the MHSA Participating Provider level of Benefits, whether the health professional is an MHSA Participating Provider or MHSA Non-Participating Provider. The Member's share of cost will not exceed the Copayment or Coinsurance due to an MHSA Participating Provider under similar circumstances.

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### **Continuity of Care**

Continuity of care with a Non-Participating Provider is available for the following Members: for Members who are currently seeing a provider who is no longer in the Blue Shield network; or for newly-covered Members whose previous health plan was withdrawn from the market.

Members who meet the eligibility requirements listed above may request continuity of care if they are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness. Continuity of care may also be requested for children who are up to 36 months old, or for Members who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment.

To request continuity of care, visit [www.blueshieldca.com](http://www.blueshieldca.com) and fill out the Continuity of Care Application. Blue Shield will review the



request. The Non-Participating Provider must agree to accept Blue Shield's Allowable Amount as payment in full for ongoing care. When authorized, the Member may continue to see the Non-Participating Provider for up to 12 months at the Participating Provider rate.

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## **Second Medical Opinion Policy**

Members who have questions about their diagnoses, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may make an appointment with another Physician for a second medical opinion. The Member's attending Physician may also offer a referral to another Physician for a second opinion.

The second opinion visit is subject to the applicable Copayment, Coinsurance, Calendar Year Deductible and all Plan contract Benefit limitations and exclusions.

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## **Services for Emergency Care**

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

For Emergency Services from either a Participating Provider or a Non-Participating Provider, the Member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowable Amount Blue Shield is obligated to pay.

Members who reasonably believe that they have an Emergency Medical Condition which requires an emergency response are encouraged to use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Provider's office.

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## **NurseHelp 24/7<sup>SM</sup>**

The NurseHelp 24/7 program offers Members access to registered nurses 24 hours a day, seven days a week. Registered nurses can provide assistance in answering many health-related questions, including concerns about:

- 1) symptoms the patient is experiencing;
- 2) minor illnesses and injuries;
- 3) chronic conditions;
- 4) medical tests and medications; and
- 5) preventive care.

Members may obtain this service by calling the toll-free telephone number at 1-877-304-0504 or by participating in a live online chat at [www.blueshieldca.com](http://www.blueshieldca.com). There is no charge for this confidential service.

In the case of a medical emergency, call 911. For personalized medical advice, Members should consult with their physicians.

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## **Retail-Based Health Clinics**

Retail-based health clinics are outpatient facilities, usually attached or adjacent to retail stores and pharmacies that provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners, under the direction of a physician, and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Participating Provider directory or the online provider directory located at [www.blueshieldca.com](http://www.blueshieldca.com). See the *Blue Shield Participating Providers* section for information on the advantages of choosing a Participating Provider.

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## **Blue Shield Online**

Blue Shield's Internet site is located at [www.blueshieldca.com](http://www.blueshieldca.com). Members with Internet access may view and download healthcare information.

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## Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Participating Providers.

<b>Urgent Care</b>	<b>Access to Care</b>
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
<b>Non-Urgent Care</b>	<b>Access to Care</b>
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
<b>Telephone Inquiries</b>	<b>Access to Care</b>
Access to a health professional for telephone screenings	24 hours/day, 7 days/week

Note: For availability of interpreter services at the time of the Member's appointment, consult the Participating Provider directory available at [www.blueshieldca.com](http://www.blueshieldca.com) or by calling Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the *Notice of the Availability of Language Assistance Services* section of this EOC.

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## Health Education and Health Promotion Services

Blue Shield offers a variety of health education and health promotion services including, but not limited to, a prenatal health education program, interactive online healthy lifestyle programs, and a monthly e-newsletter.

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## Cost-Sharing

The Summary of Benefits provides the Member's Copayment, Coinsurance, Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum amounts.

### Calendar Year Medical Deductible

The Calendar Year Medical Deductible is the amount an individual or a Family must pay for Covered Services each year before Blue Shield begins payment in accordance with this Evidence of Coverage. The Calendar Year Medical Deductible does not apply to all plans. When applied, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. Information specific to the Member's Plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Medical Deductible applies to a particular Covered Service.

There are individual and Family Calendar Year Medical Deductible amounts for both Participating Providers and Non-Participating Providers. Deductible amounts for Covered Services provided by Participating Providers, including Covered Services provided at a Participating Provider facility by health professionals who are Non-Participating Providers, accrue to both the Participating Provider and the Non-Participating Provider Medical Deductible. Deductible amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Medical Deductible.

The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Medical Deductible within the Family Medical Deductible. This means Blue Shield will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met.

Once the respective Deductible is reached, Covered Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

For Covered Services received from Non-Participating Providers, excluding Covered Services provided at a Participating Provider facility by a health professional who is a Non-Participating Provider, the Member is responsible for the applicable Copayment or Coinsurance and for amounts billed in excess of Blue Shield's Allowable Amount. Charges in excess of Blue Shield's Allowable Amount do not accrue to the Calendar Year Medical Deductible.

The Calendar Year Medical Deductible also applies to a newborn child or a child placed for adoption who is covered for the first 31 days, even if application is not made to add the child as a Dependent on the Plan. While coverage for this child is being provided, the Family Medical Deductible will apply.

### **Calendar Year Pharmacy Deductible**

The Calendar Year Pharmacy Deductible is the amount a Member must pay each Calendar Year for covered Drugs before Blue Shield begins payment in accordance with the Group Health Service Contract. The Calendar Year Pharmacy Deductible does not apply to all plans. When it does apply, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. There is an individual Deductible within the Family Calendar Year Pharmacy Deductible. Information specific to the Member's Plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Pharmacy Deductible applies to a particular Drug.

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

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. There are separate maximums for Participating Providers and Non-Participating Providers. If a benefit plan

has any Calendar Year Medical Deductible, it will accumulate toward the applicable Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers. Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Participating Providers, including Covered Services provided at a Participating Provider facility by health professionals who are Non-Participating Providers, accrue to both the Participating Provider and the Non-Participating Provider Out-of-Pocket Maximum. Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Out-of-Pocket Maximum.

There is also an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means that any Family member who meets the individual Out-of-Pocket Maximum will receive 100% Benefits for Covered Services, before the Family Out-of-Pocket Maximum is met.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amounts for Participating Providers and Non-Participating Providers at both the individual and Family levels. When the respective maximum is reached, Covered Services will be paid by Blue Shield at 100% of the Allowable Amount or contracted rate for the remainder of the Calendar Year.

Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate, and additional charges assigned to the Member under the Benefits Management Program do not accrue to the Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.



### **Prior Carrier Deductible Credit**

If a Member satisfies all or part of a medical Deductible under a health plan sponsored by the Employer under any of the following circumstances, that amount will be applied to the Deductible required under this health plan within the same Calendar Year:

- 1) The Member was enrolled in a health plan sponsored by the Employer with a prior carrier during the same Calendar Year this Contract becomes effective and the Member enrolls as of the original effective date of coverage under this Contract;
- 2) The Member was enrolled under another Blue Shield plan sponsored by the same Employer which is being replaced by this health plan;
- 3) The Member was enrolled under another Blue Shield plan sponsored by the same Employer and is transferring to this health plan during the Employer's Open Enrollment Period.

This Prior Carrier Deductible Credit provision applies only in the circumstances described above.

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### **Submitting a Claim Form**

Participating Providers submit claims for payment directly to Blue Shield, however there may be times when Members and Non-Participating Providers need to submit claims.

Except in the case of Emergency Services, Blue Shield will pay Members directly for services rendered by a Non-Participating Provider. Claims for payment must be submitted to Blue Shield within one year after the month services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of the itemized bill, along with a completed Blue Shield claim form to the Blue Shield address listed on the last page of this Evidence of Coverage.

Claim forms are available online at [www.blueshieldca.com](http://www.blueshieldca.com) or Members may call Blue Shield Customer Service to obtain a form. At a minimum, each claim submission must contain the

Subscriber's name, home address, group contract number, Subscriber number, a copy of the provider's billing showing the services rendered, dates of treatment and the patient's name.

Members should submit their claims for all Covered Services even if the Calendar Year Deductible has not been met. Blue Shield will keep track of the Deductible for the Member. Blue Shield also provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

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## **Out-of-Area Services**

### **Overview**

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

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

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### **Inter-Plan Arrangements**

#### **Emergency Services**

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

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## BlueCard Program

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

Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the *BlueCard* Program, your Member share of cost for these services, if not a flat dollar copayment, is calculated based on the lower of:

- 1) The billed charges for Covered Services; or
- 2) The negotiated price that the Host Blue makes available to Blue Shield.

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

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

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE

(2583) or go online at [www.bcbs.com](http://www.bcbs.com) and select “Find a Doctor”.

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

### Non-participating Providers Outside of California

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

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

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. Blue Shield pays claims for covered Emergency Services based on the Allowable Amount as defined in this EOC.

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## Blue Shield Global Core

### Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield

Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at [www.bcbs.com](http://www.bcbs.com); select “Find a Doctor” and then “Blue Shield Global Core”.

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

### **Submitting a Blue Shield Global Core Claim**

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider’s itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Shield Customer Service, the service center or online at [www.bcbsglobal-core.com](http://www.bcbsglobal-core.com). If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

## **Utilization Management**

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State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services

under the Plan. Blue Shield has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing Blue Shield’s Utilization Management Program is available online at [www.blueshieldca.com](http://www.blueshieldca.com) or Members may call the Customer Service Department at the number provided on the back page of this Evidence of Coverage to request a copy.

## **Benefits Management Program**

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The Benefits Management Program applies utilization management and case management principles to assist Members and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this health plan.

The Benefits Management Program includes prior authorization requirements for various medical benefits including inpatient admissions, outpatient services, and prescription Drugs administered in the office, infusion center or provided by a home infusion agency, as well as emergency admission notification, and inpatient utilization management. The program also includes Member services such as, discharge planning, case management and, palliative care services.

The following sections outline the requirements of the Benefits Management Program.

### **Prior Authorization**

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Prior authorization allows the Member and provider to verify with Blue Shield or Blue Shield’s MHSA that (1) the proposed services are a Benefit of the Member’s Plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Member and provider when Benefits are limited to services rendered by Participating Providers or MHSA Participating Providers (See the Summary of Benefits).

**For all Prior Authorizations, except prescription Drugs covered under the medical benefit:**

A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Member and provider within two business days of the decision. For Urgent Services when the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Member's condition, not to exceed 72 hours from receipt of the request.

#### **For Prior Authorizations of prescription Drugs covered under the medical benefit:**

Most prescription Drugs are covered under the *Outpatient Prescription Drug Benefits*. However, Drugs administered in the office, infusion center or provided by a home infusion agency are covered as a medical benefit. For these prescription Drugs, once all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

If prior authorization is not obtained, and services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

#### **Prior Authorization for Radiological and Nuclear Imaging Procedures**

Prior authorization is required for radiological and nuclear imaging procedures. The Member or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed within California on an outpatient, non-emergency basis:

- 1) CT (Computerized Tomography) scan
- 2) MRI (Magnetic Resonance Imaging)

- 3) MRA (Magnetic Resonance Angiography)
- 4) PET (Positron Emission Tomography) scan
- 5) Diagnostic cardiac procedure utilizing Nuclear Medicine

For authorized services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If the radiological or nuclear imaging services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

#### **Prior Authorization for Medical Services and Prescription Drugs Included on the Prior Authorization List**

The "Prior Authorization List" is a list of designated medical and surgical services and select prescription Drugs that require prior authorization. Members are encouraged to work with their providers to obtain prior authorization. Members and providers may call Customer Service at the telephone number provided on the back page of this Evidence of Coverage to inquire about the need for prior authorization. Members and Providers may also access the Prior Authorization List on the Blue Shield website at [www.blueshieldca.com](http://www.blueshieldca.com).

Failure to obtain prior authorization for hemophilia home infusion products and services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage. To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back page of this Evidence of Coverage.

For authorized services and Drugs from a Non-Participating Provider, the Member will be responsible for applicable Deductible and Copayment amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to services rendered by a Participating Provider. If the medical services or Drugs



provided to the Member are determined not to be a Benefit of the Plan or are not provided by a Participating Provider when required, coverage will be denied.

### **Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions**

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient Rehabilitative Services, Skilled Nursing care, special transplant and bariatric surgery. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When admission is authorized to a Non-Participating Hospital, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization is not obtained for an inpatient admission and the services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

Prior authorization is not required for an emergency admission; See the *Emergency Admission Notification* section for additional information.

### **Prior Authorization for Mental Health, Behavioral Health or Substance Use Disorder Hospital Admissions and Other Outpatient Services**

Prior authorization is required for all non-emergency mental health, behavioral health or substance use disorder Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Other Outpatient Mental Health Services and Behavioral Health Treatment, including, but not limited to, Behavioral Health Treatment (BHT), Partial Hospitalization Program

(PHP), Intensive Outpatient Program (IOP), and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA except for electroconvulsive therapy and Psychological Testing. Outpatient Substance Use Disorder Services, including, but not limited to, Intensive Outpatient Program (IOP), Office-Based Opioid Detoxification and/or Maintenance Therapy must be prior authorized except for Psychological Testing. If prior authorization is not obtained for a mental health or substance use disorder inpatient admission or for any Other Outpatient Mental Services and Behavioral Health Treatment, or Outpatient Substance Use Disorder Services and the services provided to the Member are determined not to be a Benefit of the Plan, coverage will be denied.

For an authorized admission to a Non-Participating Hospital or authorized Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services from a Non-Participating Provider, the Member will be responsible for applicable Deductible and Copayment amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency admission; See the *Emergency Admission Notification* section for additional information.

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### **Emergency Admission Notification**

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive emergency admission notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

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### **Inpatient Utilization Management**

Most inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an inpatient Hospital stay may be extended or reduced as warranted by the Member's condition. When a determination is made that the Member no longer requires an inpatient level of care, written notification is given to the attending Physician and the Member. If discharge does not

occur within 24 hours of notification, the Member is responsible for all inpatient charges accrued beyond the 24 hour time frame.

Maternity Admissions: the minimum length of the inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter inpatient stay is adequate.

Mastectomy: The length of the inpatient stay is determined post-operatively by the attending Physician in consultation with the Member.

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## **Discharge Planning**

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield or Blue Shield's MHSA will work with the Member, the attending Physician and the Hospital discharge planners to determine the most appropriate and cost effective way to provide this care.

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## **Case Management**

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Member access necessary services and to make the most efficient use of Plan Benefits. The Member's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Member, the provider, and Blue Shield or Blue Shield's MHSA, and will not exceed the standard Benefits available under this Plan.

The approval of alternative benefits is specific to each Member for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this health plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other Member in any other instance.

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## **Palliative Care Services**

In conjunction with Covered Services, Blue Shield provides palliative care services for Members with serious illnesses. Palliative care services include access to physicians and nurse case managers who are trained to assist Members managing symptoms, maximizing comfort, safety, autonomy and well-being, and navigating a course of care. Members can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Members may call the Customer Service Department to request more information about these services.

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## **Principal Benefits and Coverages (Covered Services)**

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Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurance and charges in excess of Benefit maximums, Participating Provider provisions and Benefits Management Program provisions. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Contract, including any conditions or limitations set forth in the Benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this Evidence of Coverage. All Benefits must be Medically Necessary to be covered. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.

The Copayment and Coinsurance amounts for Covered Services, if applicable, are shown on the Summary of Benefits. The Summary of Benefits is provided with, and is incorporated as part of, this Evidence of Coverage.

Except as may be specifically indicated, for services received from Non-Participating Providers, Subscribers will be responsible for all charges above the Allowable Amount in addition

to the indicated Copayment or Coinsurance amount.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

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### **Acupuncture Benefits**

Benefits are provided for acupuncture services for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. These services must be provided by a Doctor of Medicine, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.

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### **Allergy Testing and Treatment Benefits**

Benefits are provided for allergy testing and treatment, including allergy serum.

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### **Ambulance Benefits**

Benefits are provided for (1) emergency ambulance services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received; or (2) pre-authorized, non-emergency ambulance transportation (surface and air) from one medical facility to another. Ambulance services are required to be provided by a state licensed ambulance or a psychiatric transport van.

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### **Ambulatory Surgery Center Benefits**

Benefits are provided for surgery performed in an Ambulatory Surgery Center.

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### **Bariatric Surgery Benefits**

Benefits are provided for Hospital and professional services in connection with bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, from Blue Shield, whether the Member is a resident of a designated or non-

designated county. See the *Benefits Management Program* section for more information.

### **Services for Residents of Designated Counties**

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric services (see the list of designated counties below), Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

- 1) performed at a Participating Hospital or Ambulatory Surgery Center, and by a Participating Provider, that have both contracted with Blue Shield as a Bariatric Surgery Services Provider to provide the procedure;
- 2) the services are consistent with Blue Shield's medical policy; and
- 3) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric Benefits and to make a decision regarding Benefits based on: (1) the medical circumstances of each patient; and (2) consistency between the treatment proposed and Blue Shield medical policy.

For Members who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Participating Hospital or Ambulatory Surgery Center by a Bariatric Surgery Services Provider will result in denial of claims for this Benefit.

Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must also be provided by a Physician participating as a Bariatric Surgery Services Provider.

The following are the designated counties in which Blue Shield has designated Bariatric Surgery Services Providers to provide bariatric services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

### **Bariatric Travel Expense Reimbursement for Residents of Designated Counties**

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric services at a Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider. All requests for travel expense reimbursement must be prior authorized by Blue Shield. Approved travel-related expenses will be reimbursed as follows:

- 1) Transportation to and from the facility up to a maximum of \$130 per round trip:
  - a) for the Member for a maximum of three trips:
    - i. one trip for a pre-surgical visit;
    - ii. one trip for the surgery; and
    - iii. one trip for a follow-up visit.
  - b) for one companion for a maximum of two trips:
    - i. one trip for the surgery; and
    - ii. one trip for a follow-up visit.
- 2) Hotel accommodations not to exceed \$100 per day:
  - a) for the Member and one companion for a maximum of two days per trip:
    - i. one trip for a pre-surgical visit; and

- ii. one trip for a follow-up visit.

- b) for one companion for a maximum of four days for the duration of the surgery admission.

Hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

- 3) Related expenses judged reasonable by Blue Shield not to exceed \$25 per day per Member up to a maximum of four days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

### **Services for Residents of Non-Designated Counties**

Bariatric surgery services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

- 1) services are consistent with Blue Shield's medical policy; and
- 2) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

For Members who reside in non-designated counties, travel expenses associated with bariatric surgery services are not covered.

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### **Chiropractic Benefits**

Benefits are provided for chiropractic services rendered by a chiropractor or other appropriately licensed or certified Health Care Provider. The chiropractic Benefit includes the initial examination, subsequent office visits, adjustments, conjunctive therapy, and X-ray services.

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



Covered X-ray services provided in conjunction with this Benefit have an additional Copayment or Coinsurance as shown on the Summary of Benefits under Outpatient X-ray, Imaging, Pathology & Laboratory Benefits.

### **Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits**

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition where the clinical trial has a therapeutic intent and when prior authorized by Blue Shield, and:

- 1) the Member's Physician or another Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the Member; or
- 2) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits.

"Routine patient care" consists of those services that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial, but does not include:

- 1) the investigational item, device, or service, itself;
- 2) drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
- 3) services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
- 4) any item or service that is provided solely to satisfy data collection and analysis needs and

that is not used in the direct clinical management of the patient;

- 5) services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;
- 6) services customarily provided by the research sponsor free of charge for any enrollee in the trial;
- 7) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Approved clinical trial" means a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer and other life-threatening condition, and is limited to a trial that is:

- 1) federally funded and approved by one or more of the following:
  - a) one of the National Institutes of Health;
  - b) the Centers for Disease Control and Prevention;
  - c) the Agency for Health Care Research and Quality;
  - d) the Centers for Medicare & Medicaid Services;
  - e) a cooperative group or center of any of the entities in a) to d) above; or the federal Departments of Defense or Veterans Administration;
  - f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
  - g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific

standards by qualified individuals who have no interest in the outcome of the review; or

- 2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

“Life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition interrupted.

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## **Diabetes Care Benefits**

### **Diabetic Equipment**

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item, for the management and treatment of diabetes:

- 1) blood glucose monitors, including those designed to assist the visually impaired;
- 2) insulin pumps and all related necessary supplies;
- 3) podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; and
- 4) visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the *Outpatient Prescription Drug Benefits* section.

### **Diabetic      Outpatient      Self-Management Training**

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when

directed or prescribed by the Member’s Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

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## **Dialysis Benefits**

Benefits are provided for dialysis services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

Included in this Benefit are dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis.

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## **Durable Medical Equipment Benefits**

Benefits are provided for Durable Medical Equipment (DME) for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pumps and the home prothrombin monitor for specific conditions, as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized Durable Medical Equipment items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

No DME Benefits are provided for the following:

- 1) rental charges in excess of the purchase cost;
- 2) replacement of Durable Medical Equipment except when it no longer meets the clinical needs of the patient or has exceeded the

expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the *Outpatient Prescription Drug Benefit* section for benefits for asthma inhalers and inhaler spacers);

- 3) breast pump rental or purchase when obtained from a Non-Participating Provider;
- 4) repair or replacement due to loss or misuse;
- 5) environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and
- 6) backup or alternate items.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

For Members in a Hospice program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Disease or Terminal Illness and related conditions are provided by the Hospice Agency.

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## Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services and emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Provider's office.

Emergency Services are services provided for an unexpected medical condition, including a psychiatric Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily

functions; (3) serious dysfunction of any bodily organ or part.

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## Family Planning Benefits

Benefits are provided for the following family planning services without illness or injury being present:

- 1) family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; and
- 2) vasectomy.

No Benefits are provided for family planning services from Non-Participating Providers.

See also the *Preventive Health Benefits* section for additional family planning services.

For plans with a Calendar Year Deductible for services by Participating Providers, the Calendar Year Deductible applies only to male sterilizations and to abortions.

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## Home Health Care Benefits

Benefits are provided for home health care services from a Participating home health care agency when the services are ordered by the attending Physician, and included in a written treatment plan.

Services by a Non-Participating home health care agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by Blue Shield.

Covered Services are subject to any applicable Deductibles, Copayments and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled services are covered up to three visits per day, two hours per visit up to the Calendar Year visit maximum (including all home health visits) by any of the following professional providers:

- 1) registered nurse;

- 2) licensed vocational nurse;
- 3) physical therapist, occupational therapist, or speech therapist; or
- 4) medical social worker.

Intermittent and part-time visits by a home health agency to provide services from a Home Health Aide are covered up to four hours per visit, and are included in the Calendar Year visit maximum.

For the purpose of this Benefit, each two-hour increment of visit from a nurse, physical therapist, occupational therapist, speech therapist, or medical social worker counts as a separate visit. Visits of two hours or less shall be considered as one visit. For visits from a Home Health Aide, each four-hour increment counts as a separate visit. Visits of four hours or less shall be considered as one visit.

Medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan and related laboratory services are covered in conjunction with the professional services rendered by the home health agency.

This Benefit does not include medications, or injectables covered under the *Home Infusion and Home Injectable Therapy Benefit* or under the Benefit for *Outpatient Prescription Drugs*.

See the *Hospice Program Benefits* section for information about admission into a Hospice program and specialized Skilled Nursing services for Hospice care.

For information concerning diabetic self-management training, see the *Diabetes Care Benefits* section.

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### **Home Infusion and Home Injectable Therapy Benefits**

Benefits are provided for home infusion and injectable medication therapy. Services include home infusion agency Skilled Nursing visits, infusion therapy provided in infusion suites associated with a Participating home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit,

medications injected or administered intravenously, related laboratory services, when prescribed by a Doctor of Medicine and provided by a Participating home infusion agency. Services related to hemophilia are described separately.

This Benefit does not include medications, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefit, and services related to hemophilia which are described below.

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the Non-Participating home infusion agency and Blue Shield. Shift care and private duty nursing must be prior authorized by Blue Shield.

### **Hemophilia Home Infusion Products and Services**

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. (Note: most Participating home health care and home infusion agencies are not Participating Hemophilia Infusion Providers.) To find a Participating Hemophilia Infusion Provider, consult the Participating Provider directory. Members may also verify this information by calling Customer Service at the telephone number shown on the last page of this Evidence of Coverage.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following Member evaluation by a Doctor of Medicine, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once prior authorized by Blue Shield, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the *Emergency Room Benefits* section.)



Included in this Benefit is the blood factor product for in-home infusion by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a Participating Hemophilia Infusion Provider), and services to treat complications of hemophilia replacement therapy are not covered under this Benefit.

No Benefits are provided for:

- 1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications;
- 2) services from a hemophilia treatment center or any Non-Participating Hemophilia Infusion Provider; or,
- 3) self-infusion training programs, other than nursing visits to assist in administration of the product.

Services may be covered under Outpatient Prescription Drug Benefits, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

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## Hospice Program Benefits

Benefits are provided for services through a Participating Hospice Agency when an eligible Member requests admission to, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by his or her Participating Provider's certification and must receive prior approval from Blue Shield for the admission. Members with a Terminal Disease or Terminal Illness who have not yet elected to enroll in a Hospice program may receive a pre-hospice consultative visit from a Participating Hospice Agency.

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver

and the family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Participating Hospice Agency.

- 1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.
- 2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:
  - a) Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;
  - b) Home Health Aide services to provide personal care (supervised by a registered nurse);
  - c) homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);
  - d) bereavement services for the immediate surviving family members for a period of at least one year following the death of the Member;
  - e) medical social services including the utilization of appropriate community resources;
  - f) counseling/spiritual services for the Member and family;
  - g) dietary counseling;
  - h) medical direction provided by a licensed Doctor of Medicine acting as a consultant to the interdisciplinary Hospice team and to the Member's Participating Provider with regard to pain and symptom

management and as a liaison to community physicians;

- i) physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;
  - j) respiratory therapy;
  - k) volunteer services.
- 3) Drugs, durable medical equipment, and supplies.
  - 4) Continuous home care when Medically Necessary to achieve palliation or management of acute medical symptoms including the following:
    - a) 8 to 24 hours per day of continuous skilled nursing care (8-hour minimum);
    - b) homemaker or Home Health Aide Services up to 24 hours per day to supplement skilled nursing care.
  - 5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.
  - 6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members may receive care for either a 30 or 60-day period, depending on their diagnosis. The care continues through another Period of Care if the Physician recertifies that the Member is Terminally Ill.

Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.

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## **Hospital Benefits (Facility Services)**

### **Inpatient Services for Treatment of Illness or Injury**

Benefits are provided for the following inpatient Hospital services:

- 1) Semi-private room and board unless a private room is Medically Necessary.
- 2) General nursing care, and special duty nursing.
- 3) Meals and special diets.
- 4) Intensive care services and units.
- 5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.
- 6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
- 7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.
- 8) Drugs and oxygen.
- 9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.
- 10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.
- 11) Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
- 12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.
- 13) Subacute Care.
- 14) Medical social services and discharge planning.
- 15) Inpatient services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is

required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

- 16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder detoxification is prior authorized by Blue Shield.

### **Outpatient Services for Treatment of Illness or Injury or for Surgery**

Benefits include the following outpatient Hospital services:

- 1) Dialysis services.
- 2) Care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which an inpatient admission is planned.
- 3) Surgery.
- 4) Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
- 5) Routine newborn circumcision performed within 18 months of birth.

Covered Physical Therapy, Occupational Therapy and Speech Therapy Services provided in an outpatient Hospital setting are described under the *Rehabilitative and Habilitative Benefits (Physical, Occupational and Respiratory Therapy)* and *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* sections.

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### **Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits**

Benefits are provided for Hospital and professional services provided for conditions of the teeth, gums or jaw joints and jaw bones,

including adjacent tissues, only to the extent that they are provided for:

- 1) treatment of tumors of the gums;
- 2) treatment of damage to natural teeth caused solely by an Accidental Injury (limited to palliative services necessary for the initial medical stabilization of the Member as determined by Blue Shield);
- 3) non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
- 4) surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
- 5) treatment of maxilla and mandible (jaw joints and jaw bones);
- 6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;
- 7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair;
- 8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck;
- 9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

No Benefits are provided for:

- 1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment

of cleft palate, including treatment to alleviate TMJ;

- 2) dental implants (endosteal, subperiosteal or transosteal);
- 3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- 4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and
- 5) fluoride treatments except when used with radiation therapy to the oral cavity.

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### **Mental Health, Behavioral Health, and Substance Use Disorder Benefits**

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services for Blue Shield Members within California. See the *Out-Of-Area Services, BlueCard Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health Services, Behavioral Health Treatment and Substance Use Disorder Services, including Residential Care must be prior authorized by the MHSA. In addition, Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services are subject to the Benefits Management Program and must be prior authorized by the MHSA except for electroconvulsive therapy and Psychological Testing. See the *Benefits Management Program* section for complete information.

### **Mental Health and Behavioral Health – Office Visits**

Benefits are provided for professional (Physician) office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions in the individual, family or group setting.

### **Mental Health and Behavioral Health — Other Outpatient Services**

Benefits are provided for Outpatient Facility and professional services for Behavioral Health Treatment and for the diagnosis and treatment of Mental Health Conditions. These services may also be provided in the office, home or other non-institutional setting. Other Outpatient Mental Health Services and Behavioral Health Treatment include, but may not be limited to, the following:

- 1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

BHT is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by the MHSA. BHT delivered in the home or other non-institutional setting must be obtained from MHSA Participating Providers.

Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

- 2) Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.
- 3) Intensive Outpatient Program - an outpatient mental health or behavioral health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- 4) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.



- 5) Psychological Testing - testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.
- 6) Transcranial Magnetic Stimulation - a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

### **Outpatient Substance Use Disorder Services**

Benefits are provided for Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions. These services may also be provided in the office, home or other non-institutional setting. Outpatient Substance Use Disorder Services include, but may not be limited to, the following:

- 1) Intensive Outpatient Program - an outpatient substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- 2) Office-Based Opioid Detoxification and/or Maintenance Therapy, including Methadone maintenance treatment.
- 3) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

### **Inpatient Services**

Benefits are provided for inpatient Hospital and professional services in connection with acute hospitalization for Behavioral Health Treatment, the treatment of Mental Health Conditions or Substance Use Disorder Conditions

Benefits are provided for inpatient and professional services in connection with Residential Care admission for Behavioral Health Treatment, the treatment of Mental Health Conditions or Substance Use Disorder Conditions

See *Hospital Benefits (Facility Services)*, *Inpatient Services for Treatment of Illness or Injury* for information on Medically Necessary inpatient substance use disorder detoxification.

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### **Orthotics Benefits**

Benefits are provided for orthotic appliances and devices for maintaining normal Activities of Daily Living only. Benefits include:

- 1) shoes only when permanently attached to such appliances;
- 2) special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
- 3) knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- 4) functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- 5) initial fitting and adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

No Benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet not listed above. No Benefits are provided for backup or alternate items, or replacement due to loss or misuse.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

## Outpatient Prescription Drug Benefits

This plan provides benefits for Outpatient Prescription Drugs as specified in this section.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. Members must obtain all Drugs from a Participating Pharmacy, except as noted below.

Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section. The Member or their Physician or Health Care Provider may request prior authorization from Blue Shield.

### Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs. Drugs not listed on the Formulary may be covered if the exception request submitted by the Member or the Member's Physician or Health Care Provider is approved by Blue Shield.

Blue Shield's Formulary is established by Blue Shield's Pharmacy and Therapeutics (P&T) Committee. This committee consists of physicians and pharmacists responsible for evaluating drugs for relative safety, effectiveness, health benefit based on the medical evidence, and comparative cost. They also review new drugs, dosage forms, usage and clinical data to update the Formulary four times a year. Note: The Member's Physician or Health Care Provider might prescribe a drug even though the drug is not included on the Formulary.

The Formulary drug list is categorized into drug tiers as described in the chart below. The Member's Copayment or Coinsurance will vary based on the drug tier.

Drug Tier	Description
Tier 1	Most Generic Drugs, and low-cost, Preferred Brand Drugs.
Tier 2	1. Non-preferred Generic Drugs; 2. Preferred Brand Name Drugs; and 3. Any other Drugs recommended by the plan's Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost.
Tier 3	1. Non-preferred Brand Name Drugs; 2. Drugs that are recommended by the P&T Committee based on drug safety, efficacy and cost; or 3. Generally, have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	1. Drugs that are biologics and Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; 2. Drugs that require the Member to have special training or clinical monitoring; or 3. Drugs that cost the health plan (net of rebates) more than \$600 for a one-month supply.

Members can find the Drug Formulary at <https://www.blueshieldca.com/bsca/pharmacy/home.sp>. Members can also contact Customer Service at the number provided on the back page of this Evidence of Coverage to ask if a specific Drug is included in the Formulary, or to request a printed copy of the Formulary.

### Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug.

Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Pharmacy by visiting <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service at the number listed on the Identification Card. If the Member obtains Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny the claim, unless it is for Emergency Services.

Blue Shield negotiates contracted rates with Participating Pharmacies for Drugs. If the Member's Plan has a Calendar Year Pharmacy Deductible, the Member is responsible for paying the contracted rate for Drugs until the Calendar Year Deductible is met.

The Member must pay the applicable Copayment or Coinsurance for each prescription when the Member obtains it from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than the Member's Copayment or Coinsurance, the Member only pays the contracted rate. There is no Copayment or Coinsurance for generic FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance when Medically Necessary. See *Prior Authorization/Exception Request Process/Step Therapy* section.

Drugs not listed on the Formulary may be covered when Medically Necessary and by submitting an exception request to Blue Shield. If approved, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment or Coinsurance (refer to the Drug Tier table in the *Outpatient Drug Formulary* section of this Evidence of Coverage.). For all other Drugs, the Tier 3 Copayment or Coinsurance applies when prior authorization is obtained. If an exception is not obtained, the Member is responsible for paying 100% of the cost of the Drug(s).

If the Member, their Physician or Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, the Member pays the

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

If the Member or their Physician or Health Care Provider believes the Brand Drug is Medically Necessary, they can request an exception to the difference in cost between the Brand Drug and Generic Drug equivalent through the Blue Shield prior authorization process. The request is reviewed for Medical Necessity. If the request is approved, the Member pays the applicable tier Copayment or Coinsurance for the Brand Drug.

The prior authorization process is described in the *Prior Authorization/Exception Request Process/Step Therapy* section of this Evidence of Coverage.

### **Emergency Exception for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy**

When the Member obtains Drugs from a Non-Participating Pharmacy for Emergency Services:

- The Member must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim Form to

Blue Shield of California

P.O. Box 419019,  
Dept. 191  
Kansas City, MO 64141

- Blue Shield will reimburse the Member based on the price the Member paid for the Drug, minus any applicable Deductible, Copayment or Coinsurance.

Claim forms may be obtained by calling Customer Service or visiting [www.blueshieldca.com](http://www.blueshieldca.com). Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

### **Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program**

The Member has an option to use Blue Shield's Mail Service Prescription Drug Program when he or she takes maintenance Drugs for an ongoing condition. This allows the Member to receive up to a 90-day supply of their Drug and may help the Member to save money. The Member may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. The Member's Physician or Health Care Provider must indicate a prescription quantity equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

The Member must pay the applicable Mail Service Prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit [www.blueshieldca.com](http://www.blueshieldca.com) or call Customer Service to get additional information about the Mail Service Prescription Drug Program.

### **Obtaining Specialty Drugs through the Specialty Drug Program**

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

Specialty Drugs are available exclusively from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, upon the Member's request, will transfer the Specialty Drug to an associated retail store for pickup. See *Emergency Exception for Obtaining Outpatient Prescription Drugs at a Non-Participating Pharmacy*.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA. To select a Network Specialty Pharmacy, you may go to <http://www.blueshieldca.com> or call Customer Service.

Go to <http://www.blueshieldca.com> for a complete list of Specialty Drugs. Most Specialty Drugs require prior authorization for Medical Necessity by Blue Shield, as described in the *Prior Authorization/Exception Request Process/Step Therapy* section.

### **Prior Authorization/Exception Request Process/Step Therapy**

Some Drugs and Drug quantities require prior approval for Medical Necessity before they are eligible to be covered by the Outpatient Prescription Drug Benefit. This process is called prior authorization.

The following Drugs require prior authorization:

- 1) Some Formulary, preferred, non-preferred, compound Drugs, and most Specialty Drugs;
- 2) Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;
- 3) Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance;
- 4) When a Brand Drug is Medically Necessary, prior authorization is required if the Member, Physician or Health Care Provider is requesting an exception to the difference in cost between the Brand Drug and the Generic equivalent;



Blue Shield covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug,
- There are no FDA-approved, commercially available, medically appropriate alternatives,
- The compounded medication is self-administered, and
- Medical literature supports its use for the diagnosis.

The Member pays the Tier 3 Copayment or Coinsurance for covered compound Drugs.

The Member, their Physician or Health Care Provider may request prior authorization or an exception request for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

To request coverage for a Non-Formulary Drug, the Member, representative, or the Provider may submit an exception request to Blue Shield. Once all required supporting information is received, Blue Shield will approve or deny the exception request, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances.

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the

relative cost of treatment for a condition. If step therapy coverage requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, the Member, representative, or the Provider can file a grievance with Blue Shield, as described in the *Grievance Process* section.

### **Limitation on Quantity of Drugs that May Be Obtained Per Prescription or Refill**

- 1) Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.
- 2) If the Member or Health Care Provider requests a partial fill of a Schedule II Controlled Substance prescription, the Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.
- 3) Blue Shield has a Short Cycle Specialty Drug Program. With the Member's agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows the Member to receive a 15-day supply of the Specialty Drug and determine whether the Member will tolerate it before he or she obtains the full 30-day supply. This program can help the Member save out of pocket expenses if the Member cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the program, which the Member can elect at that time. The Member or their Physician may choose a full 30-day supply for the first fill.

If the Member agrees to a 15-day trial, the Network Specialty Pharmacy will contact the Member prior to dispensing the remaining 15-day supply to confirm that the Member is tolerating the Specialty Drug. The Member can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service.

- 4) You may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.
- 5) Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
- 6) You may receive up to a 12-month supply of contraceptive Drugs.
- 7) The Member may refill covered prescriptions at a Medically Necessary frequency.

### **Outpatient Prescription Drug Exclusions and Limitations**

Blue Shield does not provide coverage in the Outpatient Prescription Drug Benefit for the following. The Member may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Evidence of Coverage to determine if the Plan covers Drugs under that Benefit.

- 1) Any Drug the Member receives while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional Benefits and Hospital Benefits (Facility Services)* sections of this Evidence of Coverage.
- 2) Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities.

See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of this Evidence of Coverage.

- 3) Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug.
- 4) Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary by submitting an exception request to Blue Shield. See the *Prior Authorization/Exception Request Process/Step Therapy* section of this Evidence of Coverage.
- 5) Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
- 6) Drugs that are considered to be experimental or investigational.
- 7) Medical devices or supplies except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits*, and the *Orthotics Benefits* sections of this Evidence of Coverage.
- 8) Blood or blood products (see the *Hospital Benefits (Facility Services)* section of this Evidence of Coverage).
- 9) Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.
- 10) Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home*

*Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.

11) Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, Hospice Program Benefits, or Family Planning Benefits* sections of this Evidence of Coverage.

12) All Drugs for the treatment of infertility.

13) Appetite suppressants or drugs for body weight reduction. These Drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases, prior authorization by Blue Shield is required.

14) Contraceptive drugs or devices which do not meet all of the following requirements:

- Are FDA-approved,
- Are ordered by a Physician or Health Care Provider,
- Are generally purchased at an outpatient pharmacy, and
- Are self-administered.

Other contraceptive methods may be covered under the *Family Planning Benefits* section of this Evidence of Coverage.

15) Compounded medication(s) which do not meet all of the following requirements:

- The compounded medication(s) include at least one Drug,
- There are no FDA-approved, commercially available, medically appropriate alternatives,
- The compounded medication is self-administered, and

- Medical literature supports its use for the diagnosis.

16) Replacement of lost, stolen, or destroyed Drugs.

17) If the Member is enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under *Outpatient Prescription Drug Benefits* and are covered under the *Hospice Program Benefits* section of this Evidence of Coverage.

18) Drugs prescribed for treatment of dental conditions. This exclusion does not apply to

- antibiotics prescribed to treat infection,
- Drugs prescribed to treat pain, or
- Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.

19) Except for covered Emergency Services, Drugs obtained from a pharmacy:

- Not licensed by the State Board of Pharmacy, or
- Included on a government exclusion list.

20) Immunizations and vaccinations solely for the purpose of travel.

21) Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.

22) Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

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## **Outpatient X-ray, Imaging, Pathology and Laboratory Benefits**

Benefits are provided to diagnose or treat illness or injury, including:

- 1) diagnostic and therapeutic imaging services, such as X-ray and ultrasounds (certain imaging services require prior authorization);
- 2) clinical pathology, and
- 3) laboratory services.

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention.

Routine laboratory services performed as part of a preventive health screening are covered under the *Preventive Health Benefits* section.

### **Radiological and Nuclear Imaging**

The following radiological procedures, when performed on an outpatient, non-emergency basis, require prior authorization under the Benefits Management Program. See the *Benefits Management Program* section for complete information.

- 1) CT (Computerized Tomography) scans;
- 2) MRIs (Magnetic Resonance Imaging);
- 3) MRAs (Magnetic Resonance Angiography);
- 4) PET (Positron Emission Tomography) scans; and
- 5) cardiac diagnostic procedures utilizing Nuclear Medicine.

See the *Pregnancy and Maternity Care Benefits* section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

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## **PKU-Related Formulas and Special Food Products Benefits**

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products for the dietary treatment of

phenylketonuria (PKU). All formulas and Special Food Products must be prescribed and ordered through the appropriate health care professional.

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## **Podiatric Benefits**

Podiatric services include office visits and other Covered Services for the diagnosis and treatment of the foot, ankle, and related structures. These services are customarily provided by a licensed doctor of podiatric medicine. Covered lab and X-ray services provided in conjunction with this Benefit are described under the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section.

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## **Pregnancy and Maternity Care Benefits**

Benefits are provided for maternity services, including the following:

- 1) prenatal care;
- 2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy;
- 3) outpatient maternity services;
- 4) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);
- 5) inpatient hospital maternity care including labor, delivery and post-delivery care;
- 6) abortion services; and
- 7) outpatient routine newborn circumcisions performed within 18 months of birth.

See the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section for information on coverage of other genetic testing and diagnostic procedures.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.



If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

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### **Preventive Health Benefits**

Preventive Health Services are only covered when rendered by a Participating Provider. These services include primary preventive medical screening and laboratory testing for early detection of disease as specifically listed below:

- 1) evidence-based items, drugs or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- 2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- 4) with respect to women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not

limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at [www.blueshieldca.com/preventive](http://www.blueshieldca.com/preventive) or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1) through 4) above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation.

Diagnostic audiometry examinations are covered under the *Professional Benefits* section.

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### **Professional Benefits**

Benefits are provided for services of Physicians for treatment of illness or injury, as indicated below.

- 1) Office visits.
- 2) Services of consultants, including those for second medical opinion consultations.
- 3) Mammography and Papanicolaou's tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
- 4) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
- 5) Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room.
- 6) Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay.
- 7) Surgical procedures. Chemotherapy for cancer, including catheterization, and associated drugs and supplies.
- 8) Extra time spent when a Physician is detained to treat a Member in critical condition.

- 9) Necessary preoperative treatment.
- 10) Treatment of burns.
- 11) Outpatient routine newborn circumcision performed within 18 months of birth.
- 12) Diagnostic audiometry examination.
- 13) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit <http://www.teladoc.com/bsc>. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation services are not intended to replace services from your Physician but are a supplemental service. You do not need to contact your Physician before using Teladoc consultation services.

Teladoc physicians do not issue prescriptions for substances controlled by the DEA, non-therapeutic, and/or certain other drugs which may be harmful because of potential for abuse.

Note: If medications are prescribed, the applicable Copayment or Coinsurance will apply. Teladoc consultation services are not available for specialist services or Mental Health and Substance Use Disorder Services. However, telehealth services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers.

- 14) A Participating Provider may offer extended hour and urgent care services on a walk-in basis in a non-Hospital setting such as the

Physician's office or an urgent care center. Services received from a Participating Provider at an extended office hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found online at [www.blueshieldca.com](http://www.blueshieldca.com) or from Customer Service.

Professional services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab and X-ray services provided in conjunction with these professional services listed above are described under the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section.

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## Prosthetic Appliances Benefits

Benefits are provided for Prostheses for Activities of Daily Living at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized Prosthetic appliances equally appropriate for a condition, Benefits will be based on the most cost-effective Prosthetic appliance. Benefits include:

- 1) Blom-Singer and artificial larynx prostheses for speech following a laryngectomy (covered as a surgical professional benefit);
- 2) artificial limbs and eyes;
- 3) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;
- 4) contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia following cataract surgery when no intraocular lens has been implanted;
- 5) supplies necessary for the operation of prostheses;
- 6) initial fitting and replacement after the expected life of the item; and
- 7) repairs, except for loss or misuse.

No Benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided above). No Benefits are provided for backup or alternate items.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see the *Reconstructive Surgery Benefits* section.

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## **Reconstructive Surgery Benefits**

Benefits are provided 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. Benefits include dental and orthodontic services that are an integral part of this surgery for cleft palate procedures. Reconstructive Surgery is covered to create a normal appearance only when it offers more than a minimal improvement in appearance.

In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons.

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## **Rehabilitative and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy)**

Benefits are provided for outpatient Physical, Occupational, and Respiratory Therapy for the treatment of functional disability in the performance of activities of daily living. Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant

to the treatment plan, to help the Member regain his or her previous level of functioning or to keep, learn, or improve skills and functioning.

Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity.

Benefits for Speech Therapy are described in the *Speech Therapy Benefits (Rehabilitative and Habilitative Services)* section.

See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitative/Habilitative Services rendered in the home.

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## **Skilled Nursing Facility Benefits**

Benefits are provided for Skilled Nursing services in a Skilled Nursing unit of a Hospital or a free-standing Skilled Nursing Facility, up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Benefit Period, except that room and board charges in excess of the facility's established semi-private room rate are excluded. A "Benefit Period begins on the date the Member is admitted into the facility for Skilled Nursing services, and ends 60 days after being discharged and Skilled Nursing services are no longer being received. A new Benefit Period can begin only after an existing Benefit Period ends.

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## **Speech Therapy Benefits (Rehabilitative and Habilitative Services)**

Benefits are provided for outpatient Speech Therapy for the treatment of (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous performance level or to keep, learn, or improve skills and functioning. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity.

See the *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

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## **Transplant Benefits**

### **Tissue and Kidney Transplants**

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient.

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

### **Special Transplants**

Benefits are provided for certain procedures, listed below, only if: (1) performed at a Special Transplant Facility contracting with Blue Shield to provide the procedure, or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield, (2) prior authorization is obtained, in writing through the Benefits Management Program, and (3) the recipient of the transplant is a Subscriber or Dependent.

Failure to obtain prior written authorization and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this provision:

- 1) Human heart transplants.
- 2) Human lung transplants.
- 3) Human heart and lung transplants in combination.
- 4) Human liver transplants.
- 5) Human kidney and pancreas transplants in combination.
- 6) Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational.
- 7) Pediatric human small bowel transplants.

- 8) Pediatric and adult human small bowel and liver transplants in combination.

Transplant benefits include coverage for donation-related services for a living donor (including a potential donor), or a transplant organ bank. Donor services must be directly related to a covered transplant and must be prior authorized by Blue Shield. Donation-related services include harvesting of the organ, tissue, or bone marrow and treatment of medical complications for a period of 90 days following the evaluation or harvest service.

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## **Pediatric Dental Benefits**

### **(Benefits applicable to Member aged 19 and under)**

Blue Shield has contracted with a Dental Plan Administrator (DPA). All pediatric dental Benefits will be administered by the DPA. Pediatric dental Benefits are available for Members through the end of the month in which the Member turns 19. Dental services are delivered to our Members through the DPA's Dental PPO ("DPPO) network of Participating Providers. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from Non-Participating Dentists.

If the Member purchased a family dental plan that includes a supplemental pediatric dental Benefits on the Health Benefits Exchange, embedded the pediatric dental Benefits covered under this Plan will be paid first, with the supplemental pediatric dental plan covering non-covered services and/or cost sharing as described in the Member's family dental Evidence of Coverage.

If the Member has any questions regarding the pediatric dental Benefits described in this Evidence of Coverage, needs assistance, or has any problems, they may contact the Dental Member Services Department at: 1-800-286-7401.

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### **Before Obtaining Dental Services**

The Member is responsible for assuring that the Dentist they choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is the Member's obligation to verify whether the



Dentist the Member chooses is currently a Participating Dentist in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in the Member's area, can be obtained by contacting the DPA at 1-800-286-7401. The Member may also access a list of Participating Dentists through Blue Shield of California's internet site located at <http://www.blueshieldca.com>. The Member is also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

NOTE: The DPA will respond to all requests for pre-certification and prior authorization within 5 business days from receipt of the request. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, the DPA will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of benefits. However, by following the Pre-certification process both the Member and the Dentist will know in advance which services are covered and the benefits that are payable.

### Participating Dentists

The Blue Shield of California Dental DPPO Plan is specifically designed for Members to use Participating Dentists. Participating Dentists agree to accept the DPA's payment, plus the Member's payment of any applicable deductible and coinsurance amount, as payment in full for covered services. This is not true of Non-Participating Dentists.

If the Member goes to a Non-Participating Dentist, the Member will be reimbursed up to a pre-determined maximum amount, for covered services. The Member's reimbursement may be substantially less than the billed amount. The Member is responsible for all differences between the amount the Member is reimbursed and the amount billed by Non-Participating Dentists. It is therefore to the Member's advantage to obtain dental services from Participating Dentists.

Participating Providers submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. The Member or their Non-Participating Providers submits claims for reimbursement after services have been rendered. If the Member receives services from Non-Participating Providers, the Member has the option of having payments sent directly to the Non-Participating Provider or sent directly to the Member. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

The Member may access a Directory of Participating Dentists through Blue Shield of California's Internet site located at <http://www.blueshieldca.com>. The names of Participating Dentists in the Member's area may also be obtained by contacting the DPA at 1-800-286-7401.

### Timely Access to Dental Care Services

Blue Shield provides the following guidelines for timely access to care from Dental Providers:

<b><u>Service</u></b>	<b><u>Access to Care</u></b>
Urgent Care	Within 72 hours
Non-urgent care	Within 30 business days
Preventive dental care	Within 40 business days
<b><u>Telephone Inquiries</u></b>	<b><u>Access to Care</u></b>
<u>Access to a dental professional to evaluate the Member's dental concerns and symptoms</u>	<u>Within 30 minutes, 24 hours/day 7 days/week</u>

Note: For availability of interpreter services at the time of the Member's appointment, contact Customer Service at the number shown in the "Customer Service" section of this booklet. More information for interpreter services is located in

the Notice of the Availability of Language Assistance Services section of this EOC.

### **Financial Responsibility for Continuity of Care Services**

If a Member is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for Services rendered under the Continuity of Care provision shall be no greater than for the same Services rendered by a Participating Dentist in the same geographic area.

### **Pre-certification of Dental Benefits**

Before any course of treatment expected to cost more than \$250 is started, the Member should obtain Pre-certification of Benefits. The Member's Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to the DPA. The DPA will review the dental treatment plan to determine the benefits payable under the plan. The benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, the Member's claim form should be submitted to the DPA for payment determination. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

The dental plan provides benefits for Covered Services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this plan will in most cases provide benefits based on the most cost-effective procedure. The benefits provided under this plan are based on these considerations but the Member and their Dentist make the final decision regarding treatment.

Failure to obtain Pre-certification of Benefits may result in a denial of benefits. If the Pre-certification process is not followed, the DPA will still determine payment by taking into account alternative procedures; services or materials for the dental condition based on professionally recognized standards of dental practice. However,

by following the Pre-certification process both the Member and their Dentist will know in advance which services are covered and the benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material which meets professionally recognized standards of quality dental care and is the most cost effective as determined by the DPA. If the Member and their Dentist decide on a more costly procedure, service or material than the DPA determined is payable under the plan, then benefits will be applied to the selected treatment plan up to the benefit maximum for the most cost effective alternative. The Member will be responsible for any charges in excess of the benefit amount. The DPA reserves the right to use the services of dental consultants in the Pre-certification review.

Example:

- 1) If a crown is placed on a tooth which can be restored by a filling, benefits will be based on the filling;
- 2) If a semi-precision or precision partial denture is inserted, benefits may be based on a conventional clasp partial denture;
- 3) If a bridge is placed and the Member has multiple unrestored missing teeth, Benefits will be based on a partial denture.

### **Participating Dentists**

When the Member receives covered dental services from a Participating Dentist, the Member will be responsible for a coinsurance amount as outlined in the section entitled Summary of Benefits. Participating Dentists will file claims on the Member's behalf.

Participating Dentists will be paid directly by the plan, and have agreed to accept the DPA's payment, plus the Member's payment of any applicable deductible or coinsurance amount, as payment in full for covered services.

If the covered Member recovers from a third party the reasonable value of covered services rendered by a Participating Dentist, the Participating Dentist who rendered these services is not required to

accept the fees paid by the DPA as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by the DPA and the amount collected by the covered Member for these services.

### **Non-Participating Dentists**

When the Member receives covered services from a Non-Participating Dentist, the Member will be reimbursed up to a specified maximum amount as outlined in the section entitled Summary of Benefits and Member Coinsurance. The Member will be responsible for the remainder of the Dentist's billed charges. The Member should discuss this beforehand with their Dentist if he is not a Participating Dentist. Any difference between the DPA's or Blue Shield of California's payment and the Non-Participating Dentist's charges are the Member's responsibility. Members are expected to follow the billing procedures of the dental office.

If the Member receives covered Services from a Non-Participating Dentist, either the Member or their provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

1-800-286-7401

Claims for all Covered California services should be sent to:

Blue Shield of California  
Dental Plan Administrator  
P O Box 400  
Chico, CA 95927

### **Procedure for Filing a Claim**

Claims for covered dental Services should be submitted on a dental claim form which may be obtained from the DPA or at [www.blueshieldca.com](http://www.blueshieldca.com). Have the Dentist complete the form and mail it to the DPA Service Center as shown in the Pediatric Dental Benefits Customer Services section.

The DPA will provide payment in accordance with the provisions of this Agreement. The Member will receive an explanation of benefits after the claim has been processed.

All claims for reimbursement must be submitted to the DPA within one (1) year after the month in which the service is rendered. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

### **Coordination of Dental Benefits**

All medical plans include an embedded pediatric dental Benefit. For purposes of coordinating Benefits the medical plan is the primary dental Benefit plan and the pediatric dental plan is the secondary dental Benefit plan.

### **Emergency Dental Care Services**

A dental emergency means, "an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the member to undue suffering."

If the Member is in need of emergency treatment, the Member should contact a Dentist of their choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. The Member will be directly reimbursed for this treatment up to the maximum allowed under their Plan Benefits.

### **General Exclusions and Limitations**

Unless exceptions to the following general exclusions are specifically made elsewhere under this plan, this plan does not provide Benefits for:

- 1) Dental services not appearing on the Summary of Benefits or on the Dental Schedule and Limitations Table below;
- 2) Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage or on the Dental Schedule and Limitations Table below;
- 3) Services of dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Participating Dentist and authorized by the

Plan, or when required in a covered emergency;

- 4) Any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member's effective date of coverage;
- 5) Any dental services received subsequent to the time the Member's coverage ends;
- 6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
- 7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
- 8) Procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits or on the Dental Schedule and Limitations Table below;
- 9) Cosmetic dental care;
- 10) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit on the Summary of Benefits or on the Dental Schedule and Limitations Table below or is given by a Dentist for a covered oral surgery;
- 11) Hospital charges of any kind;
- 12) Loss or theft of dentures or bridgework;
- 13) Malignancies;

14) Dispensing of drugs not normally supplied in a dental office;

- 15) Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;
- 16) The cost of precious metals used in any form of dental benefits;
- 17) Services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Participating Dentist or for Medically Necessary Dental Services or his or her Participating Dentist is a pedodontist/pediatric Dentist;
- 18) Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;
- 19) Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
- 20) Treatment for which payment is made by any governmental agency, including any foreign government;
- 21) Charges for second opinions, unless previously authorized by the DPA;
- 22) Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.

#### **Preventive Exclusions and Limitations (D1000-D1999)**

- 1) Fluoride treatment (D1206 and D1208) is a Benefit only for prescription strength fluoride products;
- 2) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration



and applications of aqueous sodium fluoride;  
and

- 3) The application of fluoride is only a Benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

#### **Restorative Exclusions and Limitations (D2000-D2999)**

- 1) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
- 2) Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 3) Restorations for primary teeth near exfoliation;
- 4) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription;
- 5) Prefabricated crowns for primary teeth near exfoliation;
- 6) Prefabricated crowns are not a Benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214);
- 7) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
- 8) Prefabricated crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 9) Prefabricated crowns are not a Benefit when a tooth can be restored with an amalgam or resin-based composite restoration;

- 10) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;

- 11) Laboratory crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and

- 12) Laboratory processed crowns are not a Benefit when the tooth can be restored with an amalgam or resin-based composite.

#### **Endodontic Exclusions and Limitations (D3000-D3999)**

- 1) Endodontic procedures when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 2) Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and
- 3) Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

#### **Periodontal Exclusions and Limitations (D4000-D4999)**

- 1) Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

#### **Prosthodontic (Removable) Exclusions and Limitations (D5000-D5899)**

- 1) Prosthodontic services provided solely for cosmetic purposes;

- 2) Temporary or interim dentures to be used while a permanent denture is being constructed;
- 3) Spare or backup dentures;
- 4) Evaluation of a denture on a maintenance basis;
- 5) Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a Benefit;
- 6) Partial dentures are not a Benefit to replace missing 3rd molars;
- 7) Laboratory relines (D5760 and D5761) are not a Benefit for resin based partial dentures (D5211 and D5212);
- 8) Laboratory relines (D5750, D5751, D5760 and D5761) are not a Benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741);
- 9) Chairside relines (D5730, D5731, D5740 and D5741) are not a Benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761);
- 10) Tissue conditioning (D5850 and D5851) is only a Benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment; and
- 11) Tissue conditioning (D5850 and D5851) is a Benefit the same date of service as an immediate prosthesis that required extractions.

#### **Implant Exclusions and Limitations (D6000-D6199)**

- 1) Implant services are a Benefit only when exceptional medical conditions are documented and the services are considered Medically Necessary; and
- 2) Single tooth implants are not a Benefit.

#### **Prosthodontic (Fixed) Exclusions and Limitations (D6200-D6999)**

- 1) Fixed partial dentures (bridgework) are not a Benefit; however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture;
- 2) Fixed partial dentures are not a Benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;
- 3) Posterior fixed partial dentures are not a Benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the Member's masticatory ability;
- 4) Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and
- 5) Cast resin bonded fixed partial dentures (Maryland Bridges).

#### **Oral and Maxillofacial Surgery Exclusions and Limitations (D7000-D7999)**

- 1) The prophylactic extraction of 3rd molars is not a Benefit;
- 2) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a Benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation;
- 3) TMJ dysfunction procedures solely for the treatment of bruxism is not a Benefit; and
- 4) Suture procedures (D7910, D7911 and D7912) are not a Benefit for the closure of surgical incisions.

#### **Orthodontic Exclusions and Limitations**

Orthodontic procedures are Benefits for Medically Necessary handicapping malocclusion, cleft palate

and facial growth management cases for Members under the age of 19 and shall be prior authorized.

Medically necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. Initial orthodontic examination (D0140) called the Limited Oral Evaluation must be conducted. This examination includes completion and submission of the completed HLD Score Sheet with the Specialty Referral Request Form. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for medically necessary orthodontic services.

Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

Those immediate qualifying conditions are:

- 1) Cleft lip and or palate deformities.
- 2) Craniofacial Anomalies including the following:
  - a) Crouzon's syndrome,
  - b) Treacher-Collins syndrome,
  - c) Pierre-Robin syndrome,
  - d) Hemifacial atrophy, hemifacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- 3) Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- 4) Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors).

Treatment of bi-lateral posterior crossbite is not a benefit of the program.

- 5) Severe traumatic deviation must be justified by attaching a description of the condition.
- 6) Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

The remaining conditions must score 26 or more to qualify (based on the HLD Index).

**Excluded are the following conditions:**

- 1) Crowded dentitions (crooked teeth)
- 2) Excessive spacing between teeth
- 3) Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies
- 4) Treatment in progress prior to the effective date of this coverage
- 5) Extractions required for orthodontic purposes
- 6) Surgical orthodontics or jaw repositioning
- 7) Myofunctional therapy
- 8) Macroglossia
- 9) Hormonal imbalances
- 10) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident
- 11) Palatal expansion appliances
- 12) Services performed by outside laboratories
- 13) Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

**Medical Necessity Exclusion**

All dental services received must be Medically Necessary Dental Services. The fact that a dentist or other plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity.

### **Alternate Benefits Provision**

An alternate benefit provision allows a Benefit to be based on an alternate procedure, which is professionally acceptable and more cost effective. If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the DPA will pay Benefits based upon the less costly service.

### **Pediatric Dental Benefits Customer Services**

Questions about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that the Member has experienced should be directed to your Dental Customer Service at the phone number or address which appear below:

1-800-286-7401  
Blue Shield of California  
Dental Plan Administrator  
425 Market Street, 15th Floor  
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

Note: Dental Benefit Providers 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. Dental Benefit Providers shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. 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 Dental Customer Service Department at the number listed above.

### **Pediatric Dental Benefits Grievance Process**

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service.

Members may contact the Dental Member Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Member Service Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the Dental Member Service Department. If the Member wishes, the Dental Member Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to the DPA at the address provided below. The Member may also submit the grievance to the Dental Member Service Department online by visiting <http://www.blueshieldca.com>.

1-800-286-7401  
Blue Shield of California  
Dental Plan Administrator  
PO Box 30569  
Salt Lake City, UT 84130-0569

The DPA will acknowledge receipt of a written grievance within 5 calendar days. Grievances are resolved within 30 days.

The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Service section for information on the expedited decision process.

### **Pediatric Dental Benefits Definitions –**

Whenever the following definitions are capitalized in this section, they will have the meaning stated below.

**Dental Allowable Amount** — the Allowance is:

- 1) The amount the DPA has determined is an appropriate payment for the Service(s) rendered in the provider's geographic area, based upon such factors as 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 Participating Dentist and the DPA 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 the DPA determines is appropriate considering the particular circumstances and the Services rendered.

**Billed Charges** — the prevailing rates of the Dental office.

**Dental Care Services** — Necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

**Dental Center** — means a Dentist or a dental practice (with one or more Dentists) which has contracted with the DPA to provide dental care Benefits to Members and to diagnose, provide, refer, supervise, and coordinate the provision of all Benefits to Members in accordance with this Contract.

**Medically Necessary Dental Services** — Benefits are provided only for Dental Care Services that are Medically Necessary as defined in this Section.

- 1) Dental Care Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards, including services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which, as determined by the DPA, are:
  - a) Consistent with the symptoms or diagnosis of the condition; and
  - b) Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and

- c) Furnished in a setting appropriate for delivery of the Service (e.g., a dentist's office).

- 2) If there are two (2) or more Medically Necessary Dental Care Services that can be provided for the condition, Blue Shield will provide benefits based on the most cost-effective Service.

**Dental Plan Administrator (DPA)** — Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of dental services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims received from Non-Participating Dentists.

**Dental Provider (Plan Provider)** — means a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan Members in accordance with their Dental Care Services Contract.

**Dentist** — a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

**Elective Dental Procedure** — any dental procedures which are unnecessary to the dental health of the Member, as determined by the DPA.

**Emergency Dental Care Services** — Services provided for an unexpected dental 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:

- a) placing the Member's health in serious jeopardy;
- b) serious impairment to bodily functions;
- c) serious dysfunction of any bodily organ or part.



**Experimental or Investigational in Nature Dental Care Services** — 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/dental 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/dental 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.

**Maximum Plan Payment** — the maximum amount that the Member will be reimbursed for services obtained from a Non-Participating Dentist.

**Participating Dentist** — a Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with the DPA to provide dental services to Members.

**Pedodontics** — Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

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

**Prosthodontics** — Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

**Treatment in Progress** — Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken.

## Dental Schedule and Limitations Table

The below schedule outlines the pediatric dental Benefits covered by this Plan along with limitations related to the listed dental procedure codes:

Code	Description	Limitation
<b>Diagnostic Procedures (D0100-D0999)</b>		
D0120	Periodic oral evaluation – established patient	once every 6 months, per provider or after 6 months have elapsed following comprehensive oral evaluation (D0150), same provider.
D0140	Limited oral evaluation – problem focused	once per Member per provider.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	
D0150	Comprehensive oral evaluation – new or established patient	once per Member per provider for the initial evaluation.
D0160	Detailed and extensive oral evaluation – problem focused, by report	once per Member per provider.
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	a Benefit for the ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.
D0171	Re-evaluation – post-operative office visit	
D0180	Comprehensive periodontal evaluation – new or established patient	
D0190	Screening of a patient	not a Benefit.
D0191	Assessment of a patient	not a Benefit.
D0210	Intraoral – complete series of radiographic images	once per provider every 36 months.
D0220	Intraoral – periapical first radiographic image	up to a maximum of 20 periapicals in a 12- month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.
D0230	Intraoral – periapical each additional radiographic image	up to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.
D0240	Intraoral – occlusal radiographic image	up to a maximum of two in a 6 month period per provider.
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.
D0251	Extraoral posterior dental radiographic image	up to a maximum of 4 on the same date of service.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D0270	Bitewing – single radiographic image	once per date of service. Not a Benefit for a totally edentulous area.
D0272	Bitewings – 2 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral complete series of radiographic images (D0210), same provider; and b. for a totally edentulous area.
D0273	Bitewings – 3 radiographic images	
D0274	Bitewings – 4 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral-complete series of radiographic images (D0210), same provider; b. for Members under the age of 10; and c. for a totally edentulous area.
D0277	Vertical bitewings – 7 to 8 radiographic images	
D0310	Sialography	
D0320	Temporomandibular joint arthrogram, including injection	limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.
D0322	Tomographic survey	up to twice in a 12 month period per provider.
D0330	Panoramic radiographic image	once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12 month period per provider.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	up to a maximum of 4 per date of service.
D0351	3D photographic image	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	not a Benefit.
D0460	Pulp vitality tests	
D0470	Diagnostic casts	once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment); for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly); and when provided by a certified orthodontist.
D0502	Other oral pathology procedures, by report	must be provided by a certified oral pathologist.
D0601	Caries risk assessment and documentation, with a finding of low risk	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	
D0603	Caries risk assessment and documentation, with a finding of high risk	
D0999	Unspecified diagnostic procedure, by report	
<b>Preventive Procedures (D1000-D1999)</b>		
D1110	Prophylaxis - adult	
D1120	Prophylaxis – child	once in a 6 month period.
D1206	Topical application of fluoride varnish	once in a 6 month period.
D1208	Topical application of fluoride – excluding varnish	once in a 6 month period.



Code	Description	Limitation
D1310	Nutritional counseling for control of dental disease	
D1320	Tobacco counseling for the control and prevention of oral disease	
D1330	Oral hygiene instructions	
D1351	Sealant – per tooth	limited to the first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; and once per tooth every 36 months per provider regardless of surfaces sealed.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	limited to the for first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed.
D1353	Sealant repair – per tooth	
D1354	Interim caries arresting medicament application - per tooth	
D1510	Space maintainer-fixed – unilateral	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.
D1515	Space maintainer-fixed – bilateral	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant and for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
D1520	Space maintainer-removable – unilateral	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
D1525	Space maintainer-removable – bilateral	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
D1550	Re-cement or re-bond space maintainer	once per provider, per applicable quadrant or arch for Members under the age of 18.
D1555	Removal of fixed space maintainer	not a Benefit to the original provider who placed the space maintainer.
D1575	Distal shoe space maintainer – fixed – unilateral	
<b>Restorative Procedures (D2000-D2999)</b>		
D2140	Amalgam – 1 surface, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2150	Amalgam – 2 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2160	Amalgam – 3 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2161	Amalgam – 4 or more surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D2330	Resin-based composite – 1 surface, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2331	Resin-based composite – 2 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2332	Resin-based composite – 3 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2390	Resin-based composite crown, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2391	Resin-based composite – 1 surface, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2392	Resin-based composite – 2 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2393	Resin-based composite – 3 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2394	Resin-based composite – 4 or more surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2542	Onlay - metallic – 2 surfaces	not a Benefit.
D2543	Onlay - metallic – 3 surfaces	not a Benefit.
D2544	Onlay - metallic – 4 or more surfaces	not a Benefit.
D2642	Onlay - porcelain/ceramic – 2 surfaces	not a Benefit.
D2643	Onlay - porcelain/ceramic – 3 surfaces	not a Benefit.
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	not a Benefit.
D2662	Onlay - resin-based composite – 2 surfaces	not a Benefit.
D2663	Onlay - resin-based composite – 3 surfaces	not a Benefit.
D2664	Onlay - resin-based composite – 4 or more surfaces	not a Benefit.
D2710	Crown – resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and b. for use as a temporary crown.
D2712	Crown – 3/4 resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and b. for use as a temporary crown.
D2720	Crown - resin with high noble metal	not a Benefit.
D2721	Crown – resin with predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period.

Code	Description	Limitation
		Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2722	Crown - resin with noble metal	not a Benefit.
D2740	Crown – porcelain/ceramic substrate	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2750	Crown - porcelain fused to high noble metal	not a Benefit.
D2751	Crown – porcelain fused to predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2752	Crown - porcelain fused to noble metal	not a Benefit.
D2780	Crown - 3/4 cast high noble metal	not a Benefit.
D2781	Crown – 3/4 cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2782	Crown - 3/4 cast noble metal	not a Benefit.
D2783	Crown – 3/4 porcelain/ceramic	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2790	Crown - full cast high noble metal	not a Benefit.
D2791	Crown – full cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2792	Crown - full cast noble metal	not a Benefit.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider.
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D2920	Re-cement or re-bond crown	the original provider is responsible for all re- cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a Benefit within 12 months of a previous re-cementation by the same provider.
D2921	Reattachment of tooth fragment, incisal edge or cusp	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	once in a 12 month period.
D2930	Prefabricated stainless steel crown – primary tooth	once in a 12 month period.
D2931	Prefabricated stainless steel crown – permanent tooth	once in a 36 month period. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2932	Prefabricated resin crown	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2933	Prefabricated stainless steel crown with resin window	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2940	Protective restoration	once per tooth in a 6 month period, per provider. Not a Benefit: a. when performed on the same date of service with a permanent restoration or crown, for same tooth; and b. on root canal treated teeth.
D2941	Interim therapeutic restoration – primary dentition	
D2949	Restorative foundation for an indirect restoration	
D2950	Core buildup, including any pins when required	
D2951	Pin retention – per tooth, in addition to restoration	for permanent teeth only; when performed on the same date of service with an amalgam or composite; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves 3 or more connected surfaces and at least 1 cusp; or, for an anterior restoration when extensive coronal destruction involves the incisal angle.
D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
D2953	Each additional indirectly fabricated post – same tooth	
D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
D2955	Post removal	
D2957	Each additional prefabricated post - same tooth	
D2971	Additional procedures to construct new crown under existing partial denture framework	
D2980	Crown repair, necessitated by restorative material failure	limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.
D2999	Unspecified restorative procedure, by report	
<b>Endodontic Procedures (D3000-D3999)</b>		
D3110	Pulp cap – direct (excluding final restoration)	
D3120	Pulp cap – indirect (excluding final restoration)	

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. for a primary tooth with a necrotic pulp or a periapical lesion; c. for a primary tooth that is non-restorable; and d. for a permanent tooth.
D3221	Pulpal debridement, primary and permanent teeth	once per permanent tooth; over-retained primary teeth with no permanent successor. Not a Benefit on the same date of service with any additional services, same tooth.
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	once per permanent tooth. Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3331	Treatment of root canal obstruction; non-surgical access	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	not a Benefit.
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy – anterior	once per tooth after more than 12 months has elapsed from initial treatment.
D3347	Retreatment of previous root canal therapy – bicuspid	once per tooth after more than 12 months has elapsed from initial treatment.
D3348	Retreatment of previous root canal therapy – molar	once per tooth after more than 12 months has elapsed from initial treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D3351	Apexification/recalcification - initial visit (apical closure/calccific repair of perforations, root resorption, etc.)	once per permanent tooth. Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3352	Apexification/recalcification – interim medication replacement	once per permanent tooth and only following apexification/recalcification initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calccific repair of perforations, root resorption, etc.)	not a Benefit.
D3410	Apicoectomy – anterior	for permanent anterior teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.
D3421	Apicoectomy – bicuspid (first root)	for permanent bicuspid teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented, after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3425	Apicoectomy – molar (first root)	for permanent 1st and 2nd molar teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3426	Apicoectomy – (each additional root)	for permanent teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.
D3427	Periradicular surgery without apicoectomy	
D3430	Retrograde filling – per root	
D3450	Root amputation - per root	not a Benefit.
D3910	Surgical procedure for isolation of tooth with rubber dam	
D3920	Hemisection (including any root removal), not including root canal therapy	not a Benefit.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D3950	Canal preparation and fitting of preformed dowel or post	not a Benefit.
D3999	Unspecified endodontic procedure, by report	
<b>Periodontal Procedures (D4000-D4999)</b>		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	not a Benefit.
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	not a Benefit.
D4265	Biologic materials to aid in soft and osseous tissue regeneration	for Members age 13 or older.
D4266	Guided tissue regeneration - resorbable barrier, per site	not a Benefit.
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	not a Benefit.
D4270	Pedicle soft tissue graft procedure	not a Benefit.
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	not a Benefit.
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	



<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	for Members age 13 or older.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	for Members age 13 or older.
D4910	Periodontal maintenance	once in a calendar quarter and only in the 24 month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning.
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
D4999	Unspecified periodontal procedure, by report	for Members age 13 or older.
<b>Prosthodontics (Removable) Procedures (D5000-D5899)</b>		
D5110	Complete denture – maxillary	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.
D5120	Complete denture – mandibular	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5751) or chairside reline (D5731) is a Benefit 12 months after the date of service for this procedure.
D5130	Immediate denture – maxillary	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 6 months after the date of service for this procedure.
D5140	Immediate denture – mandibular	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.



Code	Description	Limitation
		Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	not a Benefit.
D5410	Adjust complete denture – maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130) or overdenture- complete (D5863 & D5865); b. same date of service or within 6 months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850); and c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D5411	Adjust complete denture – mandibular	<p>once per date of service per provider and no more than twice in a 12 month period per provider.</p> <p>Not a Benefit:</p> <p>a. same date of service or within 6 months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture- complete (D5863 &amp; D5865);</p> <p>b. same date of service or within 6 months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851); and</p> <p>c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 &amp; D5512) and replace missing or broken teeth complete denture (D5520).</p>
D5421	Adjust partial denture – maxillary	<p>once per date of service per provider and no more than twice in a 12 month period per provider.</p> <p>Not a Benefit:</p> <p>a. Same date of service or within 6 months of the date of service of a maxillary partial resin base (5211) or maxillary partial denture cast metal framework with resin denture bases (D5213);</p> <p>b. same date of service or within 6 months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850); and</p> <p>c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 &amp; D5612), repair cast framework (D5621 &amp; D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).</p>
D5422	Adjust partial denture – mandibular	<p>once per date of service per provider and no more than twice in a 12month period per provider.</p> <p>Not a Benefit:</p> <p>a. same date of service or within 6 months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214);</p> <p>b. same date of service or within 6 months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851); and</p> <p>c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 &amp; D5612), repair cast framework (D5621 &amp; D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).</p>
D5511	Repair broken complete denture base, mandibular	<p>once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).</p>
D5512	Repair broken complete denture base, maxillary	<p>once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture</p>

Code	Description	Limitation
		(chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
D5520	Replace missing or broken teeth – complete denture (each tooth)	up to a maximum of 4, per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5611	Repair resin denture base, mandibular	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5612	Repair resin denture base, maxillary	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5621	Repair cast framework, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider.
D5622	Repair cast framework, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider.
D5630	Repair or replace broken clasp – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5640	Replace broken teeth – per tooth	up to a maximum of 4, per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only.
D5650	Add tooth to existing partial denture	once per tooth and up to a maximum of 3, per date of service per provider. Not a Benefit for adding 3rd molars.
D5660	Add clasp to existing partial denture – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	not a Benefit.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	not a Benefit.
D5710	Rebase complete maxillary denture	not a Benefit.
D5711	Rebase complete mandibular denture	not a Benefit.
D5720	Rebase maxillary partial denture	not a Benefit.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D5721	Rebase mandibular partial denture	not a Benefit.
D5730	Reline complete maxillary denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
D5731	Reline complete mandibular denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
D5740	Reline maxillary partial denture (chairside)	once in a 12 month period; 6 months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions; or 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
D5741	Reline mandibular partial denture (chairside)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture resin base (D5212) or mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).
D5750	Reline complete maxillary denture (laboratory)	once in a 12 month period; 6 months after the date of service for an immediate denture- maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
D5751	Reline complete mandibular denture (laboratory)	once in a 12 month period; 6 months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D5760	Reline maxillary partial denture (laboratory)	once in a 12 month period and 6 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit: a. within 12 months of a reline maxillary partial denture (chairside) (D5740); and b. for maxillary partial denture resin base (D5211).
D5761	Reline mandibular partial denture (laboratory)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit: a. within 12 months of a reline mandibular partial denture (chairside) (D5741); and b. for a mandibular partial denture resin base (D5212).
D5850	Tissue conditioning, maxillary	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); and b. same date of service as a prosthesis that did not require extractions.
D5851	Tissue conditioning, mandibular	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.
D5862	Precision attachment, by report	
D5863	Overdenture – complete maxillary	once in a 5 year period.
D5864	Overdenture – partial maxillary	once in a 5 year period.
D5865	Overdenture – complete mandibular	once in a 5 year period.
D5866	Overdenture – partial mandibular	once in a 5 year period.
D5899	Unspecified removable prosthodontic procedure, by report	
<b>Maxillofacial Prosthetics Procedures (D5900-D5999)</b>		
D5911	Facial moulage (sectional)	
D5912	Facial moulage (complete)	
D5913	Nasal prosthesis	
D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5916	Ocular prosthesis	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D5923	Ocular prosthesis, interim	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5924	Cranial prosthesis	
D5925	Facial augmentation implant prosthesis	
D5926	Nasal prosthesis, replacement	
D5927	Auricular prosthesis, replacement	
D5928	Orbital prosthesis, replacement	
D5929	Facial prosthesis, replacement	
D5931	Obturator prosthesis, surgical	not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
D5932	Obturator prosthesis, definitive	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
D5933	Obturator prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
D5934	Mandibular resection prosthesis with guide flange	
D5935	Mandibular resection prosthesis without guide flange	
D5936	Obturator prosthesis, interim	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).
D5937	Trismus appliance (not for TMD treatment)	
D5951	Feeding aid	for Members under the age of 18 only.
D5952	Speech aid prosthesis, pediatric	for Members under the age of 18 only.
D5953	Speech aid prosthesis, adult	for Members under the age of 18 only.
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis, definitive	not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).
D5958	Palatal lift prosthesis, interim	not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
D5959	Palatal lift prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).
D5960	Speech aid prosthesis, modification	twice in a 12 month period. not a Benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).
D5982	Surgical stent	
D5983	Radiation carrier	
D5984	Radiation shield	
D5985	Radiation cone locator	
D5986	Fluoride gel carrier	a Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.
D5987	Commissure splint	
D5988	Surgical splint	
D5991	Vesiculobullous disease medicament carrier	
D5999	Unspecified maxillofacial prosthesis, by report	

Code	Description	Limitation
<b>Implant Service Procedures (D6000-D6199)</b>		
D6010	Surgical placement of implant body: endosteal implant	
D6011	Second stage implant surgery	
D6013	Surgical placement of mini implant	
D6040	Surgical placement: eposteal implant	
D6050	Surgical placement: transosteal implant	
D6052	Semi-precision attachment abutment	
D6055	Connecting bar – implant supported or abutment supported	
D6056	Prefabricated abutment – includes modification and placement	
D6057	Custom fabricated abutment – includes placement	
D6058	Abutment supported porcelain/ceramic crown	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	
D6062	Abutment supported cast metal crown (high noble metal)	
D6063	Abutment supported cast metal crown (predominantly base metal)	
D6064	Abutment supported cast metal crown (noble metal)	
D6065	Implant supported porcelain/ceramic crown	
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	
D6068	Abutment supported retainer for porcelain/ceramic FPD	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	
D6075	Implant supported retainer for ceramic FPD	
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	



Code	Description	Limitation
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	
D6085	Provisional implant crown	
D6090	Repair implant supported prosthesis, by report	
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	
D6092	Re-cement or re-bond implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	not a Benefit within 12 months of a previous recementation by the same provider.
D6094	Abutment supported crown (titanium)	
D6095	Repair implant abutment, by report	
D6096	Remove broken implant retaining screw	
D6100	Implant removal, by report	
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	
D6190	Radiographic/surgical implant index, by report	
D6194	Abutment supported retainer crown for FPD (titanium)	
D6199	Unspecified implant procedure, by report	
<b>Fixed Prosthodontic Procedures (D6200-D6999)</b>		
D6205	Pontic - indirect resin based composite	not a Benefit.
D6210	Pontic - cast high noble metal	not a Benefit.
D6211	Pontic – Cast Predominately Base Metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6212	Pontic - cast noble metal	not a Benefit.
D6214	Pontic - titanium	not a Benefit.



<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D6240	Pontic - porcelain fused to high noble metal	not a Benefit.
D6241	Pontic – porcelain fused to predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6242	Pontic - porcelain fused to noble metal	not a Benefit.
D6245	Pontic – porcelain/ceramic	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6250	Pontic - resin with high noble metal	not a Benefit.
D6251	Pontic – resin with predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6252	Pontic - resin with noble metal	not a Benefit.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	not a Benefit.
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	not a Benefit.
D6549	Retainer – for resin bonded fixed prosthesis	not a Benefit.
D6608	Retainer onlay - porcelain/ceramic, two surfaces	not a Benefit.
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	not a Benefit.
D6610	Retainer onlay - cast high noble metal, two surfaces	not a Benefit.
D6611	Retainer onlay - cast high noble metal, three or more surfaces	not a Benefit.
D6612	Retainer onlay - cast predominantly base metal, two surfaces	not a Benefit.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	not a Benefit.
D6614	Retainer onlay - cast noble metal, two surfaces	not a Benefit.
D6615	Retainer onlay - cast noble metal, three or more surfaces	not a Benefit.
D6634	Retainer onlay - titanium	not a Benefit.
D6710	Retainer crown - indirect resin based composite	not a Benefit.
D6720	Retainer crown - resin with high noble metal	not a Benefit.
D6721	Retainer crown – resin with predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6722	Retainer crown - resin with noble metal	not a Benefit.
D6740	Retainer crown – porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6751	Retainer crown – porcelain fused to predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D6781	Retainer crown – 3/4 cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6782	Retainer crown - 3/4 cast noble metal	not a Benefit.
D6783	Retainer crown – 3/4 porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6791	Retainer crown – full cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6930	Recement or re-bond fixed partial denture	The original provider is responsible for all re- cementations within the first 12 months following the initial placement of a fixed partial denture. Not a Benefit within 12 months of a previous re- cementation by the same provider.
D6980	Fixed partial denture repair necessitated by restorative material failure	not a Benefit within 12 months of initial placement or previous repair, same provider.
D6999	Unspecified fixed prosthodontic procedure, by report	
<b>Oral and Maxillofacial Surgery Procedures (D7000-D7999)</b>		
D7111	Extraction, coronal remnants – deciduous tooth	not a Benefit for asymptomatic teeth.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	not a Benefit when removed by the same provider who performed the initial tooth extraction.
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	a Benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
D7220	Removal of impacted tooth – soft tissue	a Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
D7230	Removal of impacted tooth – partially bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
D7240	Removal of impacted tooth – completely bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
D7250	Removal of residual tooth roots (cutting procedure)	a Benefit when the root is completely covered by alveolar bone. Not a Benefit to the same provider who performed the initial tooth extraction.
D7260	Oroantral fistula closure	a Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
D7261	Primary closure of a sinus perforation	a Benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oronasal communication, subsequent to the removal of a tooth.
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	once per arch regardless of the number of teeth involved and for permanent anterior teeth only.
D7280	Exposure of an unerupted tooth	not a Benefit: a. for Members age 21 or older, or b. for 3rd molars.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D7283	Placement of device to facilitate eruption of impacted tooth	only for Members in active orthodontic treatment. Not a Benefit: a. for Members age 21 years or older; and b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	for the removal of the specimen only and once per arch, per date of service regardless of the areas involved. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
D7286	Incisional biopsy of oral tissue – soft	for the removal of the specimen only and up to a maximum of 3 per date of service. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous
D7287	Exfoliative cytological sample collection	not a Benefit.
D7288	Brush biopsy - transepithelial sample collection	not a Benefit.
D7290	Surgical repositioning of teeth	for permanent teeth only; once per arch; and only for Members in active orthodontic treatment.
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	once per arch and only for Members in active orthodontic treatment.
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit regardless of the number of teeth or tooth spaces.
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	once in a 5 year period per arch.
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch. Not a Benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; and b. on the same date of service with extractions (D7111-D7250) same arch.
D7410	Excision of benign lesion up to 1.25 cm	
D7411	Excision of benign lesion greater than 1.25 cm	
D7412	Excision of benign lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.
D7413	Excision of malignant lesion up to 1.25 cm	
D7414	Excision of malignant lesion greater than 1.25 cm	
D7415	Excision of malignant lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.

Code	Description	Limitation
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7465	Destruction of lesion(s) by physical or chemical method, by report	
D7471	Removal of lateral exostosis (maxilla or mandible)	once per quadrant and for the removal of buccal or facial exostosis only.
D7472	Removal of torus palatinus	once in the Member's lifetime.
D7473	Removal of torus mandibularis	once per quadrant.
D7485	Reduction of osseous tuberosity	once per quadrant.
D7490	Radical resection of maxilla or mandible	
D7510	Incision and drainage of abscess – intraoral soft tissue	once per quadrant, same date of service.
D7511	Incision and drainage of abscess – intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	once per quadrant, same date of service.
D7520	Incision and drainage of abscess – extraoral soft tissue	
D7521	Incision and drainage of abscess – extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per quadrant per date of service and only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a Benefit within 30 days of an associated extraction (D7111-D7250).
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
D7610	Maxilla – open reduction (teeth immobilized, if present)	
D7620	Maxilla – closed reduction (teeth immobilized, if present)	
D7630	Mandible – open reduction (teeth immobilized, if present)	
D7640	Mandible – closed reduction (teeth immobilized, if present)	
D7650	Malar and/or zygomatic arch – open reduction	
D7660	Malar and/or zygomatic arch – closed reduction	
D7670	Alveolus – closed reduction, may include stabilization of teeth	

Code	Description	Limitation
D7671	Alveolus – open reduction, may include stabilization of teeth	
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	for the treatment of simple fractures only.
D7710	Maxilla – open reduction	
D7720	Maxilla – closed reduction	
D7730	Mandible – open reduction	
D7740	Mandible – closed reduction	
D7750	Malar and/or zygomatic arch – open reduction	
D7760	Malar and/or zygomatic arch – closed reduction	
D7770	Alveolus – open reduction stabilization of teeth	
D7771	Alveolus – closed reduction stabilization of teeth	
D7780	Facial bones – complicated reduction with fixation and multiple approaches	for the treatment of compound fractures only.
D7810	Open reduction of dislocation	
D7820	Closed reduction of dislocation	
D7830	Manipulation under anesthesia	
D7840	Condylectomy	
D7850	Surgical discectomy, with/without implant	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthroscopic lysis and lavage	
D7872	Arthroscopy – diagnosis, with or without biopsy	
D7873	Arthroscopy – lavage and lysis of adhesions	
D7874	Arthroscopy – disc repositioning and stabilization	
D7875	Arthroscopy – synovectomy	
D7876	Arthroscopy – discectomy	
D7877	Arthroscopy – debridement	
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.
D7881	Occlusal orthotic device adjustment	
D7899	Unspecified TMD therapy, by report	not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.
D7910	Suture of recent small wounds up to 5 cm	not a Benefit for the closure of surgical incisions.
D7911	Complicated suture – up to 5 cm	not a Benefit for the closure of surgical incisions.
D7912	Complicated suture – greater than 5 cm	not a Benefit for the closure of surgical incisions.
D7920	Skin graft (identify defect covered, location and type of graft)	not a Benefit for periodontal grafting.
D7940	Osteoplasty – for orthognathic deformities	
D7941	Osteotomy – mandibular rami	

Code	Description	Limitation
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	
D7944	Osteotomy – segmented or subapical	
D7945	Osteotomy – body of mandible	
D7946	LeFort I (maxilla – total)	
D7947	LeFort I (maxilla – segmented)	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	
D7949	LeFort II or LeFort III – with bone graft	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	not a Benefit for periodontal grafting.
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	only for Members with authorized implant services.
D7952	Sinus augmentation via a vertical approach	only for Members with authorized implant services.
D7955	Repair of maxillofacial soft and/or hard tissue defect	not a Benefit for periodontal grafting.
D7960	Frenulectomy also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	once per arch per date of service and only when the permanent incisors and cuspids have erupted.
D7963	Frenuloplasty	once per arch per date of service and only when the permanent incisors and cuspids have erupted. Not a Benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
D7970	Excision of hyperplastic tissue – per arch	once per arch per date of service.
D7971	Excision of pericoronal gingiva	
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.
D7979	Non-surgical Sialolithotomy	
D7980	Sialolithotomy	
D7981	Excision of salivary gland, by report	
D7982	Sialodochoplasty	
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft – mandible or facial bones, by report	not a Benefit for periodontal grafting.
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers.
D7999	Unspecified oral surgery procedure, by report	
<b>Orthodontics Procedures (D8000-D8999)</b>		
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate	for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per Member per phase of treatment.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management	for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per Member per phase of treatment.
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.
D8660	Pre-orthodontic treatment examination to monitor growth and development	once every 3 months for a maximum of 6 and must be done prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.
D8670	Periodic orthodontic treatment visit handicapping malocclusion	once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8670	Periodic orthodontic treatment visit cleft palate – primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit cleft palate – mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit (cleft palate – permanent dentition	up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity)
D8670	Periodic orthodontic treatment visit facial growth management – primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management – mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management – permanent dentition	up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	once per appliance. Not a Benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
D8692	Replacement of lost or broken retainer	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).
D8693	Re-cement or re-bond fixed retainer	once per provider.
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	
<b>Adjunctive Services Procedures (D9000-D9999)</b>		



<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D9110	Palliative (emergency) treatment of dental pain – minor procedure	once per date of service per provider regardless of the number of teeth and/or areas treated. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
D9120	Fixed partial denture sectioning	a Benefit when at least one of the abutment teeth is to be retained.
D9210	Local anesthesia not in conjunction with operative or surgical procedures	once per date of service per provider and only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia in conjunction with operative or surgical procedures	
D9222	Deep sedation/analgesia - first 15 minutes	not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9223	Deep sedation/general anesthesia - each 15 minute increment	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	not a benefit: a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D9248	Non-intravenous conscious sedation	once per date of service; for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9243); and b. when all associated procedures on the same date of service by the same provider are denied.
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	
D9311	Consultation with a medical health professional	
D9410	House/extended care facility call	once per Member per date of service and only in conjunction with procedures that are payable.
D9420	Hospital or ambulatory surgical center call	a Benefit for each hour or fraction thereof as documented on the operative report.
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	once per date of service per provider. Not a Benefit: a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service; and b. for visits to Members residing in a house/ extended care facility.
D9440	Office visit – after regularly scheduled hours	once per date of service per provider and only with treatment that is a Benefit.
D9450	Case presentation, detailed and extensive treatment planning	not a Benefit.
D9610	Therapeutic parenteral drug, single administration	up to a maximum of 4 injections per date of service. Not a Benefit: a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	
D9910	Application of desensitizing medicament	once in a 12 month period per provider and for permanent teeth only.
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; and for the removal of bony fragments within 30 days of the date of service of an extraction. Not a Benefit: a. for the removal of bony fragments on the same date of service as an extraction; and b. for routine post- operative visits.
D9940	Occlusal guard, by report	not a Benefit.
D9942	Repair and/or relines of occlusal guard	not a Benefit.

<b>Code</b>	<b>Description</b>	<b>Limitation</b>
D9943	Occlusal guard adjustment	not a Benefit.
D9950	Occlusion analysis – mounted case	once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ dysfunction only; and for permanent dentition. Not a Benefit for bruxism only.
D9951	Occlusal adjustment – limited	once in a 12 month period per quadrant per provider; for Members age 13 and older; and for natural teeth only. Not a Benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.
D9952	Occlusal adjustment – complete	once in a 12 month period following occlusion analysis-mounted case (D9950); for Members age 13 and older; for diagnosed TMJ dysfunction only; and for permanent dentition.
D9999	Unspecified adjunctive procedure, by report	

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## **Pediatric Vision Benefits**

Blue Shield covers pediatric vision Benefits for individuals through the end of the month in which the Member turns 19 years of age. Blue Shield's pediatric vision Benefits are administered by a contracted Vision Plan Administrator (VPA). The VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this pediatric vision Benefit. The VPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for Covered Services received from Non-Participating Providers.

### **Principal Benefits and Coverages for Pediatric Vision Benefits**

Blue Shield will pay for Covered Services rendered by VPA Participating Providers as indicated in the Summary of Benefits. For Covered Services rendered by Non-Participating Providers, Blue Shield will pay up to the Allowable Amount as shown in the Summary of Benefits. Members will be responsible for all charges in excess of those amounts.

The following is a complete list of Covered Services provided under this pediatric vision Benefit:

- 1) One comprehensive eye examination in a Calendar Year. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, a determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in the presence of trauma or severe inflammation. In addition, it includes dilation if professionally indicated.
- 2) One of the following in a Calendar Year:
  - a) One pair of spectacle lenses which include choice of glass, plastic or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, and oversized and glass-grey #3 prescription sunglass lenses (Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions  $> \pm 6.00$  diopters),
  - b) Elective Contact Lenses (for cosmetic reasons or for convenience), or
  - c) Non-Elective (Medically Necessary) Contact Lenses, which are lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus, 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) astigmatism (over 3 diopters), or other conditions as listed in

the definition of Non-Elective Contact Lenses.

A report from the provider and prior authorization from the contracted VPA is required.

- 3) One frame in a Calendar Year.
- 4) The need for Low Vision Testing is triggered during a comprehensive eye exam. This exam may only be obtained from VPA Participating Providers and only once in a consecutive five Calendar Year period. VPA Participating Providers specializing in low vision care may prescribe optical devices, such as high-power spectacles, magnifiers and telescopes, to maximize the remaining usable vision. One aid per Calendar Year is covered. A report from the provider conducting the initial examination and prior authorization from the VPA is required for both the exam and any prescribed device. Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200.
- 5) One diabetic management referral per calendar year to a Blue Shield disease management program. The contracted VPA will notify Blue Shield's disease management program subsequent to the annual comprehensive eye exam, when the Member is known to have or be at risk for diabetes.

### **Important Information about Pediatric Vision Benefits**

Pediatric vision services are covered when provided by a vision provider and when necessary and customary as determined by the standards of generally accepted vision practice. Coverage for these services is subject to any conditions or limitations set forth in the Benefit descriptions

above, and to all terms, conditions, limitations and exclusions listed in this Evidence of Coverage.

Payments for pediatric vision services are based on Blue Shield's Allowable Amount and are subject to any applicable Deductibles, Copayments, Coinsurance and Benefit maximums as specified in the Summary of Benefits. Vision providers do not receive financial incentives or bonuses from Blue Shield or the VPA.

### **Exclusions for Pediatric Vision Benefits**

Unless exemptions are specifically made elsewhere in this Evidence of Coverage, these pediatric vision Benefits exclude the following:

- 1) orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;
- 2) replacement or repair of lost or broken lenses or frames, except as provided under this Evidence of Coverage;
- 3) any eye examination required by the employer as a condition of employment;
- 4) medical or surgical treatment of the eyes (see the *Ambulatory Surgery Center Benefits*, *Hospital Benefits (Facility Services)* and *Professional Benefits* sections of the Evidence of Coverage);
- 5) contact lenses, except as specifically provided under this Evidence of Coverage and in the Summary of Benefits;

See the Principal Limitations, Exceptions, Exclusions and Reductions section of this Evidence of Coverage for complete information on Plan general exclusions, limitations, exceptions and reductions.

### **Payment of Benefits for Pediatric Vision Benefits**

Prior to service, the Subscriber should review his or her Benefit information for coverage details. The Subscriber may identify a VPA Participating Provider by calling the VPA's Customer Service Department at 1-877-601-9083 or online at [www.blueshieldca.com](http://www.blueshieldca.com). When an appointment is made with a VPA Participating Provider, the

Subscriber should identify the Member as a Blue Shield/VPA Member.

The VPA Participating Provider will submit a claim for Covered Services online or by claim form obtained from the VPA after services have been received. The VPA will make payment on behalf of Blue Shield directly to the VPA Participating Provider. VPA Participating Providers have agreed to accept Blue Shield's payment as payment in full except as noted in the Summary of Benefits.

When services are provided by a Non-Participating Provider, a Vision Service Report (claim form C-4669-61) should be submitted to the VPA. This form may be obtained at [www.blueshieldca.com](http://www.blueshieldca.com) and must be completed in full and submitted with all related receipts to:

Blue Shield of California  
Vision Plan Administrator  
P O Box 25208  
Santa Ana, CA 92799-5208

Information regarding the Member's Non-Participating Provider Benefits is available in the Summary of Benefits or by calling Blue Shield / VPA Customer Service at 1-877-601-9083.

When the Member receives Covered Services from a Non-Participating Provider, the Subscriber or the provider may submit a claim for payment after services have been received. The VPA will make payment directly to the Subscriber. The Subscriber is responsible for any applicable Deductible, Copayment and Coinsurance amounts and for amounts billed in excess of the Allowable Amount. The Subscriber is also responsible for making payment to the Non-Participating Provider.

A listing of VPA Participating Providers may be obtained by calling the VPA at the telephone number listed in the Customer Service section of this Evidence of Coverage.

### **Choice of Providers for Pediatric Vision Benefits**

Members may select any licensed ophthalmologist, optometrist, or optician to provide Covered Services under this pediatric

vision benefit, including providers outside of California. However, Members will usually pay more for services from a Non-Participating Provider. A list of VPA Participating Providers in the Member's local area can be obtained by contacting the VPA at 1-877-601-9083.

The Member should contact Member Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a VPA Participating Provider level.

The Subscriber may also obtain a list of VPA Participating Providers online at [www.blueshieldca.com](http://www.blueshieldca.com).

### **Time and Payment of Claims**

Claims will be paid promptly upon receipt of written proof and determination that Benefits are payable.

### **Payment of Claims**

VPA Participating Providers will submit a claim for Covered Services on line or by claim form obtained from the VPA and are paid directly by Blue Shield of California.

If the Member receives services from a Non-Participating Provider, payment will be made directly to the Subscriber, and the Member is responsible for payment to the Non-Participating Provider.

### **Eligibility Requirements for Pediatric Vision Benefits**

The Member must be actively enrolled in this health plan and must be under the age of 19.

### **Customer Service for Pediatric Vision Benefits**

For questions about these pediatric vision Benefits, information about pediatric vision providers, pediatric vision services, or to discuss concerns regarding the quality of care or access to care experienced, the Subscriber may contact:



Blue Shield of California  
Vision Plan Administrator  
Customer Service Department  
P. O. Box 25208  
Santa Ana, CA 92799-5208

The Subscriber may also contact the VPA at the following telephone numbers:

1-714-619-4660 or  
1-877-601-9083

The VPA has established a procedure for Subscribers to request an expedited authorization decision. A Subscriber, Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The VPA shall make a decision and notify the Subscriber and Physician as soon as possible to accommodate the Member's condition, not to exceed 72 hours following the receipt of the request. For additional information regarding the expedited decision process, or if the Subscriber believes a particular situation qualifies for an expedited decision, please contact the VPA Customer Service Department at the number listed above.

### **Grievance Process for Pediatric Vision Benefits**

Subscribers, a designated representative, or a provider on behalf of the Subscriber, may contact the Vision Customer Service Department by telephone, letter or online to request a review of an initial determination concerning a claim for services. Subscribers may contact the Vision Customer Service Department at the telephone number noted below. If the telephone inquiry to the Vision 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 Vision Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may

request this Form from the Vision Customer Service Department. If the Subscriber wishes, the Vision Customer Service staff will assist in completing the grievance form. Completed grievance forms should be mailed to the Vision Plan Administrator at the address provided below. The Subscriber may also submit the grievance to the Vision Customer Service Department online at [www.blueshieldca.com](http://www.blueshieldca.com).

1-877-601-9083  
Vision Plan Administrator  
P. O. Box 25208  
Santa Ana, CA 92799-5208

The Vision Plan Administrator will acknowledge receipt of a written grievance within five (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.

### **Definitions for Pediatric Vision Benefits**

**Elective Contact Lenses** — prescription lenses that are chosen for cosmetic or convenience purposes. Elective Contact Lenses are not medically necessary.

**Non-Elective (Medically Necessary) Contact Lenses** — lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Contact lenses may also be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

**Prescription Change** – any of the following:

- 1) change in prescription of 0.50 diopter or more; or



- 2) shift in axis of astigmatism of 15 degrees; or
- 3) difference in vertical prism greater than 1 prism diopter; or
- 4) change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

**Vision Plan Administrator (VPA)** – Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered under this Benefit through a network of VPA Participating Providers.

**VPA Participating Provider** – For purposes of this pediatric vision Benefit, VPA participating provider refers to a provider that has contracted with the VPA to provide vision services to Blue Shield Members.

## **Principal Limitations, Exceptions, Exclusions and Reductions**

### **General Exclusions and Limitations**

No Benefits are provided for the following:

- 1) routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
- 2) hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
- 3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot (e.g., weak or fallen arches); flat or pronated foot; pain or cramp of the foot; special footwear required for foot
- disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under *Orthotics Benefits* and *Diabetes Care Benefits*; bunions; muscle trauma due to exertion; or any type of massage procedure on the foot;
- 4) services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
- 5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or domiciliary Care, except as provided under *Hospice Program Benefits*;
- 6) services in connection with private duty nursing, except as provided under *Home Health Care Benefits*, *Home Infusion/Home Injectable Therapy Benefits*, and except as provided through a Participating Hospice Agency;
- 7) prescription and non-prescription food and nutritional supplements, except as provided under *Home Infusion/Home Injectable Therapy Benefits*, *PKU-Related Formulas and Special Food Products Benefits*, or as provided through a Participating Hospice Agency;
- 8) hearing aid instruments, examinations for the appropriate type of hearing aid, device checks, electroacoustic evaluation for hearing aids and other ancillary equipment;
- 9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;
- 10) surgery to correct refractive error (such as but

not limited to radial keratotomy, refractive keratoplasty);

- 11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under *Prosthetic Appliances Benefits*;
- 12) for dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits* and *Hospital Benefits (Facility Services)*;
- 13) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Pediatric Dental Benefits* and *Hospital Benefits (Facility Services)*;
- 14) Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages);
- 15) Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;
- 16) sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
- 17) for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;
- 18) any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
- 19) services incident to bariatric surgery services, except as specifically provided under *Bariatric Surgery Benefits*;
- 20) home testing devices and monitoring equipment except as specifically provided in the *Durable Medical Equipment Benefits*;
- 21) genetic testing except as described in the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* and *Pregnancy and Maternity Care Benefits*;
- 22) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family

planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Participating Providers;

- 23) services performed in a Hospital by house officers, residents, interns, and other professionals in training without the supervision of an attending physician in association with an accredited clinical education program;
- 24) services performed by a Close Relative or by a person who ordinarily resides in the Member's home;
- 25) services (except for services received under the Behavioral Health Treatment benefit under Mental Health, Behavioral Health, and Substance Use Disorder Benefits) provided by an individual or entity that:
  - is not appropriately licensed or certified by the state to provide health care services;
  - is not operating within the scope of such license or certification; or
  - does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;
- 26) massage therapy that is not Physical Therapy or a component of a multiple-modality Rehabilitative Services treatment plan;
- 27) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits or Preventive Health Services. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
- 28) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This

exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

- 29) services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;
- 30) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;
- 31) non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under *Preventive Health Benefits, Home Health Care Benefits, Home Infusion /Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits*;
- 32) patient convenience items such as telephone, television, guest trays, and personal hygiene items;
- 33) disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the *Durable*

*Medical Equipment Benefits, Home Health Care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits;*

- 34) services for which the Member is not legally obligated to pay, or for services for which no charge is made;
- 35) services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;
- 36) Drug's dispensed by a Physician or Physician's office for outpatient use;
- 37) transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van); and
- 38) services not specifically listed as a Benefit. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child.

See the *Grievance Process* section for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your right to independent medical review.

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### **Medical Necessity Exclusion**

The Benefits of this health plan are provided only for services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary and may use the

services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants to evaluate claims.

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### **Limitation for Duplicate Coverage**

#### **Medicare Eligible Members**

- 1) Blue Shield will provide Benefits before Medicare in the following situations:
  - a) When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
  - b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
  - c) When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
- 2) Blue Shield will provide Benefits after Medicare in the following situations:
  - a) When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
  - b) When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
  - c) When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that you are eligible to receive benefits for end-stage renal disease from Medicare.
  - d) When the Member is retired and age 65 years or older.



When Blue Shield provides Benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare allowed amount. The Blue Shield group plan Deductible and copayments will be waived.

### **Medi-Cal Eligible Members**

Medi-Cal always provides benefits last.

### **Qualified Veterans**

If the Member is a qualified veteran Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided at a Veterans Administration facility for a condition that is not related to military service. If the Member is a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided at a Department of Defense facility, even if provided for conditions related to military service.

### **Members Covered by Another Government Agency**

If the Member is entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and this Blue Shield group Plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowable Amount).

Contact Customer Service if you have any questions about how Blue Shield coordinates your group Plan Benefits in the above situations.

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### **Exception for Other Coverage**

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

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### **Claims Review**

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

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### **Reductions – Third Party Liability**

If another person or entity, through an act or omission, causes a Member to suffer an injury or illness, and if Blue Shield paid Benefits for that injury or illness, the Member must agree to the provisions listed below. In addition, if the Member is injured and no other person is responsible but the Member receives (or is entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, the Member must agree to the following provisions.

- 1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for Benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.
- 2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- 3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (1) because the Member

does not receive the full amount of damages that the Member claimed or (2) because the Member had to pay attorneys' fees.

- 4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

If the Member does seek damages for his or her illness or injury, the Member must tell Blue Shield promptly that the Member has made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for, the Member must seek recovery of Blue Shield's Benefit payments and liabilities, and the Member must tell us about any recoveries the Member obtains, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of the Member's claim in order to reimburse Blue Shield to the full amount of Benefits Blue Shield has paid or will pay. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code Section 3040.

Blue Shield may request that the Member sign a reimbursement agreement consistent with this provision.

Further, if the Member receives services from a Participating Hospital for such injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by Blue Shield and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

IF THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"), THE MEMBER IS ALSO REQUIRED TO DO THE FOLLOWING:

- 1) Ensure that any recovery is kept separate from and not comingled with any other funds or the

Member's general assets and agree in writing that the portion of any recovery required to satisfy the lien or other right of recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield;

- 2) Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to Blue Shield of the monies owed.

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## Coordination of Benefits

Coordination of Benefits is utilized when a Member is covered by more than one group health plan. Payments for allowable expenses will be coordinated between the two plans up to the maximum benefit amount payable by each plan separately. Coordination of Benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable expenses. The coordination of benefits rules also provide consistency in determining which group health plan is primary and avoid delays in benefit payments. Blue Shield follows the rules for Coordination of Benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group health plans. The following is a summary of those rules.

- 1) When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering the Member as an employee will provide its benefits before the plan covering the Member as a Dependent.
- 2) Coverage for dependent children:
  - a) When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.
  - b) When the parents are divorced and the specific terms of the court decree state that

one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.

- c) When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.
- d) When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:
  - i. The plan of the custodial parent
  - ii. The plan of the stepparent
  - iii. The plan of the non-custodial parent.
- 3) If the above rules do not apply, the plan which has covered the Member for the longer period of time is the primary plan. There may be exceptions for laid-off or retired employees.
- 4) When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.
- 5) Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

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

## Conditions of Coverage

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### Eligibility and Enrollment

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the Employer. An Employee is eligible for

coverage as a Subscriber the day following the date he or she completes the Waiting Period established by the Employer. The Employee's spouse or Domestic Partner and all Dependent children are eligible for coverage at the same time.

An Employee or the Employee's Dependents may enroll when initially eligible or during the Employer's annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, the Employer's annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in the health program offered by the Employer. Please see the definition of Late Enrollee and Special Enrollment Period in the *Definitions* section for details on these rights. For additional information on enrollment periods, please contact the Employer or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be covered immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their eligibility under this health plan solely because of age, may be eligible for coverage if they continue to meet the definition of Dependent. See the *Definitions* section.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group health plan. If the Employer fails to meet these requirements, this coverage will terminate. See the *Termination of Benefits* section of this Evidence of Coverage for further information. Employees will



receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

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

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### **Effective Date of Coverage**

Blue Shield will notify the eligible Employee/Subscriber of the effective date of coverage for the Employee and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the effective date.

Dependents may be enrolled within 31 days of the Employee's eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the Employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents are Late Enrollees who qualify for a Special Enrollment Period, and the premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the premium payment is delivered or postmarked after the 15<sup>th</sup> of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Late Enrollee qualifies for a Special Enrollment Period as a result of a birth, adoption, foster care, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 60 days of the event, the effective date of enrollment will be as follows:

- 1) For the case of a birth, adoption, placement for adoption, placement in foster care, or

guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption, placement in foster care or court order of guardianship.

- 2) For marriage or Domestic Partnership the coverage shall be effective on the date of the establishment of marriage or domestic partnership.

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### **Premiums (Dues)**

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. Blue Shield will provide the Employer with information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the Employer to Blue Shield. Any amount the Subscriber must contribute is set by the Employer. The Employer's rates will remain the same during the Contract's term; the term is the 12-month period beginning with the eligible Employer's effective date of coverage. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

A Subscriber's contribution may change during the contract term (1) if the Employer changes the amount it requires its Employees to pay for coverage; (2) if the Subscriber adds or removes a Dependent from coverage; (3) if a Subscriber moves to a different geographic rating region; or (4) if a Subscriber joins the Plan at a time other than during the annual Open Enrollment Period. Please check with Blue Shield or the Employer on when these contribution changes will take effect.

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### **Grace Period**

After payment of the first Premium, the Contractholder is entitled to a grace period of 30 days for the payment of any Premiums due. During this grace period, the Contract will remain in force. However, the Contractholder will be liable for payment of Premiums accruing during the period the Contract continues in force.

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## **Plan Changes**

The Benefits and terms of this health plan, including but not limited to, Covered Services, Deductible, Copayment, Coinsurance and annual Out-of-Pocket Maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days written notice of any such change.

Benefits for services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

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## **Renewal of the Group Health Service Contract**

This Contract has a 12-month term beginning with the eligible Employer's effective date of coverage. So long as the Employer continues to qualify for this health plan and continues to offer this Plan to its Employees, Employees and Dependents will have an annual Open Enrollment period of 30 days before the end of the term to make changes to their coverage. The Employer will give notice of the annual Open Enrollment period.

Blue Shield will offer to renew the Employer's Group Health Service Contract except in the following instances:

- 1) non-payment of Premium;
- 2) fraud, misrepresentations or omissions;
- 3) failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
- 4) termination of plan type by Blue Shield;
- 5) Employer relocates outside of California; or
- 6) Employer is an association and association membership ceases.

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## **Termination of Benefits (Cancellation and Rescission of Coverage)**

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive Benefits of this health plan following termination of a Member's coverage.

## **Cancellation at Member Request**

The Member can cancel his or her coverage, including as a result of the Member obtaining other minimum essential coverage, with 14 days' notice to Blue Shield. If coverage is terminated at a Member's request, coverage will end at 11:59 p.m. Pacific Time on (a) the cancellation date specified by the Member if the Member gave 14 days' notice; (b) 14 days after the cancellation is requested, if the Member gave less than 14 days' notice; or (c) a date Blue Shield specifies if the Member gave less than 14 days' notice and the Member requested an earlier termination effective date. If the Member is newly eligible for Medi-Cal, Children's Health Insurance Program (CHIP) or the Basic Health Plan (if a Basic Health Plan is operating in the service area of Covered California), the last day of coverage is the day before such coverage begins.

## **Cancellation of Member's Enrollment by Blue Shield**

Blue Shield may cancel a Member's coverage in this Plan in the following circumstances:

- 1) The Member is no longer eligible for coverage in the Plan.
- 2) Non-payment of Premiums by the Employer for coverage of the Member.
- 3) Termination or decertification of this Blue Shield Plan.
- 4) The Subscriber changes from one health plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber and Employer:

- 1) Providing false or misleading material information on the enrollment application or otherwise to the Employer or Blue Shield; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;

- 2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
- 3) Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the Employer does not meet the applicable eligibility, participation and contribution requirements of the Contract, Blue Shield will cancel this coverage after 30 days' written notice to the Employer.

Any Premiums paid to Blue Shield for a period extending beyond the cancellation date will be refunded to the Employer. The Employer will be responsible to Blue Shield for unpaid Premiums prior to the date of cancellation.

Blue Shield will honor all claims for Covered Services provided prior to the effective date of cancellation.

See the *Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact* section.

### **Cancellation By The Employer**

This health plan may be cancelled by the Employer at any time provided written notice is given to all Employees and Blue Shield to become effective upon receipt, or on a later date as may be specified by the notice.

### **Cancellation for Employer's Non-Payment of Premiums**

Blue Shield may cancel this health plan for non-payment of Premiums. If the Employer fails to pay the required Premiums when due, coverage will terminate upon expiration of the 30-day grace period following notice of termination for nonpayment of premium. The Employer will be liable for all Premium accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will mail the Employer a Cancellation Notice (or Notice Confirming Termination of Coverage). The Employer must provide enrolled Employees with

a copy of the Notice Confirming Termination of Coverage.

### **Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact**

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield or the Employer, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

If a Member is hospitalized or undergoing treatment for an ongoing condition and the Contract is cancelled for any reason, including non-payment of Premium, no Benefits will be provided unless the Member obtains an Extension of Benefits. (See the *Extension of Benefits* section for more information.)

### **Date Coverage Ends**

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Employer Group Health Service Contract is discontinued; (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the Employer; (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer (see Cancellation for Non-Payment of Premiums); or (4) the last day of the month in which the Subscriber and Dependents become ineligible for coverage, except as provided below.

Even if a Subscriber remains covered, his Dependents' coverage may end if a Dependent become ineligible. A Dependent spouse becomes

ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent. Coverage ends on the last day of the month in which the Dependent child becomes ineligible.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 60 days following that Dependent's birth or placement for adoption, Benefits under this health plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the Employer or Blue Shield for information on options for continued group coverage or individual options. If the Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

### **Reinstatement**

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact Blue Shield or the Employer regarding reinstatement options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or

Dependents qualify for a Special Enrollment Period (see Special Enrollment Periods in the Definitions section). The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

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### **Extension of Benefits**

If a Member becomes Totally Disabled while validly covered under this health plan and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on which a replacement carrier provides coverage to the Member.

No extension will be granted unless Blue Shield receives written certification of such Total Disability from a Doctor of Medicine within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Blue Shield.

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### **Group Continuation Coverage**

Please examine group continuation coverage options carefully before declining this coverage.

A Member can continue his or her coverage under this group health plan when the Subscriber's Employer is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member may elect to continue group coverage under this Plan if



the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

### **Qualifying Event**

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

- 1) With respect to the Subscriber:
  - a) the termination of employment (other than by reason of gross misconduct); or
  - b) the reduction of hours of employment to less than the number of hours required for eligibility.
- 2) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
  - a) the death of the Subscriber;
  - b) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct);

- c) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility;
- d) the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership;
- e) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
- f) a Dependent child's loss of Dependent status under this Plan.

Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

- 3) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
- 4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

### **Notification of a Qualifying Event**

- 1) With respect to COBRA enrollees:

The Member is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

The Employer is responsible for notifying its COBRA administrator (or plan administrator if the Employer does not have a COBRA administrator) of the Subscriber's death, termination, or reduction of hours of employment, the Subscriber's Medicare

entitlement or the Employer's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by first class mail of the Member's right to continue group coverage under this Plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2) With respect to Cal-COBRA enrollees:

The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this Plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation

coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If the Member does not notify Blue Shield within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

#### **Duration and Extension of Group Continuation Coverage**

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this Plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

### **Notification Requirements**

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuation of coverage under Cal-COBRA. If the enrollee is eligible and chooses to continue coverage under Cal-COBRA, the enrollee must notify Blue Shield of their Cal-COBRA election at least 30 days before COBRA termination.

### **Payment of Premiums or Dues**

Premiums for the Member continuing coverage shall be 102 percent of the applicable group Premium rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Premium rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the Premiums for months 19 through 29 shall be 150 percent of the applicable group Premium rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, Premiums for Cal-COBRA coverage shall be 110 percent of the applicable group Premium rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all Premium contributions to Blue Shield in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premiums must be paid within 45 days of the date the Member

provided written notification to Blue Shield of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The Premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Member from continuation coverage.

### **Effective Date of the Continuation of Coverage**

The continuation of coverage will begin on the date the Member's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as Premiums are timely paid.

### **Termination of Group Continuation Coverage**

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

- 1) discontinuance of this group health service contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
- 2) failure to timely and fully pay the amount of required Premiums to the COBRA administrator or the Employer or to Blue Shield as applicable. Coverage will end as of the end of the period for which Premiums were paid;
- 3) the Member becomes covered under another group health plan;
- 4) the Member becomes entitled to Medicare;
- 5) the Member commits fraud or deception in the use of the services of this Plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.



## **Continuation of Group Coverage for Members on Military Leave**

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the (USERRA). Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, Labor Code requirements for Medical Disability.

## **General Provisions**

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### **Liability of Subscribers in the Event of Non-Payment by Blue Shield**

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield and its Participating Providers stipulates that the Subscriber shall not be responsible to the Participating Provider for compensation for any services to the extent that they are provided in the Member's group contract. Participating Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments and Coinsurance, and amounts in excess of specified Benefit maximums, or as provided under the *Exception for Other Coverage* and *Reductions-Third Party Liability* sections.

If services are provided by a Non-Participating Provider, the Member is responsible for all amounts Blue Shield does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Member is responsible for any charges above the Benefit maximums.

### **Right of Recovery**

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or,

if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

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### **No Maximum Aggregate Payment Amount**

There is no maximum limit on the aggregate payments by Blue Shield for Covered Services provided under the Contract and this health plan.

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### **No Annual Dollar Limit On Essential Health Benefits**

This health plan contains no annual dollar limits on essential health benefits as defined by federal law.

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### **Independent Contractors**

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, or other provider or their employees.

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### **Non-Assignability**

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield. Possession of a Blue Shield ID card confers no right to Covered Services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber, or Dependent who has been accepted by the Employer and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

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

If the Member receives services from a Non-Participating Provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the Non-Participating Provider. The Member or the provider of service may not request that the payment be made directly to the provider of service.

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### **Plan Interpretation**

Blue Shield shall have the power and 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 shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan.

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### **Public Policy Participation Procedure**

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

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

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

Sr. Manager, Regulatory Filings  
Blue Shield of California  
50 Beale Street  
San Francisco, CA 94105  
Phone: 1-415-229-5065

Please follow the following procedure:

- 1) Recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.
- 2) Please include name, address, phone number, Subscriber number, and group number with each communication.
- 3) The public 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) Public 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. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes within 10 business days after the minutes have been approved.

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### **Confidentiality of Personal and Health Information**

Blue Shield protects the privacy of individually identifiable personal information, including Protected Health Information. Individually identifiable personal information includes health, financial, and/or demographic information - such as name, address, and social security number. Blue Shield will not disclose this information without authorization, except as permitted or required 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 "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this Evidence of Coverage, or by accessing Blue Shield's internet site at [www.blueshieldca.com](http://www.blueshieldca.com) and printing a copy.

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

**Correspondence Address:**

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

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**Access to Information**

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in the Member's possession.

Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

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**Grievance Process**

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

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**Medical Services**

The Member, a designated representative, or a provider on behalf of the Member, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact Blue Shield at the telephone number as noted on the back page of this Evidence of Coverage. If the telephone inquiry to Customer Service does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Member may also submit the grievance online by visiting [www.blueshieldca.com](http://www.blueshieldca.com).

**For all grievances except denial of coverage for a Non-Formulary Drug:** Blue Shield will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service

**For grievances due to denial of coverage for a Non-Formulary Drug:** If Blue Shield denies an

exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

**For all grievances:** The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction.

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### **Mental Health, Behavioral Health, and Substance Use Disorder Services**

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

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Department. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms should be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting [www.blueshieldca.com](http://www.blueshieldca.com).

1-877-263-9952  
Blue Shield of California  
Mental Health Service Administrator  
P.O. Box 719002  
San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within five 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 Member'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 Member should contact the Blue Shield Customer Service Department as shown on the back page of this Evidence of Coverage.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE 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. Additionally, you and your employer health benefit plan may have other voluntary alternative dispute resolution options, such as mediation.

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### **External Independent Medical Review**

For grievances involving claims 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-Kowles Experimental Treatment Act of 1996),



Members 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. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member 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 the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's 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 and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member 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.

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## 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 **1-888-319-5999** 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 **(1-888-466-2219)** and a TDD line **(711)** for the hearing and speech impaired. The Department's Internet Web site, (<http://www.dmhc.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.

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## Customer Service

For questions about services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care, contact Blue Shield's Customer Service Department. Customer Service can answer many questions over the

telephone. Contact Information is provided on the last page of this Evidence of Coverage.

For all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, MHSA Participating Providers, or Mental Health, Behavioral Health, and Substance Use Disorder Benefits. Members may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952  
Blue Shield of California  
Mental Health Service Administrator  
P.O. Box 719002  
San Diego, CA 92171-9002

## Definitions

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When the following terms are capitalized in this Evidence of Coverage, they will have the meaning set forth below:

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

**Activities of Daily Living (ADL)** — mobility skills required for independence in normal, everyday living. Recreational, leisure, or sports activities are not considered ADL.

**Allowable Amount (Allowance)** — the total amount Blue Shield allows for Covered Service(s) rendered, or the provider's billed charge for those Covered Services, whichever is less. The Allowable Amount, unless specified for a particular service elsewhere in this Evidence of Coverage, is:

- 1) For a Participating Provider: the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.

- 2) For a Non-Participating Provider who provides Emergency Services, anywhere within or outside of the United States:

- a) Physicians and Hospitals – the amount is the Reasonable and Customary Charge; or
- b) All other providers – the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount.

- 3) For a Non-Participating Provider in California (including an Other Provider), who provides services (other than Emergency Services): the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or

- a) Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable and Customary Charge.

- 4) For a provider outside of California (within or outside of the United States), that has a contract with the local Blue Cross and/or Blue Shield plan: the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.

- 5) For a Non-Participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services (other than Emergency Services): the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a non-participating provider performing the same services. Or, if the local Blue Cross and/or Blue Shield plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

**Alternate Care Services Provider** — refers to a supplier of Durable Medical Equipment, or a certified orthotist, prosthetist, or prosthetist-orthotist.



**Ambulatory Surgery Center** — an outpatient surgery facility providing outpatient services which:

- 1) is either licensed by the state of California as an ambulatory surgery center, or is a licensed facility accredited by an ambulatory surgery center accrediting body; and
- 2) provides services as a free-standing ambulatory surgery center, which is licensed separately and bills separately from a Hospital, and is not otherwise affiliated with a Hospital.

**Anticancer Medications** — Drugs used to kill or slow the growth of cancerous cells.

**Bariatric Surgery Services Provider** — a Participating Hospital, Ambulatory Surgery Center, or a Physician that has been designated by Blue Shield to provide bariatric surgery services to Members who are residents of designated counties in California (described in the Covered Services section of this Evidence of Coverage).

**Behavioral Health Treatment** — professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

**Benefits (Covered Services)** — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to the Group Health Service Contract.

**BlueCard Service Area** — the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

**Blue Shield of California** — a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this Evidence of Coverage, as Blue Shield.

**Brand Drugs** — Drugs which are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer.

**Calendar Year** — the 12-month consecutive period beginning on January 1 and ending on December 31 of the same calendar year.

**Close Relative** — the spouse, Domestic Partner, children, brothers, sisters, or parents of a Member.

**Coinsurance** — the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

**Copayment** — the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

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

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

**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 insurance, 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) The Medicare Program pursuant to Title XVIII of the Social Security Act.

- 3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as Medi-Cal in California).
- 4) Any other publicly sponsored program of medical, hospital or surgical care, provided in this state or elsewhere.
- 5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq.
- 6) A medical care program of the Indian Health Service or of a tribal organization.
- 7) A state health benefits high risk pool.
- 8) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.
- 9) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
- 10) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).
- 11) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

**Custodial Care 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 Doctor of Medicine) 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 individual to live outside an institution providing such care; or

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

**Deductible** — the Calendar Year amount which the Member must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Group Health Service Contract.

**Dependent** — the spouse or Domestic Partner, or child, of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber.

- 1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
- 2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in this Agreement.
- 3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship). A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
- 4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:
  - a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

- b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 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 must be submitted to Blue Shield on the following schedule:
  - i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
  - ii. 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 for any reason other than attained age.
- 4) Diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets);
- 5) Over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;
- 6) Contraceptive drugs and devices, including:
  - diaphragms,
  - cervical caps,
  - contraceptive rings,
  - contraceptive patches,
  - oral contraceptives,
  - emergency contraceptives, and
  - female OTC contraceptive products when ordered by a Physician or Health Care Provider;
- 6) Inhalers and inhaler spacers for the management and treatment of asthma.

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

**Domestic Partner** — an individual who is personally related to the Subscriber by a registered domestic partnership.

Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

**Drugs** — Drugs are:

- 1) FDA-approved medications that require a prescription either by California or Federal law;
- 2) Insulin, and disposable hypodermic insulin needles and syringes;
- 3) Pen delivery systems for the administration of insulin, as Medically Necessary;

**Emergency Medical Condition (including a psychiatric emergency)** — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

**Emergency Services** — the following services provided for an Emergency Medical Condition:

- 1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, and
- 2) Such further medical examination and treatment, to the extent they are within the

capabilities of the staff and facilities available at the hospital, to stabilize the Member.

‘Stabilize’ means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize” means to deliver (including the placenta).

“Post-Stabilization Care” means Medically Necessary services received after the treating physician determines the Emergency Medical Condition is stabilized.

Emergency Services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition. If the Member reasonably should have known that an Emergency Medical Condition did not exist, the services will be covered at the applicable Participating or Non-Participating Provider level of Benefits.

**Employee** — an individual who meets the eligibility requirements set forth in the Group Health Service Contract between Blue Shield and the Employer.

**Employer (Contractholder)** — any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least 1 employee and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

**Experimental or Investigational in Nature** — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical

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

**Family** — the Subscriber and all enrolled Dependents.

**Formulary** — A list of preferred Generic and Brand Drugs maintained by Blue Shield’s Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

**Generic Drugs** — Drugs that are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug.

**Group Health Service Contract (Contract)** — the contract for health coverage between Blue Shield and the Employer (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.

**Habilitative Services (Habilitation Services)** — Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both.



**Health Care Provider** — An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietitian; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

**Hemophilia Infusion Provider** — a provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

Note: A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

**Home Health Aide** — an individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the patient's home.

**Hospice or Hospice Agency** — an entity which provides hospice services to persons with a Terminal Disease or Illness and holds a license as a hospice pursuant to California Health and Safety Code Section 1747, or a home health agency licensed pursuant to California Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

**Hospital** — an entity which is:

- 1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the 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;

- 2) a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
- 3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

A facility which is principally a rest home, nursing home, or home for the aged, is not included in this definition.

**Host Blue** – The local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the BlueCard Service Area.

**Infertility** —

- 1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- 2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

**Intensive Outpatient Program** — an outpatient mental Health, behavioral health or substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.

**Inter-Plan Arrangements** – Blue Shield's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

**Late Enrollee** — an eligible Employee or Dependent who has declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage. An eligible Employee or Dependent who is a Late Enrollee may qualify for a Special Enrollment Period. If the eligible Employee or Dependent does not qualify for a Special Enrollment Period, the Late Enrollee may only enroll during the annual Open Enrollment period.

**Medical Necessity (Medically Necessary) —**

Benefits are provided only for services that are Medically Necessary.

- 1) Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:
  - a) consistent with Blue Shield medical policy;
  - b) consistent with the symptoms or diagnosis;
  - c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
  - d) furnished at the most appropriate level which can be provided safely and effectively to the patient.
- 2) If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.
- 3) Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services that are not Medically Necessary include hospitalization:
  - a) for diagnostic studies that could have been provided on an outpatient basis;
  - b) for medical observation or evaluation;
  - c) for personal comfort;
  - d) in a pain management center to treat or cure chronic pain; and

- e) for inpatient Rehabilitative Services that can be provided on an outpatient basis.

- 4) Blue Shield reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

**Member** — an individual who is enrolled and maintains coverage in the Group Health Service Contract as either a Subscriber or a Dependent.

**Mental Health Condition** — mental disorders listed in the Fourth Edition of the Diagnostic & Statistical Manual of Mental Disorders (DSM), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

**Mental Health Service Administrator (MHSA)**

— The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver Blue Shield's Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

**Mental Health Services** — services provided to treat a Mental Health Condition.

**MHSA Non-Participating Provider** — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment or Substance Use Disorder Services to members of this Plan.

**MHSA Participating Provider** — a provider who has an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services to members of this Plan.

**Network Specialty Pharmacy** — select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.

**Non-Participating (Non-Participating Provider)** — refers to any provider who has not contracted with Blue Shield to accept Blue Shield's payment,



plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

This definition does not apply to providers of Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, which is defined separately under the MHSA Non-Participating Provider definition.

**Non-Participating Pharmacy** — a pharmacy which does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.

**Non-Preferred Drugs** — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Preferred Drugs and are always subject to the Non-Preferred Copayment or Coinsurance.

**Occupational Therapy** — treatment under the direction of a Doctor of Medicine and provided by a certified occupational therapist or other appropriately licensed Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

**Office Visits for Outpatient Mental Health Services and Behavioral Health Treatment** — professional office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including the individual, family or group setting.

**Open Enrollment Period** — that period of time set forth in the Contract during which eligible Employees and their Dependents may enroll in this coverage, or transfer from another health benefit plan sponsored by the Employer to this coverage.

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

**Other Outpatient Mental Health Services and Behavioral Health Treatment** — Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including, but not limited to the following:

- 1) Partial Hospitalization
- 2) Intensive Outpatient Program
- 3) Electroconvulsive Therapy
- 4) Transcranial Magnetic Stimulation
- 5) Behavioral Health Treatment
- 6) Psychological Testing.

These services may also be provided in the office, home or other non-institutional setting.

**Other Providers** —

- 1) Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed nurse practitioners, licensed psychiatric nurses; registered dietitians and other nutrition advisors; certified nurse midwives; licensed occupational therapists; licensed acupuncturist; certified respiratory therapists; enterostomal therapists; licensed speech and language therapists or pathologists; applied behavior analysis therapists, dental technicians; and lab technicians.
- 2) Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and outpatient clinics not MD-owned; portable X-ray companies; 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.

**Out-of-Area Covered Health Care Services** — Medically Necessary Emergency Services, Urgent Services, or Out-of-Area Follow-up Care provided outside the Plan Service Area.

**Out-of-Area Follow-up Care** — non-emergent Medically Necessary services to evaluate the

Member's progress after Emergency or Urgent Services provided outside the service area.

**Out-of-Pocket Maximum** — the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate, do not accrue to the Calendar Year Out-of-Pocket Maximum.

**Outpatient Facility** — a licensed facility which provides medical and/or surgical services on an outpatient basis. The term does not include a Physician's office or a Hospital.

**Outpatient Substance Use Disorder Services** — Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions, including, but not limited to the following:

- 1) Professional (Physician) office visits
- 2) Partial Hospitalization
- 3) Intensive Outpatient Program
- 4) Office-Based Opioid Detoxification and/or Maintenance Therapy.

These services may also be provided in the office, home or other non-institutional setting.

**Partial Hospitalization Program (Day Treatment)** — an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Patients may be admitted directly to this level of care, or transferred from inpatient care following stabilization.

**Participating (Participating Provider)** — refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

This definition does not apply to providers of Mental Health Services, Behavioral Health

Treatment, and Substance Use Disorder Services, which is defined separately under the MHSA Participating Provider definition.

**Participating Pharmacy** — a pharmacy which has agreed to a contracted rate for covered Drugs for Blue Shield Members. These pharmacies participate in the Blue Shield Pharmacy Network.

**Period of Care** — the timeframe the Participating Provider certifies or recertifies that the Member requires and remains eligible for Hospice care, even if the Member lives longer than one year. A Period of Care begins the first day the Member receives Hospice services and ends when the certified timeframe has elapsed.

**Physical Therapy** — treatment provided by a physical therapist, occupational therapist, or other appropriately licensed Health Care Provider. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

**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.

**Plan** — this Blue Shield PPO Plan.

**Preferred Drugs** — Drugs listed on Blue Shield's Formulary and determined by Blue Shield's Pharmacy and Therapeutics Committee as products that have a clear advantage over Non-Formulary Drug alternatives.

**Premium (Dues)** — the monthly prepayment made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Group Health Service Contract.

**Preventive Health Services** — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically described in the *Preventive Health Benefits* section of this Evidence of Coverage.

**Prosthesis(es) (Prosthetics)** — an artificial part, appliance or device used to replace a missing part of the body.

**Psychological Testing** — testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

**Reasonable and Customary Charge** —

- 1) In California: The lower of: (a) the provider's billed charge, or (b) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a Non-Participating Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered.
- 2) Outside of California: The lower of: (a) the provider's billed charge, or (b) the amount, if any, established by the laws of the state to be paid for Emergency Services.

**Reconstructive Surgery** — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance to the extent possible; dental and orthodontic services that are an integral part of surgery for cleft palate procedures.

**Rehabilitative Services** — inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, in order to restore an individual's ability to function to the maximum extent practical. Rehabilitative Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

**Residential Care** — Mental Health Services, Behavioral Health Treatment or Substance Use Disorder Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

**Respiratory Therapy** — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

**Schedule II Controlled Substance** — prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.

**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.

**Severe Mental Illnesses** — conditions with the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders,

panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

**Skilled Nursing** — services performed by a licensed nurse (either a registered nurse or a licensed vocational nurse).

**Skilled Nursing Facility** — a facility with a valid license issued by the California Department of Public Health as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing unit within a Hospital.

**Special Enrollment Period** — a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this health plan outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee's Dependent has a 60-day Special Enrollment Period if any of the following occurs:

- 1) An Employee or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis or rescission.
- 2) An Employee loses Medi-Cal coverage for pregnancy-related services or loses access to CHIP unborn child coverage due to the birth of the child.
- 3) An Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan's coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an Employer's contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.
- 4) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The health benefit plan shall enroll such a Dependent child within 60 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.
- 5) An Employee or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility and requests enrollment within 60 days of the loss of coverage.
- 6) An Employee or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal premium assistance program and requests enrollment within 60 days of the notice of eligibility for these premium assistance programs.
- 7) An Employee who declined coverage, or an Employee enrolled in this Plan, subsequently acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption, placement for adoption or placement in foster care.
- 8) An Employee's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of Blue Shield as evaluated and determined by Blue Shield. In such cases, Blue Shield may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
- 9) An Employee or Dependent adequately demonstrates to Blue Shield that the health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Employee or Dependent.
- 10) An Employee or Dependent gains access to



new health plans as a result of a permanent move and:

- a) Had minimum essential coverage for one or more days during the 60 days preceding the date of the move; or
  - b) Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the move.
- 11) An Employee or Dependent has been released from incarceration.
  - 12) An Employee or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
  - 13) An Employee or Dependent demonstrates to Covered California, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as Covered California may provide.
  - 14) An Employee or Dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the health benefit plan.
  - 15) An Employee or Dependent is a member of an Indian tribe which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, as described in Title 25 of the United States Code Section 1603 (Special enrollment period is limited to once per month for this event).
  - 16) An Employee or Dependent qualifies for continuation coverage as a result of a qualifying event, as described in the Group Continuation Coverage section of this Evidence of Coverage.

**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.

**Specialist** — Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

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

**Speech Therapy** — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider 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 Services 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 eligible Employee who is enrolled and maintains coverage under the Group Health Service Contract.

**Substance Use Disorder Condition** — drug or alcohol abuse or dependence.

**Substance Use Disorder Services** — services provided to treat a Substance Use Disorder Condition.

**Terminal Disease or Terminal Illness (Terminally Ill)** — a medical condition resulting in a life expectancy of one year or less, if the disease follows its natural course.

**Total Disability (or Totally Disabled)** —

- 1) in the case of an Employee, or Member otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;
- 2) in the case of a Dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

**Urgent Services** — those Covered Services rendered outside of the Plan Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury, or complications of an existing medical condition, for

which treatment cannot reasonably be delayed until the Member returns to the Plan Service Area.



## **Contacting Blue Shield of California**

### **For information, including information about claims submission:**

Members may call Customer Service toll free at 1-888-319-5999.

The hearing impaired may call Customer Service through Blue Shield's toll-free TTY number at 711.

### **For prior authorization:**

Please call the Customer Service telephone number listed above.

### **For prior authorization of Benefits Management Program radiological services:**

Please call 1-888-642-2583.

### **For prior authorization of inpatient Mental Health, Behavioral Health, and Substance Use Disorder Services:**

Please contact the Mental Health Service Administrator at 1-877-263-9952.

Please refer to the *Benefits Management Program* section of this Evidence of Coverage for additional information on prior authorization.

### **Please direct correspondence to:**

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





## Domestic Partner Supplement

### *Supplement to your Blue Shield Evidence of Coverage*

Your employer has elected to establish Domestic Partner eligibility requirements as described in this Supplement. The following changes have been made to your EOC:

Under the Definitions section of your EOC, the definition of Domestic Partner is changed to read as follows:

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

1. Both partners are (a) 18 years of age or older and (b) of the same or different sex;
2. The partners share (a) an intimate and committed relationship of mutual caring and (b) the same common residence;
3. The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
4. Both partners were mentally competent to consent to a contract when their domestic partnership began.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

# Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

**This Notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.**

## Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this Notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

## How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

## How we use and disclose your PHI

### Uses of PHI without your authorization.

We may disclose your PHI without your written authorization if necessary while providing health benefits and services

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to you. We may disclose your PHI for the following purposes:

- **Treatment:**

- To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
- To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
- To coordinate your health care and related services with a healthcare facility or professional.

- **Payment:**

- To obtain payment of premiums for your coverage.
- To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
- To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
- To obtain payment from a third party that may be responsible for payment, such as a family member.
- To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.

- **Healthcare operations:**

- To provide customer service.
- To support and/or improve the programs or services we offer you.
- To assist you in managing your health – for example, to provide you

with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.

- To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
- For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**

- If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
- If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement



with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

- We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.

- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.

- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
  - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
  - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.
- **Health oversight activities.** We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.

- Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

#### **Uses of PHI that require your authorization.**

Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

**Uses and disclosure of certain PHI deemed "highly confidential."** For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

**Authorization cancellation.** At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

## **Your individual rights**

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this Notice. We are not required to agree to your restriction requests, but we will consider them carefully.

If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a "designated record set." This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request.
  - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
  - Certain other disclosures that we are allowed by law to exclude from the accounting.

If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the "Notice Availability and Duration" section of this Notice.

## Actions you may take

**Contact Blue Shield.** If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

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

**Phone:** (888) 266-8080 (toll-free)

**Fax:** (800) 201-9020 (toll-free)

**Email:** [privacy@blueshieldca.com](mailto:privacy@blueshieldca.com)

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at [blueshieldca.com/bsca/about-blue-shield/privacy/home.sp](https://blueshieldca.com/bsca/about-blue-shield/privacy/home.sp).

**Contact a government agency.** You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at [www.hhs.gov/ocr/privacy/hipaa/complaints](https://www.hhs.gov/ocr/privacy/hipaa/complaints).

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

**Region IX Regional Manager**  
**Office for Civil Rights**  
**U.S. Department of Health & Human Services**  
**90 7th St., Suite 4-100**  
**San Francisco, CA 94103**

**Phone:** (800) 368-1019

**Fax:** (202) 619-3818

**TTY:** (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

## Notice availability and duration

**Notice availability.** A copy of this Notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at [blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp](https://blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp).

**Right to change terms of this Notice.** We are required to abide by the terms of this Notice as long as it remains in effect. We may change the terms of this Notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new Notice when and as required by law.

**Effective date.** This Notice is effective as of August 16, 2013.

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

Blue Shield of California cumple con las leyes estatales y las leyes federales de derechos civiles vigentes, y no discrimina por motivos de raza, color, país de origen, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Blue Shield of California 遵循適用的州法律和聯邦公民權利法律，並且不以種族、膚色、原國籍、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡或殘障為由而進行歧視。

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

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

Blue Shield of California:

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

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

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

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

**Phone: (844) 831-4133 (TTY: 711)**

**Fax: (844) 696-6070**

**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)**

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

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

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).



# Notice of the Availability of Language Assistance Services

## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

**重要通知：** 您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

**QUAN TRỌNG:** Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

**MAHALAGA:** Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

**Baa' ákohwiindzindooígí:** Díí naaltsoosish yíiniłta'go bííniłhah? Doo bííniłhahgóó éí, naaltsoos nich'í' yiidóoltałhígíí łá' nihee hółq. Díí naaltsoos áldó' t'áá Diné k'ehjí ádooníł nínízingo bíighah. Doo baah ílínígó shíká' adoowoł nínízingo nihich'í' béesh bee hodíłnih dóó námboo éí díí Blue Shield bee néłho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodíłnih. (Navajo)

**중요:** 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

**ԿԱՐԵՎՈՐ Է:** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

**ВАЖНО:** Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

**重要：** お客様は、この手紙を読むことができますか？もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)



**مهم:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیاراتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات اعضا/مشتری تماس بگیرید. (Persian)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្ទងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

**المهم:** هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

**TSEEM CEEB:** Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

**สำคัญ:** คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้  
คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย  
โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร  
(866) 346-7198 (Thai)

**महत्वपूर्ण:** क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मँबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສຳຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້.  
ທ່ານຍັງສາມາດຂໍໃຫ້ແບ່ງຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ  
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ,  
ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

# Notice of the Availability of Language Assistance Services

## Blue Shield of California Life & Health Insurance Company

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվական Ծառայություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ գնդահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով գնդահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

**خدمات مجانی مربوط به زبان.** می‌توانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ 'ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាភីខ្មែរ:** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកលើឯខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمة بدون تكلفة.** يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากสาม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

**Doo bááh ílínígó saad bee yát'i' bee aná'áwo'.** Díí shá ata'halne'dooígí hółóqodoo nínízingo éí bííghah. Naaltsoos naanínáhájeehígí shich'í' yíidooltah éí doodagó ła' shich'í' ádoolníní nínízingo bííghah. Shíká a'doowoł nínízingo nihich'í' béesh bee hodílnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílnínígí bine'déé' bikáá' éí doodagó éí (866)346-7198jí' hodílnih. Hózhq' shíká anáá'doowoł nínízingo éí díí béeso ách'áah naa'nil bíł haz'áají' 1-800-927-4357jí' hodílnih. Navajo

**ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ.** ທ່ານສາມາດຂໍອົງຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີ ໃນບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ 1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ 1-800-927-4357. Laotian





