

# CDHP (Consumer Driven Health Plan)

## **Benefit Booklet**

Group Number: W0051589-M0009311  
Effective Date: January 1, 2016



This Plan is intended to qualify as a “high deductible health plan” for the purposes of qualifying for a health savings account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Although the Claims Administrator believes that this Plan meets these requirements, the Internal Revenue Service has not ruled on whether the Plan is qualified as a high deductible health plan. In the event that any court, agency, or administrative body with jurisdiction over the matter makes a final determination that this Plan does not qualify, the Claims Administrator will make efforts to amend this Plan, if necessary, to meet the requirements of a qualified plan. If the Claims Administrator determines that the amendment necessitates a change in the Plan provisions, the Claims Administrator will provide written notice of the change, and the change shall become effective on the date provided in the written notice.

#### Important Information Regarding HSAs

The CDHP Plan is not a “Health Savings Account” or an “HSA”, but is designed as a “high deductible health plan” that may allow you, if you are eligible, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this Plan. This booklet describes the CDHP, not the HSA.

If this Plan was selected in order to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this Plan does not qualify as a high deductible health plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

**NOTICE:** The Claims Administrator does not provide tax advice. If you intend to purchase this Plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

If you are interested in learning more about Health Savings Accounts, eligibility and the law’s current provisions, ask your Claims Administrator and consult with a financial advisor.

# The Preferred Health Plan

## Participant Bill of Rights

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As a CDHP Participant, 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 Preferred Medical 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 Claims Administrator dispute procedure and understand how to use it without fear of interruption of health care.
15. Voice complaints or grievances about the Preferred Medical Plan or the care provided to you.
16. Make recommendations regarding the Claims Administrator's Participant rights responsibilities policy.

# The Preferred Health Plan

## Participant Responsibilities

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As a CDHP Participant, you have the responsibility to:

1. Carefully read all Claims Administrator Preferred Medical Plan 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 Claims Administrator Preferred Medical Plan as explained in this booklet.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.
4. Understand your health problems and take an active role in developing treatment goals with your medical 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 Claims Administrator Preferred Medical Plan.
10. Help the Claims Administrator to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
11. Notify the Claims Administrator as soon as possible if you are billed inappropriately or if you have any complaints or questions.
12. Treat all Plan personnel respectfully and courteously as partners in good health care.
13. Pay your fees and charges for non-covered services on time.
14. For all Mental Health Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization for all Inpatient Mental Health Services, Behavioral Health Treatment, Residential Care Program Services, Intensive Outpatient Care, Outpatient Partial Hospitalization, Outpatient electroconvulsive therapy (ECT) Services and Non-routine Outpatient Care.
15. Follow the provisions of the Claims Administrator's Benefits Management Program.

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**This booklet constitutes only a summary of the health Plan. The health Plan document must be consulted to determine the exact terms and conditions of coverage.**

The Plan Document is on file with your Employer and a copy will be furnished upon request.

This is a Preferred Medical Plan. Be sure you understand the Benefits of this Plan before Services are received.

**NOTICE**

Please read this Benefit Booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage.

Should you have any questions regarding your health Plan, see your Employer or contact any of the Claims Administrator offices listed on the last page of this booklet.

**IMPORTANT**

No Participant has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision, and when applicable, the Group Continuation Coverage provision in this booklet.

Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Plan.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the plan document 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.

PayPal Holdings, Inc. is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

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

**Note: The following Summary of Benefits contains the Benefits and applicable Co-payments of your Plan. The Summary of Benefits represents only a brief description of the Benefits. Please read this booklet carefully for a complete description of provisions, Benefits and exclusions of the Plan.**



## CDHP Summary of Benefits

See the end of this Summary of Benefits for footnotes providing important additional information.

### Summary of Benefits

CDHP

Individual Calendar Year Medical Deductible <sup>1</sup> (Medical and Prescription Drug Plan Deductible)	Individual Participant Deductible Responsibility <sup>1, 3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by any combination of Preferred, Participating, Other Providers, Non-Preferred, Non-Participating Providers and Prescription Drugs
<b>Calendar Year Medical and Prescription Drug Deductible</b> Deductible charges cross accumulate for services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Provider and Out-patient Prescription Drugs.	\$1,300 per Participant /	\$2,100 per Participant

Individual Calendar Year Out-of-Pocket Maximum <sup>2</sup>	Individual Participant Maximum Calendar Year Out-of-Pocket Amount <sup>2, 3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by any combination of Preferred, Participating, Other Providers, Non-Preferred, Non-Participating Providers and Prescription Drugs
<b>Calendar Year Out-Of-Pocket Maximum</b> Participant maximum calendar year charges cross accumulate for services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers and Outpatient Prescription Drugs.	\$3,000 per Participant	\$5,000 per Participant

<b>Family Calendar Year Medical Deductible <sup>1</sup> (Medical Plan and Prescription Drug Deductible)</b>	<b>Family Participant Deductible Responsibility <sup>1, 3</sup></b>	
	<b>Services by Preferred, Participating, and Other Providers <sup>4</sup></b>	<b>Services by any combination of Preferred, Participating, Other Providers, Non-Preferred, Non-Participating Providers and Prescription Drugs</b>
<b>Calendar Year Medical and Prescription Drug Deductible</b> Deductible charges cross accumulate for services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Provider and Out-patient Prescription Drugs.	\$2,600 per Family <sup>2</sup>	\$4,200 per Family <sup>2</sup>

<b>Family Calendar Year Out-of-Pocket Maximum <sup>2</sup></b>	<b>Family Participant Maximum Calendar Year Out-of-Pocket Amount <sup>2, 3</sup></b>	
	<b>Services by Preferred, Participating, and Other Providers <sup>4</sup></b>	<b>Services by any combination of Preferred, Participating, Other Providers, Non-Preferred, Non-Participating Providers and Prescription Drugs</b>
<b>Calendar Year Out-Of-Pocket Maximum</b> Participant maximum calendar year charges cross accumulate for services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Provider and Outpatient Prescription Drugs.	\$6,000 per Family	\$10,000 per Family

<b>Maximum Lifetime Benefits</b>	<b>Maximum Claims Administrator Payment</b>	
	<b>Services by Preferred, Participating, and Other Providers <sup>4</sup></b>	<b>Services by Non-Preferred and Non-Participating Providers</b>
<b>Lifetime Benefit Maximum</b>	No maximum	

<b>Benefit</b>	<b>Participant Copayment <sup>3</sup></b>	
	<b>Services by Preferred, Participating, and Other Providers <sup>4</sup></b>	<b>Services by Non-Preferred and Non-Participating Providers <sup>5</sup></b>
<b>Acupuncture Benefits</b>  (24 visits per Participant per Calendar Year maximum)		
Acupuncture services – office location	10%	30% up to a maximum Plan payment of \$25 per visit
<b>Allergy Testing and Treatment Benefits</b>		
Allergy serum purchased separately for treatment	10%	30%
Office visits (includes visits for allergy serum injections)	10%	30%
<b>Ambulance Benefits</b>		
Emergency or authorized transport	10%	10%
<b>Ambulatory Surgery Center Benefits</b>  Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery services may also be obtained from a Hospital or an Ambulatory Surgery Center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.		
Ambulatory Surgery Center outpatient surgery facility services	10%	30% up to a maximum Plan payment of \$350 per day
Ambulatory Surgery Center outpatient surgery Physician services	10%	30%
<b>Autism Spectrum Disorders (ASD) and Pervasive Developmental Disorders (PDD) Benefits</b>		
For Benefits for the treatment of Autism Spectrum Disorders (ASD)/ Pervasive Developmental Disorders (PDD) including Applied Behavioral Analysis, see the Mental Health Benefits section of this Summary of Benefits.		

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Bariatric Surgery</b> All bariatric surgery services must be prior authorized, in writing, from the Claims Administrator's Medical Director. Prior authorization is required for all Members.		
Ambulatory surgery center Outpatient surgery facility Services	10%	30% up to a Plan payment maximum of \$350 per day
Hospital inpatient services	10%	30%
Hospital outpatient services	10%	30%
Physician bariatric surgery services	10%	30%
<b>Chiropractic Benefits</b> (24 visits per Participant per Calendar Year maximum)		
Chiropractic services – office location	10%	30% up to a maximum Plan payment of \$25 per visit
<b>Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits</b>		
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Covered Services for Members who have been accepted into an approved clinical trial when prior authorized by the Claims Administrator. Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.	You pay nothing	You pay nothing
<b>Diabetes Care Benefits</b>		
Devices, equipment and supplies <sup>6</sup>	10%	30%
Diabetes self-management training - office location	10%	30%
<b>Dialysis Center Benefits</b>		
Dialysis services Note: Dialysis services may also be obtained from a Hospital. Dialysis services obtained from a Hospital will be paid at the Participating or Non-Participating level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.	10%	30% up to a maximum Plan payment of \$350 per day

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Durable Medical Equipment Benefits</b>		
Breast pump <sup>1</sup>	You pay nothing	30%
Eye glasses following cataract surgery	10%	30%
Other Durable Medical Equipment	10%	30%
<b>Emergency Room Benefits</b>		
Emergency Room Physician services	10%	10%
Emergency Room services not resulting in admission	10%	10%
Emergency Room services resulting in admission (billed as part of inpatient Hospital services)	10%	10%
<b>Family Planning Benefits</b>		
Note: Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the applicable facility benefit in the Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), an intrauterine device (IUD), and tubal ligation.		
Counseling and consulting <sup>1</sup> (Including Physician office visit for diaphragm fitting, or injectable contraceptives.)	You pay nothing	30%
Diaphragm fitting procedure <sup>1</sup>	You pay nothing	30%
Implantable contraceptives <sup>1</sup>	You pay nothing	30%
Injectable contraceptives <sup>1</sup>	You pay nothing	30%
Insertion and/or removal of intrauterine device (IUD) <sup>1</sup>	You pay nothing	30%
Intrauterine device (IUD) <sup>1</sup>	You pay nothing	30%
Tubal ligation <sup>1</sup>	You pay nothing	30%
Vasectomy	10%	30%
<b>Hearing Aid Benefits</b>		
Audiological Examination	10%	30%
Hearing aid	10%	30%

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Home Health Care Benefits</b>		
Home health care agency services (Including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist or occupational therapist) Up to a maximum of 120 visits per Participant, per Calendar Year, by home health care agency providers. The number of visits starts counting toward the maximum when services are first provided even if the Calendar Year Medical Deductible has not been met.	10%	30% <sup>7</sup>
Medical supplies	10%	30% <sup>7</sup>

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Home Infusion/Home Injectable Therapy Benefits</b>		
Hemophilia home infusion services Services provided by a hemophilia infusion provider and prior authorized by the Claims Administrator. Includes blood factor product.	10%	30% up to a maximum Plan payment of \$600 for hemophilia home infusion Services received during any one day if not prior authorized <sup>7</sup>
Home infusion therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.)	10%	30% up to a maximum Plan payment of \$600 for services and supplies received during any one day if not prior authorized <sup>7</sup>
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency. (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.) Note: Non-intravenous self-administered injectable drugs are covered under the Outpatient prescription drug Benefit selected by your Employer through an entity other than the Claims Administrator as shown below: CVS/Caremark at 1-(844)-287-1297	10%	30% <sup>7</sup>
Home visits by an infusion nurse Hemophilia home infusion nursing visits are not subject to the Home Health Care and Home Infusion/Home Injectable Therapy Benefits Calendar Year visit limitation.	10%	30% <sup>7</sup>
<b>Hospice Program Benefits</b> Covered Services for Members who have been accepted into an approved Hospice Program. The Hospice Program Benefit must be received from a Hospice Agency. When prior authorized, Non-Participating Hospice Program Services will be covered at the Participating Hospice Benefit level.		
24-hour continuous home care	10%	30% <sup>8</sup>
Short term inpatient care for pain and symptom management	10%	30% <sup>8</sup>
Inpatient respite care	10%	30% <sup>8</sup>
Pre-hospice consultation	10%	30% <sup>8</sup>
Routine home care	10%	30% <sup>8</sup>

<b>Benefit</b>	<b>Participant Copayment <sup>3</sup></b>	
	<b>Services by Preferred, Participating, and Other Providers <sup>4</sup></b>	<b>Services by Non-Preferred and Non-Participating Providers <sup>5</sup></b>
<b>Hospital Benefits (Facility Services)</b>		
Inpatient Facility Services Semi-private room and board, services and supplies, including Subacute Care.	10%	30%
Inpatient skilled nursing services, including Subacute Care Up to a maximum of 120 days per Participant, per Calendar Year, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. The number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	10%	30%
Inpatient services to treat acute medical complications of detoxification	10%	30%
Outpatient diagnostic testing: X-Ray, diagnostic examination and clinical laboratory services	10%	30%
Outpatient dialysis services	10%	30% up to a Plan payment maximum of \$350 per day
Outpatient Facility services	10%	30%
Outpatient services for treatment of illness or injury, radiation therapy, chemotherapy, and supplies.	10%	30%



Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Infertility Benefits</b>		
Diagnosis and treatment of underlying medical condition causing Infertility	10%	30%
Gamete intrafallopian transfer (GIFT), Zygote intrafallopian transfer (ZIFT) and In vitro fertilization (IVF)	10%	30%
Inpatient Hospital Services	10%	30%
Inpatient Physician Services	10%	30%
Natural (without ovum [oocyte or ovarian tissue (egg)] stimulation) artificial inseminations	10%	30%
Office visit	10%	30%
Sperm purchase for artificial insemination from a sperm bank	10%	30%
Stimulated (with ovum [oocyte or ovarian tissue] stimulation) artificial inseminations	10%	30%
Note: All Infertility Benefits cover cryopreservation and storage of oocytes and/or embryo absent of medical necessity. Infertility Benefits, except for diagnosis and treatment of underlying medical condition causing Infertility, are limited to a Benefit maximum of \$10,000 per Participant per lifetime. There is a separate per Participant per lifetime maximum of \$10,000 on prescription drugs which are covered through an entity other than the Claims Administrator as shown below: CVS/Caremark at 1-(844)-287-1297		
<b>Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits</b>		
Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated, and orthognathic surgery for skeletal deformity.		
Ambulatory Surgery Center outpatient surgery facility services	10%	30% up to a Plan payment maximum of \$350 per day
Inpatient Hospital services	10%	30%
Office location	10%	30%
Outpatient department of a Hospital	10%	30%

Benefit	Participant Copayment <sup>3</sup>	
Mental Health and Substance Abuse Benefits <sup>10</sup>	Services by Participating Providers	Services by Non-Participating Providers <sup>9</sup>
<b>Inpatient Mental Health and Substance Abuse Services</b>		
Inpatient Hospital services	10%	30% <sup>11</sup>
Inpatient Professional (Physician) services	10%	30%
Residential care for Mental Health Condition	10%	30%
Residential care for Substance Abuse Condition	10%	30%
<b>Non-Routine Outpatient Mental Health and Substance Abuse Services</b>		
Behavioral Health Treatment in home or other non-institutional setting for Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD) including Applied Behavioral Analysis	10%	10%
Behavioral Health Treatment in an office-setting. for Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD) including Applied Behavioral Analysis	10%	10%
Electroconvulsive Therapy (ECT) <sup>13</sup>	10%	30%
Intensive Outpatient Program <sup>13</sup>	10%	30%
Office-based opioid treatment: outpatient opioid detoxification and/or maintenance therapy including methadone maintenance treatment	10%	30%
Partial Hospitalization Program <sup>12</sup>	10% per episode	30% per episode
Psychological testing to determine mental health diagnosis	10%	30%
Transcranial magnetic stimulation	10%	30%
<b>Routine Outpatient Mental Health and Substance Abuse Services</b>		
Professional (Physician) office visits	10%	30%

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Nutritional Counseling Benefits</b>		
Office visits	10%	30%
Note: Benefits are provided for chronic disease in which dietary adjustment has a therapeutic role when prescribed by a physician and furnished by a provider who is a registered dietician, licensed nutritionist or other qualified health professional.		
<b>Orthotics Benefits</b>		
Office visits	10%	30%
Orthotic equipment and devices	10%	30%
<b>Outpatient Prescription Drug Benefits</b>		
CVS/Caremark at 1-(844)-287-1297		

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Outpatient X-Ray, Pathology, and Laboratory Benefits</b>  Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.  See Radiological and Nuclear Imaging Benefits for CT scans, MRIs, MRAs, PET scans, etc.		
Outpatient Laboratory Center or Outpatient Radiology Center Note: Preferred Laboratory Centers and Preferred Radiology Centers may not be available in all areas.	10%	30%
<b>PKU Related Formulas and Special Food Products Benefits</b>		
Formulas and Special Food Products	10%	30%
<b>Podiatric Benefits</b>		
Podiatric Services – office location	10%	30%
<b>Pregnancy and Maternity Care Benefits</b>  Note: Routine newborn circumcision is only covered as described in the Covered Services section of the Evidence of Coverage. Services will be covered as any other surgery and paid as noted in this Summary of Benefits.		
Inpatient Hospital services for normal delivery, Cesarean section, and complications of pregnancy	10%	30%
Prenatal and preconception Physician office visit: initial visit	10%	30%
Prenatal and preconception Physician office visit: subsequent visits See Outpatient X-Ray, Pathology, and Laboratory Benefits for prenatal genetic testing.	10%	30%
Postnatal Physician office visits	10%	30%
Abortion Services Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility coinsurance may apply.	10%	30%
<b>Preventive Health Benefits<sup>1</sup></b>		
Preventive Health Services See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the Evidence of Coverage, for more information.	You pay nothing	30% Well baby immunizations for Dependent child under age 7 are subject to a maximum Plan payment of \$12 per immunization.

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Professional (Physician) Benefits</b>		
Inpatient Physician Services	10%	30%
Outpatient Physician Services, other than an office setting	10%	30%
Physician home visits	10%	30%
Physician office visits Note: For other services with the office visit, you may incur an additional Copayment as listed for that service within this Summary of Benefits.	10%	30%
Physician services in an Urgent Care Center	10%	30%
Teladoc consultations Teladoc consultation Services provide confidential consultations using a network of board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. over secure video, 7 days a week. See the Principal Benefits and Coverages section, Professional (Physician) Benefits for detailed information.	10%	Not covered
<b>Prosthetic Appliance Benefits</b>		
Office visits	10%	30%
Prosthetic equipment and devices	10%	30%
<b>Radiological and Nuclear Imaging Benefits</b> Outpatient non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Prior authorization required by the Plan.		
Outpatient department of a Hospital Prior authorization required by the Plan.	10%	30%
Radiology Center Note: Preferred Radiology Centers may not be available in all areas. Prior authorization required by the Plan.	10%	30%
<b>Reconstructive Surgery Benefits</b> For Physician services for these Benefits, see the “Professional (Physician) Benefits” section of this Summary of Benefits.		
Ambulatory Surgery Center outpatient surgery facility services	10%	30% up to a Plan payment maximum of \$350 per day
Inpatient Hospital services	10%	30%
Outpatient department of a Hospital	10%	30%

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy)</b>  Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.		
Physical and Occupational Therapy in an Office location	10%	30% up to a maximum Plan payment of \$25 per visit
Physical and Occupational Therapy in an Outpatient department of a Hospital	10%	30% up to a maximum Plan payment of \$25 per visit
Note: Outpatient Occupational and Physical Therapy (including Services in an office location) are limited to a combined maximum Benefit of 24 visits per Participant per Calendar Year. Additional visits may be allowed if Medically Necessary and prior authorized by the Claims Administrator.		
Respiratory Therapy in an Office location	10%	30%
Respiratory therapy in an Outpatient department of a Hospital	10%	30%
<b>Skilled Nursing Facility (SNF) Benefits</b>		
Skilled nursing services by a free-standing Skilled Nursing Facility Up to a maximum of 120 days per Participant, per Benefit Period, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing SNF.  The number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	10%	10%

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Speech Therapy Benefits</b>  Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits		
Office location	10%	30%
Outpatient department of a Hospital	10%	30%
Note: Outpatient Speech Therapy Benefits (including Services in an office location) for developmental delay are limited to a Benefit maximum of 100 visits per Participant per Calendar Year. Outpatient Speech Therapy Benefits (including Services in an office location) for injury or organic disease are limited to a Benefit maximum of 60 visits per Participant per Calendar Year.		
<b>Transgender Benefits</b>  All Transgender surgical Services must be prior authorized, in writing, from the Claims Administrator's Medical Director. Services received from a non-network provider are not covered unless prior authorized by the Claims Administrator. When authorized by the Claims Administrator, the non-network provider will be reimbursed at a rate determined by the Claims Administrator and the non-network provider. Benefits follow the World Professional Association for Transgender Health (WPATH) Standards of Care and are subject to the Claims Administrator's conditions of coverage, exclusions, and limitations.		
Ambulatory surgery center Outpatient surgery facility Services	10%	Not covered
Hospital Inpatient Services	10%	Not covered
Hospital Outpatient Services	10%	Not covered
Physician surgery Services	10%	Not covered
Note: Benefits are provided for authorized travel related expenses for up to a Benefit maximum of \$10,000 per treatment.  Approved gender reassignment surgical Services and professional Services related to gender reassignment surgical Services are not limited to a per Participant per lifetime benefit maximum. Authorized travel expenses are not included in this Benefit maximum.		
<b>Transplant Benefits – Tissue and Kidney</b>  Organ Transplant Benefits for transplant of tissue or kidney.		
Hospital services	10%	30%
Professional (Physician) services	10%	30%

Benefit	Participant Copayment <sup>3</sup>	
	Services by Preferred, Participating, and Other Providers <sup>4</sup>	Services by Non-Preferred and Non-Participating Providers <sup>5</sup>
<b>Transplant Benefits – Special</b> The Claims Administrator requires prior authorization for all Special Transplant Services, and all services must be provided at a Special Transplant Facility designated by the Claims Administrator.		
Facility services in a Special Transplant Facility	10%	Not covered
Professional (Physician) services	10%	Not covered
Note: Benefits are provided for authorized travel expenses in connection with an organ transplant up to a Benefit maximum of \$10,000 per organ transplant.		
<b>Wig Benefits</b>		
Benefits are provided for wigs and toupees based on Medical Necessity up to a Benefit maximum of one wig per Participant every two years.	10%	10%



## Summary of Benefits

### Endnotes:

- <sup>1</sup> Individual coverage has an Individual Calendar Year Medical Deductible. Family coverage has a Family Calendar Year Medical Deductible; the entire Family Calendar Year Medical Deductible must be met before the Claims Administrator begins payment for Covered Services, and can be met by any one or more family Members. The Covered Services listed below (as they appear in the Summary of Benefits) are not subject to, and will not accrue to, the Calendar Year Medical Deductible.
  - Durable medical equipment: breast pump
  - Family planning benefits by Preferred Providers; counseling and consulting; diaphragm fitting procedure; implantable contraceptives; injectable contraceptives; insertion and/or removal of IUD device; IUD; and tubal ligation
  - Preventive health services by Preferred Providers;
- <sup>2</sup> Individual coverage has an Individual Calendar Year Out-of-Pocket Maximum. Family coverage has a Family Calendar Year Out-of-Pocket Maximum; the entire Family Calendar Year Out-of-Pocket Maximum can be met by any one or more family Members. Copayments or Coinsurance for Covered Services accrue to the Calendar Year Out-of-Pocket Maximum, except Copayments or Coinsurance for Covered Services listed in the following sections of this Summary of Benefits:
  - Charges in excess of specified benefit maximums
  - Bariatric surgery: covered travel expenses for bariatric surgery.Copayments or Coinsurance for Emergency Services received from Non-Participating Providers accrue to the Calendar Year Out-of-Pocket Maximum established for Services by Participating Providers.  
Note: Copayments, Coinsurance, and charges for services not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Participant's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.
- <sup>3</sup> Coinsurance is calculated based on the Allowable Amount unless otherwise specified.
- <sup>4</sup> For Covered Services from Other Providers, you are responsible for any applicable deductible Copayment/Coinsurance and all charges above the Allowable Amount.
- <sup>5</sup> For Covered Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.
- <sup>6</sup> Professional (Physician) office visit copayment/coinsurance may also apply.
- <sup>7</sup> When Services from a Non-Participating Home Health Care/Home Infusion Agency are authorized by the Plan, the Participant's Copayment or Coinsurance for the Non-Participating Agency will be calculated at the Participating Provider level, based upon the agreed upon rate determined between the Plan and the agency.
- <sup>8</sup> When Services from a Non-Participating Hospice Agency are authorized by the Plan, the Participant's Copayment or Coinsurance for the Non-Participating Agency will be calculated at the Participating Provider level, based upon the agreed upon rate between the Claims Administrator and the agency.
- <sup>10</sup> For Covered Services from Non-Participating Providers, you are responsible for a Copayment/Coinsurance and all charges above the Allowable Amount.
- <sup>11</sup> Prior authorization from the MHSA is required for all non-Emergency or non-Urgent Inpatient Services, and Non-Routine Outpatient Mental Health and Substance Abuse Services. No prior authorization is required for Routine Outpatient Mental Health and Substance Abuse Services – Professional (Physician) Office Visit.
- <sup>12</sup> For Emergency Services from a Non-Participating Hospital, the Participant's Copayment or Coinsurance will be the Participating level, based on Allowable Amount.
- <sup>13</sup> For Non-Routine Outpatient Mental Health and Substance Abuse Services - Partial Hospitalization Program services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.
- <sup>14</sup> The Participant's Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.

## WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including Plan Deductibles and Copayments, as well as some medical expenses not covered by your health Plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

## HOW A HEALTH SAVINGS ACCOUNT WORKS

An HSA is very similar to the flexible spending accounts currently offered by some employers. If you qualify for and set up an HSA with a qualified institution, the money deposited will be tax-deductible and can be used tax-free to reimburse you for many medical expenses. So, instead of using taxed income for medical care as you satisfy your Deductible, you may use 100% of every dollar invested (plus interest). And, as with an Individual Retirement Account, any amounts you do not use (or withdraw with penalty) can grow. Your principal and your returns may be rolled over from year to year to provide you with tax-deferred savings for future medical or other uses.

Please note that the Claims Administrator does not offer HSAs itself, and only offers high deductible health plans.

If you are interested in learning more about Health Savings Accounts, eligibility and the law's current provisions, ask your Claims administrator and consult with a financial advisor.

## INTRODUCTION

If you have questions about your Benefits, contact the Claims Administrator before Hospital or medical Services are received.

This Plan is designed to reduce the cost of health care to you, the Participant. In order to reduce your costs, much greater responsibility is placed on you.

You should read your Benefit Booklet carefully. Your booklet tells you which services are covered by your health Plan and which are excluded. It also lists your Copayment and Deductible responsibilities.

When you need health care, present your Benefits Administrator ID card to your Physician, Hospital, or other licensed healthcare provider. Your ID card has your Participant and group numbers on it. Be sure to include these numbers on all claims you submit to the Benefits Administrator.

In order to receive the highest level of Benefits, you should assure that your provider is a Preferred Provider (see the "Preferred Providers" section).

You are responsible for following the provisions shown in the "Benefits Management Program" section of this booklet, including:

1. You or your Physician must obtain the Claims Administrator approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services or obtain approval from the MHSA for all Inpatient Mental Health or substance abuse Services, Behavioral Health treatment, Residential Care Program admissions for Mental Health Condition or Substance Abuse Condition, Outpatient Partial Hospitalization, Intensive Outpatient Care, Outpatient ECT Services and Non-routine Outpatient Care (except for Emergency and urgent Services). (See the "Preferred Providers" section for information.)
2. You or your Physician must notify the Claims Administrator or the MHSA for Mental Health or Substance Abuse Services within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.
3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See "Prior Authorization" in the "Benefits Management Program" section for a listing of Services requiring prior authorization.

Failure to meet these responsibilities may result in your incurring a substantial financial liability. Some Services may not be covered unless prior review and other requirements are met.

Note: The Claims Administrator or MHSA will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Participant within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Participant or when the Participant is experiencing severe pain, the Claims Administrator will respond as soon as possible to accommodate the Participant's condition not to exceed 72 hours from receipt of the request.

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

## PREFERRED PROVIDERS

The Claims Administrator Preferred Plan is specifically designed for you to use the Claims Administrator Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and Other Providers. Preferred Providers are listed in the Preferred Provider Directories. All Claims Administrator Physician Members are Preferred Providers. So are selected Hospitals in your community. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and fam-

ily therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

To determine whether a provider is a Preferred Provider, access the Claims Administrator's Internet site located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal), or call Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by the Claims Administrator for services.

Preferred Providers agree to accept the Claims Administrator's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums, as payment in full for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability. This is not true of Non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision.

The Claims Administrator 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. If you want to know more about this payment system, contact Customer Service at the number provided on the back page of this booklet.

If you go to a Non-Preferred Provider, the Claims Administrator's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount the Claims Administrator pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Claims Administrator within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

If you would like a hard copy directory, please contact the Claims Administrator and request them at the telephone number listed on the last page of this booklet.

## **CONTINUITY OF CARE BY A TERMINATED PROVIDER**

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Claims Administrator provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

## **FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES**

If a Participant is entitled to receive Services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Participant to that provider for Services rendered under the Continuity of Care provisions shall be no greater than for the same Services rendered by a Preferred Provider in the same geographic area. If you have questions about Continuity of Care Service, please call the Claims Administrator at the telephone number on the last page of this booklet.

## **SUBMITTING A CLAIM FORM**

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by the Claims Administrator if Services are rendered by a Non-Preferred Provider. Payments to you for covered Services are in amounts identical to those made directly to providers. Requests for payment must be submitted to the Claims Administrator within 12 months after the month Services were provided. Special claim forms are not necessary, but each claim submission must contain your name, home address, Plan number, Participant's number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Claims Administrator Participant's Statement of Claim form to the Claims Administrator service center listed on the last page of this booklet.

Claim forms are available on the Claims Administrator's Internet site located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal) or you may call Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Claims Administrator claim form.

Be sure to send in a claim for all covered Services even if you have not yet met your Calendar Year Deductible. The Claims

Administrator will keep track of the Deductible for you. The Claims Administrator uses an Explanation of Benefits to describe how your claim was processed and to inform you of your financial responsibility.

## **ELIGIBILITY**

To enroll and continue enrollment, a Participant must meet all of the eligibility requirements of the Plan.

For information regarding Plan eligibility requirements, please see your Employer's Health and Welfare SPD.

## **EFFECTIVE DATE OF COVERAGE**

Coverage will become effective for Employees and Dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your Employer.

For information regarding your Effective Date of Coverage, please see your Employer's Health and Welfare SPD.

## **SERVICES FOR EMERGENCY CARE**

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

Participants who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

Note: 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 Physician's office.

## **SECOND MEDICAL OPINION POLICY**

If you have a question about your diagnosis, or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all Plan Benefit limitations and exclusions.

## **UTILIZATION REVIEW**

The Claims Administrator has a documented utilization review process. To request a copy of this document, call the Customer Service Department at the number listed on the last page of this booklet.

## **HEALTH EDUCATION AND HEALTH PROMOTION SERVICES**

Health education and health promotion Services provided by the Claims Administrator's Center for Health and Wellness

offer a variety of wellness resources including, but not limited to: a Participant newsletter and a prenatal health education program.

## **RETAIL-BASED HEALTH CLINICS**

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which 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 Preferred Provider Directory or the Online Physician Directory located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal). See the Preferred Providers section for information on the advantages of choosing a Preferred Provider.

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

If you are unsure about what care you need, you should contact your Physician's office. In addition, your Plan includes a service, NurseHelp 24/7, which provides licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week. You can call NurseHelp 24/7 for immediate answers to your health questions. Registered nurses are available 24 hours a day to answer any of your health questions, including concerns about:

1. Symptoms you are experiencing, including whether you need emergency care;
2. Minor illnesses and injuries;
3. Chronic conditions;
4. Medical tests and medications;
5. Preventive care.

If your Physician's office is closed, just call NurseHelp 24/7 at 877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is listed on your Participant identification card.

## **THE CLAIMS ADMINISTRATOR ONLINE**

The Claims Administrator's Internet site is located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal). Members with Internet access and a Web browser may view and download healthcare information.

## **BENEFITS MANAGEMENT PROGRAM**

The Claims Administrator has established the Benefits Management Program to assist Participants and their providers in identifying the most appropriate and cost-effective course of treatment for which certain Benefits will be provided under this health Plan and for determining whether the services are Medically Necessary. However, Participants and their

providers make the final decision concerning treatment. The Benefits Management Program includes: prior authorization review for certain services; emergency admission notification; Hospital Inpatient review, discharge planning, and case management if determined to be applicable and appropriate by the Claims Administrator.

Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in non-payment if the Claims Administrator determines the service was not a covered Service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. All provisions of the Benefits Management Program apply to all Participants.

The Claims Administrator requires prior authorization for selected Inpatient and Outpatient services, supplies and Durable Medical Equipment; admission into an approved Hospice Program; and certain radiology procedures. Preadmission review is required for all Inpatient Hospital and Skilled Nursing Facility services (except for Emergency Services\*).

\*See the paragraph entitled Emergency Admission Notification later in this section for notification requirements on page 28.

By obtaining prior authorization for certain services prior to receiving services, Participants and their providers can verify: (1) If the Claims Administrator considers the proposed treatment Medically Necessary, (2) if Plan Benefits will be provided for the proposed treatment, and (3) if the proposed setting is the most appropriate as determined by the Claims Administrator. Participants and their providers may be informed about Services that could be performed on an Outpatient basis in a Hospital or Outpatient Facility.

## PRIOR AUTHORIZATION

For services and supplies listed in the section below, Participants and their providers can determine before the service is provided whether a procedure or treatment program is a Covered Service and may also receive a recommendation for an alternative Service.

For Services other than those listed in the sections below, Participants or their providers should consult the Principal Benefits and Coverages (Covered Services) section of this booklet to determine whether a service is covered.

Participants or their providers must call the Customer Service telephone number indicated on the back of the Participant's identification card for prior authorization for the services listed in this section.

The Claims Administrator requires prior authorization for the following services:

1. Admission into an approved Hospice Program as specified under Hospice Program Benefits in the Covered Services section.

2. Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits.

Participants who have been accepted into an approved clinical trial for treatment of cancer or life-threatening condition as defined under the Covered Services section must obtain prior authorization from the Claims Administrator in order for the routine patient care delivered in a clinical trial to be covered.

3. Select injectable drugs, except injectable contraceptives (prior authorization not required) administered in the Physician office setting.
4. Durable Medical Equipment Benefits, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Glucose Monitoring Systems (CGMS), except breast pumps (prior authorization not required).
5. Reconstructive Surgery.
6. Orthognathic surgery of the temporomandibular joint (TMJ) Services.
7. Hemophilia home infusion products and Services.
8. The following radiological procedures when performed in an Outpatient setting on a non-emergency basis:  
CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnostic procedure utilizing Nuclear Medicine.
9. Special Transplant Benefits as specified under Transplant Benefits - Special in the Covered Services section.
10. Bariatric surgery.
11. Hospital and Skilled Nursing Facility admissions (see the subsequent Hospital and Skilled Nursing Facility Admissions section for more information).
12. Medically Necessary dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.
13. Transgender Services.
14. Chiropractic visits exceeding the visit maximum shown on the Summary of Benefits to determine Medical Necessity for additional visits.
15. Outpatient Occupational and Physical Therapy visits exceeding the visit maximum shown on the Summary of Benefits to determine Medical Necessity for additional visits.

Failure to obtain prior authorization or to follow the recommendations of the Claims Administrator for the services described above may result in non-payment if the Claims Administrator determines that the service is not a covered Service.

Other specific services and procedures may require prior authorization as determined by the Claims Administrator. A list of services and procedures requiring prior authorization can be obtained by your provider by going to [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal) or by calling the Customer Service telephone number indicated on the back of the Participant's identification card.

## **HOSPITAL AND SKILLED NURSING FACILITY ADMISSIONS**

Prior authorization must be obtained from the Claims Administrator for all Hospital and Skilled Nursing Facility admissions (except for admissions required for Emergency Services). Included are hospitalizations for continuing Inpatient Rehabilitation and skilled nursing care, transplants, bariatric surgery, and Inpatient Mental Health Services if this health plan provides these benefits.

### **Prior Authorization for Other than Mental Health or Substance Abuse Admissions**

Whenever a Hospital or Skilled Nursing Facility admission is recommended by your Physician, Participants or their providers must contact the Claims Administrator at the Customer Service telephone number indicated on the back of the Participant's identification card at least 5 business days prior to the admission. However, in case of an admission for Emergency Services, the Claims Administrator should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. The Claims Administrator will discuss the Benefits available, review the medical information provided and may recommend that to obtain the full Benefits of this health Plan that the Services be performed on an Outpatient basis.

Examples of procedures that may be recommended to be performed on an Outpatient basis if medical conditions do not indicate Inpatient care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact the Claims Administrator as described or failure to follow the recommendations of the Claims Administrator may result non-payment by the Claims Administrator if it is determined that the admission is not a covered Service.

### **Prior Authorization for Inpatient Mental Health or Substance Abuse Admissions or Residential Care Program,**

All Inpatient Mental Health or Substance Abuse Services and Residential Care Program except for Emergency Services, and must be prior authorized by the MHSA.

For an admission for Emergency Mental Health or substance abuse Services, the MHSA should receive emergency admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the Participant may be responsible for the additional payment as described below.

For prior authorization of Inpatient Mental Health or Substance Abuse Services or Residential Care Program, call the Claims Administrator at the Customer Service telephone number indicated on the back of the Participant's identification card.

Failure to contact the Claims Administrator or the MHSA as described above or failure to follow the recommendations of the Claims Administrator or MHSA may result in non-payment by the Claims Administrator if it is determined that the admission is not a covered Service.

Note: The Claims Administrator or MHSA will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Participant within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Participant or when the Participant is experiencing severe pain, the Claims Administrator or MHSA will respond as soon as possible to accommodate the Participant's condition not to exceed 72 hours from receipt of the request.

### **Emergency Admission Notification**

When a Participant 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.

### **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 Participant's condition. When a determination is made that the Participant no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Participant. If discharge does not occur within 24 hours of notification, the Participant is responsible for all Inpatient charges accrued beyond the 24 hour timeframe.

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 consul-

tation 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 Participant.

### **Discharge Planning**

If further care at home or in another facility is appropriate following discharge from the Hospital, the Claims Administrator will work with the Participant, the attending Physician and the Hospital discharge planner to determine the most appropriate and cost effective way to provide this care.

### **Case Management**

The Benefits Management Program includes case management, which is a service that provides the assistance of a health care professional to help the Participant access necessary Services and to make the most efficient use of Plan Benefits. The Participant'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 Participant, the provider, and the Claims Administrator, and will not exceed the standard Benefits available under this Plan.

The approval of alternative benefits is specific to each Participant for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this 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 Participant in any other instance.

### **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 in managing symptoms, in maximizing comfort, safety, autonomy and well-being, and in 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.

## **DEDUCTIBLES**

### **INDIVIDUAL COVERAGE DEDUCTIBLE (APPLICABLE TO 1 PARTICIPANT COVERAGE)**

This plan's Deductible is for services rendered by Preferred and Non-Preferred Providers combined.

The Calendar Year Deductible amount is shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan and must be satisfied once during each Calendar Year. After the Calendar Year Deductible

is satisfied for those Services to which it applies, Benefits will be provided for covered Services.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

Note: If you are enrolled in an Individual Deductible Plan, and have a newborn or a child placed for adoption, the child is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan. While the child's coverage is provided, you and this Dependent will be enrolled in the Family Coverage Deductible Plan. The Family Deductible amount as described in the Family Coverage Deductible section below will apply to you and this Dependent.

### **FAMILY COVERAGE DEDUCTIBLE (APPLICABLE TO 2 OR MORE PARTICIPANT COVERAGE)**

The Calendar Year per Family Deductible amount is shown in the Summary of Benefits. This Deductible must be made up of charges covered by the Plan, and must be satisfied once during each Calendar Year. Charges Incurred by one or all of the Family members in combination will be used to calculate the Calendar Year Family Coverage Deductible. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services to any and all Family members.

Charges in excess of the Allowable Amount do not apply toward the Deductible.

These Calendar Year Deductibles will count towards the Calendar Year maximum out-of-pocket responsibility.

### **SERVICES NOT SUBJECT TO THE DEDUCTIBLE**

The Calendar Year Deductible applies to all covered Services Incurred during a Calendar Year except for certain Services as listed in the Summary of Benefits.

### **PRIOR CARRIER DEDUCTIBLE CREDIT**

If you satisfied all or part of a medical Deductible under a health plan sponsored by your Employer or under an Individual and Family Health Plan (IFP) issued by the Benefits Administrator during the same Calendar Year this Plan becomes effective, that amount will be applied to the medical Deductible required under this Plan.

Note: This Prior Carrier Deductible Credit provision applies only to new Employees who are enrolling on the original effective date of this Plan, if this health Plan allows credit of the medical Deductible from the Employer's previous health plan.

### **NO PARTICIPANT MAXIMUM LIFETIME BENEFITS**

There is no maximum limit on the aggregate payments by the Plan for covered Services provided under the Plan.

## NO ANNUAL DOLLAR LIMIT ON ESSENTIAL BENEFITS

This Plan contains no annual dollar limits on essential benefits as defined by federal law.

## PAYMENT

The Participant Copayment amounts, applicable Deductibles, and Copayment maximum amounts for covered Services are shown in the Summary of Benefits. The Summary of Benefits also contains information on Benefit and Copayment maximums and restrictions.

Complete benefit descriptions may be found in the Principal Benefits and Coverages (Covered Services) section. Plan exclusions and limitations may be found in the Principal Limitations, Exceptions, Exclusions and Reductions section.

### Accessing Blue Cross and/or Blue Shield Providers

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services you may obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Plan”). In some instances, you may obtain care from non-participating healthcare providers. The Plan’s payment practices in both instances are described in this booklet.

**Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant’s liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits Booklet). However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.**

Whenever you access Covered Services and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to the Claims Administrator.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Plan 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 for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID Card.

### Accessing Covered Urgent Care and Emergency Services Outside the United States - BlueCard Worldwide

Benefits will also be provided for covered urgent and emergency services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (800-810-2583) or collect (804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call the Claims Administrator at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal) and select “Find a Doctor or Hospital” and “BlueCard Worldwide.”

### Special Cases: Value-Based Programs

#### Claims Administrator Value-Based Programs

You may have access to covered services from providers that participate in a Claims Administrator Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode



Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

If you receive covered services under a Claims Administrator Value-Based Program, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement.

### **BlueCard® Program**

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

### **Negotiated (non-BlueCard Program) Arrangements**

If Blue Shield has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Blue Shield will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

## **PARTICIPANT'S MAXIMUM CALENDAR YEAR COPAYMENT RESPONSIBILITY**

### **INDIVIDUAL COVERAGE (APPLICABLE TO 1 PARTICIPANT COVERAGE)**

The per Participant maximum out-of-pocket responsibility required each Calendar Year for covered Services is shown in the Summary of Benefits.

Once the maximum out-of-pocket responsibility has been met, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

### **FAMILY COVERAGE (APPLICABLE TO 2 OR MORE PARTICIPANT COVERAGE)**

The per Family maximum out-of-pocket responsibility required each Calendar Year for covered Services\* is shown in the Summary of Benefits. The Family maximum out-of-pocket responsibility will be satisfied by the Participant and all of his covered Dependents collectively.

Once the maximum out-of-pocket responsibility has been met\*, the Plan will pay 100% of the Allowable Amount for covered Services for the remainder of that Calendar Year.

\*Note: Certain Services and amounts are not included in the Calendar Year maximum out-of-pocket responsibility calculations. These items are shown in the Summary of Benefits.

Charges for Services which are not covered, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and Reduced Payments Incurred under the Benefits Management Program are the Participant's respon-

sibility and are not included in the Calendar Year maximum out-of-pocket responsibility calculations.

Charges for these items may cause a [Participant's payment responsibility to exceed](#) the [maximums](#).

Copayments and charges for Services not accruing to the Participant's maximum Calendar Year Copayment responsibility continue to be the Participant's responsibility after the Calendar Year Copayment maximum is reached.

## **PRINCIPAL BENEFITS AND COVERAGES (COVERED SERVICES)**

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

The Copayments for covered Services, if applicable, are shown on the Summary of Benefits.

Note: Except as may be specifically indicated, for Services received from Non-Preferred and Non-Participating Providers Participants will be responsible for all charges above the Allowable Amount in addition to the indicated dollar or percentage Participant Copayment.

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.

### **ACUPUNCTURE BENEFITS**

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.) or any licensed provider certified to provide acupuncture up to a per Participant per Calendar Year Benefit maximum as shown on the Summary of Benefits.

### **ALLERGY TESTING AND TREATMENT BENEFITS**

Benefits are provided for allergy testing and treatment.

### **AMBULANCE BENEFITS**

Benefits are provided for (1) Medically Necessary ambulance Services (surface and air) when used to transport a Participant from place of illness or injury to the closest medical facility where appropriate treatment can be received, or (2) Medically Necessary ambulance transportation from one medical facility to another.

## **AMBULATORY SURGERY CENTER BENEFITS**

Ambulatory surgery Services means surgery which does not require admission to a Hospital (or similar facility) as a registered bed patient.

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant'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.

Note: Reconstructive Surgery is only covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery or as authorized under the Transgender Benefit:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

## **AUTISM SPECTRUM DISORDERS (ASD) AND PERVASIVE DEVELOPMENTAL DISORDERS (PDD) BENEFITS**

The Claims Administrator's MHSA manages the Plan's Mental Health Services including a majority of the Benefits provided for the treatment of Autism Spectrum Disorders ASD and Pervasive Developmental Disorders PDD.

Benefits are provided for the treatment of Autism Spectrum Disorders (ASD)/ Pervasive Developmental Disorders (PDD), including Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder Not Otherwise Specified/Atypical Autism, Childhood Disintegrative Disorder (Heller's Syndrome), and Rett's Disorder. Covered treatment includes the following services: Behavioral Health Treatment including Applied Behavioral Analysis, speech therapy, physical therapy or occupational therapy. Applied Behavioral Analysis visits will not accumulate toward any visit maximums provided under the plan. Benefits will be provided in accordance with guidelines established by the Claims Administrator. Most services must be prior authorized by the Plan. See the Mental Health Benefits section for information on how to obtain prior authorization.

If prior authorization is received, the plan will pay for psychiatric services for autism spectrum disorders that are focused on treating a severe challenging behavior that presents a health or safety risk to self or others (such as self-injury, aggression toward others, destruction of property, stereotyped/repetitive behaviors, elopement, severe disruptive behavior); or significantly interferes with home or community activities.

Each case will be reviewed, diagnosis validated, and treatment plan evaluated for appropriateness, based on the level of care standards of the Claims Administrator's MHSA. Individual, family, and group therapy, medication management, and diagnosis and psychological testing services are covered when provided by appropriate licensed health care professionals. Applied Behavioral Analysis (ABA) services are covered when rendered by providers who have met established qualifications for certification by the Behavior Analyst Certification Board (known as "certified providers") or providers who perform services under supervision with a certified provider (known as "therapy assistants"). ABA coverage must be deemed medically necessary. Claims for ABA services should clearly list who provided the service (a certified provider/program manager or therapy assistant), the level of service, the date of service was provided, the time the service started and ended, and the hourly and total charge for the service. Services will be billed using the service codes designated for these services by the Claims Administrator.

The Claims Administrator will work with the Participant's physician or mental health professional to determine the appropriate level of care and duration of treatment that is necessary to decrease the symptoms that the Participant is currently experiencing. The Participant and Participant's physician or mental health professional will develop a treatment plan that will include specific behaviors/goals indicating that continuation of treatment is deemed necessary. All treatment goals will have measurable outcomes that are expected within defined timeframes. The Claims Administrator will review progress made as compared to the agreed upon treatment plan and determine appropriateness of continued treatment at least every six months.

Note: See the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) section for Occupational and

Physical Therapy Services related to the treatment of Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD). See the Speech Therapy Benefits section for Speech Therapy Services related to the treatment of Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD).

### **BARIATRIC SURGERY BENEFITS**

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

Bariatric surgery Services will be paid as any other surgery as described in the Summary of Benefits when:

1. Services are consistent with the Claims Administrator's medical policy; and,
2. prior authorization is obtained, in writing, from the Claims Administrator's Medical Director.

### **CHIROPRACTIC BENEFITS**

Benefits are provided for Medically Necessary Chiropractic Services rendered by a chiropractor. The chiropractic Benefit includes the initial and subsequent office visits, an initial examination, adjustments, conjunctive therapy, and X-ray Services up to the Benefit maximum.

Benefits are limited to a per Participant per Calendar Year visit maximum as shown on the Summary of Benefits. Additional visits may be allowed if Medically Necessary and prior authorized by the Claims Administrator.

Covered X-ray Services provided in conjunction with this Benefit have an additional Copayment as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

### **CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS**

Benefits are provided for routine patient care for a Participant who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by the Claims Administrator, and:

1. the clinical trial has a therapeutic intent and a Participating Provider determines that the Participant's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and
2. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

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 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.

An "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 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) 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 is interrupted.

## DIABETES CARE BENEFITS

### Diabetes Equipment

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

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;
4. visual aids, excluding eyewear and/or video-assisting 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 Benefit selected by your Employer through an entity other than the Claims Administrator as shown below:

CVS/Caremark at 1-(844)-287-1297.

### Diabetes Outpatient Self-Management Training

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Participant 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 Participant'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 thereby avoid frequent hospitalizations and complications. Services will be covered when provided by Physicians, registered dietitians or registered nurses who are certified diabetes educators.

## DIALYSIS CENTERS BENEFITS

Benefits are provided for Medically Necessary dialysis Services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

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

## DURABLE MEDICAL EQUIPMENT BENEFITS

Medically necessary Durable Medical Equipment 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 are covered. 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 pump and the home prothrombin monitor for specific conditions as determined by the Claims Administrator. 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 appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.

Medically necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section, except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;
2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item\*

\*This 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. (Note: For benefits for asthma inhalers and inhaler spacers, see the Outpatient prescription drug Benefit selected by your Employer through an entity other than the Claims Administrator as shown below:

CVS/Caremark at 1-(844)-287-1297.);

3. Breast pump rental or purchase is only covered if obtained from a designated Participating Provider in accordance with the Claims Administrator medical policy. For further information call Customer Service or go to [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal).

No benefits are provided for 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. No benefits are provided for backup or alternate items.

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

For Participants 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 Illness and related conditions are provided by the Hospice Agency.

## EMERGENCY ROOM BENEFITS

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician'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 Participant's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Note: Emergency Room Services resulting in an admission to a Non-Preferred Hospital which the Claims Administrator determines is not an emergency will be paid as part of the Inpatient Hospital Services. The Participant Copayment for non-emergency Inpatient Hospital Services from a Non-Preferred Hospital is shown on the Summary of Benefits.

## **FAMILY PLANNING BENEFITS**

Benefits are provided for the following Family Planning Services without illness or injury being present.

For Family Planning Services, for Plans with a Calendar Year Deductible for Services by Preferred Providers, the Calendar Year Deductible only applies to male sterilizations and to abortions.

Note: No benefits are provided for IUDs when used for non-contraceptive reasons except the removal to treat Medically Necessary Services related to complications.

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fitting or injectable contraceptives;
2. Intrauterine devices (IUDs), including insertion and/or removal;
3. Implantable contraceptives;
4. Injectable contraceptives when administered by a Physician;
5. Voluntary sterilization (tubal ligation and vasectomy) and abortion services;
6. Diaphragm fitting procedure.

## **HEARING AID BENEFITS**

### **Audiological Evaluation**

Benefits are provided for Audiological Evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

### **Hearing Aids and Ancillary Equipment**

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

The following services and supplies are not covered:

1. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
2. Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
3. Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any period of 24-month period;
4. Surgically implanted hearing devices.

## **HOME HEALTH CARE BENEFITS**

Benefits are provided for home health care Services when the Services are Medically Necessary, 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 that are prior authorized by the Claims Administrator are paid at the Preferred Benefit level.

Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Person 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 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2. or 3. above;
5. Medical social worker.

For the purpose of this Benefit, visits from home health aides of 4 hours or less shall be considered as one visit.

In conjunction with professional Services rendered by a home health agency, medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan are covered to the extent the Benefits would have been provided had the Participant remained in the Hospital or Skilled Nursing Facility.

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or the Outpatient prescription drug Benefit selected by your Employer through an entity other than the Claims Administrator as shown below:

CVS/Caremark at 1-(844)-287-1297.

Skilled Nursing Services are defined as a level of care that includes Services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: See the Hospice Program Services section for information about when a Participant is admitted into a Hospice Program and a specialized description of Skilled Nursing Services for hospice care.

Note: For information concerning diabetes self-management training, see the Diabetes Care Benefits section.

## **HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS**

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutritional Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency. Services from Non-Participating Home Infusion Agencies, shift care and private duty nursing that are prior authorized by the Claims Administrator are covered at the Preferred Benefit level.

This Benefit does not include medications, drugs, Insulin, Insulin syringes, certain Specialty Drugs and Services related to hemophilia which are described below and the Outpatient prescription drug Benefit selected by your Employer through an entity other than the Claims Administrator as shown below:

CVS/Caremark at 1-(844)-287-1297.

Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Note: Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Infusion Agency.

Note: Benefits for infusion therapy rendered by a Non-Preferred Provider which have not been prior authorized are limited to a Benefit maximum as shown on the Summary of Benefits.

Note: Services rendered by Non-Participating Home Health Care and Home Infusion Agencies that are prior authorized by the Claims Administrator are paid at the Preferred Benefit level.

### **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 the Claims Administrator (see the Benefits Management Program section for spe-

cific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling Customer Service at the telephone number shown on the last page of this booklet.

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

Following evaluation by your Physician, a prescription for a blood factor product must be submitted to and approved by the Claims Administrator. Once prior authorized by the Claims Administrator, 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 use by the Participant, 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 Preferred Hemophilia Infusion Provider, and Medically Necessary Services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other medical benefits described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

This Benefit does not include:

1. physical therapy, gene therapy or medications including antifibrinolytic and hormone medications\*;
2. services from a hemophilia treatment center or any Non-Preferred 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 the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), the Outpatient prescription drug Benefit selected by your Employer through an entity other than the Claims Administrator as shown below:

CVS/Caremark at 1-(844)-287-1297,

or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

## **HOSPICE PROGRAM BENEFITS**

Benefits are provided for the following Services through a Hospice Agency when an eligible Participant requests admission to and is formally admitted to an approved Hospice Program. The Participant must have a Terminal Illness as determined by their Physician's certification and the admission must receive prior approval from the Claims Administrator. (Note: Participants with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Hospice Agency.) Covered Ser-

vices are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Participants can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider. Note: Hospice Services provided by a Non-Participating hospice agency are covered at the Non-Preferred Benefit level if Services are not prior authorized. If Non-Participating Hospice Services are prior authorized by the Claims Administrator, Benefits will be paid at the Preferred Benefit level.

All of the Services listed below must be received through a Hospice Agency.

1. Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (Participants do not have to be enrolled in the Hospice Program to receive this Benefit).
2. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
3. Skilled Nursing Services, certified health aide Services and homemaker Services under the supervision of a qualified registered nurse.
4. Bereavement Services.
5. Social Services/Counseling Services with medical social Services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
6. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Participant to the extent that these needs are not met by the Participant's other providers.
7. Volunteer Services.
8. Short-term Inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology Services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
11. Nursing care Services are covered on a continuous basis for as much as 24 hours a day during Periods of Crisis as necessary to maintain a Participant at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods of Crisis but the care provided during these periods must be predominantly nursing care.
12. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Participants are allowed to change their Participating Hospice Agency only once during each Period of Care. Participants can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Provider recertifies that the Participant is Terminally ill.

## DEFINITIONS

**Bereavement Services** - services available to the immediate surviving family members for a period of at least one year after the death of the Participant. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Participant.

**Continuous Home Care** - home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

**Home Health Aide Services** - services providing for the personal care of the Terminally Ill Participant and the performance of related tasks in the Participant's home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

**Homemaker Services** - services that assist in the maintenance of a safe and healthy environment and services to enable the Participant to carry out the treatment plan.

**Hospice Service or Hospice Program** - a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Participant who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

1. Considers the Participant and the Participant's family in addition to the Participant, as the unit of care.
2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Participant and their family.
3. Requires the interdisciplinary team to develop an overall Plan of Care and to provide coordinated care which em-

phasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.
5. Provides for Bereavement Services following the Participant's death to assist the family to cope with social and emotional needs associated with the death.
6. Actively utilizes volunteers in the delivery of Hospice Services.
7. Provides Services in the Participant's home or primary place of residence to the extent appropriate based on the medical needs of the Participant.
8. Is provided through a Participating Hospice.

**Interdisciplinary Team** - the hospice care team that includes, but is not limited to, the Participant and their family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

**Medical Direction** - Services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Participant's Provider, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these Services shall be referred to as the "medical director".

**Period of Care** - the time when the Participating Provider recertifies that the Participant still needs and remains eligible for hospice care even if the Participant lives longer than one year. A Period of Care starts the day the Participant begins to receive hospice care and ends when the 90 or 60- day period has ended.

**Period of Crisis** - a period in which the Participant requires continuous care to achieve palliation or management of acute medical symptoms.

**Plan of Care** - a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Participant and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of Services delivered.

**Respite Care Services** – short-term Inpatient care provided to the Participant only when necessary to relieve the family members or other persons caring for the Participant.

**Skilled Nursing Services** - nursing Services provided by or under the supervision of a registered nurse under a Plan of

Care developed by the Interdisciplinary Team and the Participant's provider to the Participant and his family that pertain to the palliative, supportive services required by the Participant with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Participant assessment, evaluation, and case management of the medical nursing needs of the Participant, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Participant and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of Services for the Participant and his family and are available on a 24-hour on-call basis.

**Social Service/Counseling Services** - those counseling and spiritual Services that assist the Participant and his family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

**Terminal Disease or Terminal Illness** - a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

**Volunteer Services** - Services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Participant and his family during the remaining days of the Participant's life and to the surviving family following the Participant's death.

## **HOSPITAL BENEFITS (FACILITY SERVICES)**

**(Other than Infertility Benefits, Mental Health Benefits, Hospice Program Benefits, Skilled Nursing Facility Benefits, and Dialysis Center Benefits which are described elsewhere under Covered Services)**

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

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3. In conjunction with a covered delivery, routine nursery care for a newborn of the Participant, covered spouse or Domestic Partner.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of pros-



thetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
6. Rehabilitation when furnished by the Hospital and approved in advance by the Claims Administrator under its Benefits Management Program.
7. Drugs and oxygen.
8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
9. X-ray examination and laboratory tests.
10. Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
11. Use of medical appliances and equipment.
12. Subacute Care.
13. 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 Participant is under the age of seven or developmentally disabled regardless of age or when the Participant'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.
14. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Participant is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the MHSA.

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

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.
2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.
3. Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
4. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. For coverage of prosthetic devices incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery or as authorized under the Enhanced Transgender benefit:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a Hospital because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant'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.

6. Outpatient routine newborn circumcisions.\*

Covered Physical Therapy and Speech Therapy Services provided in an Outpatient Hospital setting are described under the Rehabilitation (Physical, Occupational and Respiratory Therapy) Benefits and Speech Therapy Benefits sections.

## INFERTILITY BENEFITS

Only the Participant, spouse or Domestic Partner is entitled to benefits under this Infertility benefit. Infertility Services include all professional, Hospital, ambulatory surgery center, and ancillary Services and injectable drugs administered or prescribed by a Physician to a Participant, spouse or Domestic Partner covered hereunder to diagnose and treat the cause of Infertility including inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility means the Participant must actively be trying to conceive and has, with respect to a Participant, spouse or Domestic Partner covered hereunder:

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive, or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
4. three or more pregnancy losses.

### Benefits

Benefits are provided for a medically appropriate diagnostic work-up and the following procedures per lifetime for a Participant, spouse or Domestic Partner who is covered within and has a current diagnosis of Infertility:

1. Natural (without ovum [oocyte or ovarian tissue (egg)] stimulation) artificial inseminations up to the combined per Participant lifetime Benefit maximum as shown on the Summary of Benefits;
2. Stimulated (with ovum [oocyte or ovarian tissue] stimulation) artificial inseminations up to the combined per Participant lifetime Benefit maximum as shown on the Summary of Benefits;
3. Gamete intrafallopian transfer (GIFT), Zygote intrafallopian transfer (ZIFT) and In vitro fertilization (IVF) up to the combined per Participant lifetime Benefit maximum as shown on the Summary of Benefits;
4. Sperm purchase for artificial insemination from a sperm bank;
5. Cryopreservation of sperm/oocytes/embryos when retrieved from a Participant, spouse or Domestic Partner covered within. Benefits include cryopreservation Ser-

vices for a condition which the treating Physician anticipates will cause Infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). Benefits are limited to one retrieval and 1 year of storage per Participant per lifetime.

Note: Infertility Benefits are limited to a per Participant lifetime Benefit maximum, except for diagnosis and treatment of cause of Infertility, as shown on the Summary of Benefits. Once the maximum Benefit has been reached for the above procedures, no services related to or performed in conjunction with the procedures will be covered.

Procedures must be consistent with established medical practice in the treatment of Infertility and authorized by the Claims Administrator.

No benefits are provided for:

1. Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which covered Services are provided only under the medical benefits portion of your Benefit Booklet;
2. Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Claims Administrator health plan, covered Services for Pregnancy and Maternity Care for the surrogate mother will be covered under that health plan;
3. Services for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Participant or enrolled spouse or enrolled Domestic Partner as defined, except as specifically listed;
4. Covered Services in excess of the per Participant lifetime Benefit maximum;
5. Services for or incident to a condition which the Participant anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of sperm/oocytes/ovarian tissue/embryos;
5. Any services not specifically listed as a covered Service, above.

Benefits are limited to a Participant, spouse or Domestic Partner covered hereunder who has diagnosed Infertility as defined at the time services are provided.

## MEDICAL TREATMENT OF THE TEETH, GUMS, JAW JOINTS OR 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. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary

Services until the Services result in initial, palliative stabilization of the Participant as determined by the Plan;

Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.

3. Medically Necessary 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. Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones);
6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or
7. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

1. services performed on the teeth, gums (other than for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair) and associated periodontal structures, routine care of teeth and gums, diagnostic services, preventive or periodontic services, dental orthoses and prostheses, including hospitalization incident thereto;
2. orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except for orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair), including treatment to alleviate TMJ;
3. dental implants (endosteal, subperiosteal or transosteal);
4. any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
5. 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;
6. fluoride treatments except when used with radiation therapy to the oral cavity.

See Principal Limitations, Exceptions, Exclusions and Reductions, General Exclusions for additional services that are not covered.

## **MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS**

See the Out-Of-Area Program, BlueCard Program section for an explanation of how payment is made for out of state services. The Claims Administrator's MHSA manages the Plan's Mental Health Services.

For Non-Emergency Inpatient Mental Health and Substance Abuse Services, including Residential Care, and Non-Routine Outpatient Mental Health and Substance Abuse Services are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the Benefits Management Program section for complete information.

### **Routine Outpatient Mental Health and Substance Abuse Services**

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

### **Non-Routine Outpatient Mental Health and Substance Abuse Services**

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

1. Behavioral Health Treatment (BHT) for Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD) –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 Claims Administrator.

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.

Note: See the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy) section for Occupational and Physical Therapy Services related to the treatment of Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD). See the Speech Therapy Benefits section for Speech Therapy Services related to the treatment of Autism Spectrum Disorders (ASD)/Pervasive Developmental Disorders (PDD).

2. Residential Care Program for Mental Health Condition

Benefits are provided for 24-hour care in a residential treatment facility pursuant to written, specific and detailed treatment programs for full-time participating clients under the direction of an administrator and Physician for chronic mental health conditions. Residential Care Program Services must be prior authorized by the MHSA.

The residential facility cannot accept or retain clients who require Inpatient Hospital level or acute psychiatric care.

3. Residential Care Program for Substance Abuse Condition

Benefits are provided for structured 24-hour residential services designed to promote treatment and maintain recovery from the recurrent use of alcohol, drugs, and/or related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

The residential facility cannot accept or retain clients who require Inpatient Hospital level or acute psychiatric care.

4. 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.
5. Intensive Outpatient Program - an Outpatient mental health or substance abuse treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
6. Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment
7. Partial Hospitalization Program – an Outpatient treatment program that may be freestanding 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.
8. Psychological Testing - testing to diagnose a Mental Health Condition when referred by a Participating Provider.
9. Transcranial Magnetic Stimulation - a noninvasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

### **Inpatient Services**

Benefits are provided for Inpatient Hospital and professional Services in connection with acute hospitalization for the treatment of Mental Health Conditions or Substance Abuse Conditions.

Benefits are provided for Inpatient and professional Services in connection with a Residential Care admission for the treatment of Mental Health Conditions or Substance Abuse Conditions.

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

### **ORTHOTICS BENEFITS**

Benefits are provided for orthotic appliances, including:

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. Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
4. Medically Necessary 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 replacement after the expected life of the orthosis is covered.

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. 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. No benefits are provided for backup or alternate items.

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

### **OUTPATIENT X-RAY, PATHOLOGY AND LABORATORY BENEFITS**

Benefits are provided for diagnostic X-ray Services, diagnostic examinations, clinical pathology, and laboratory Services, when provided to diagnose illness or injury. Routine laboratory Services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Benefits are provided for genetic testing for certain conditions when the Participant 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 and determined to be Medically Necessary and appropriate in accordance with the Claims Administrator medical policy. (Note: See the section on Pregnancy and Maternity Care Benefits for genetic testing for prenatal diagnosis of genetic disorders of the fetus).

See the section on Radiological and Nuclear Imaging Benefits and the Benefits Management Program section for radiological procedures which require prior authorization by the Claims Administrator.

## **PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS BENEFITS**

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) or any condition in which it is the only source of nutrition in a life-sustaining situation to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU as well as any condition in which it is the only source of nutrition in a life-sustaining situation. All Benefits must be prescribed and/or ordered by the appropriate health care professional.

## **PODIATRIC BENEFITS**

Podiatric Services include office visits, surgical procedures, and other covered Services customarily provided by a licensed doctor of podiatric medicine. Covered surgical procedures provided in conjunction with this Benefit, are described under the Professional (Physician) Benefits section. Covered lab and x-ray Services provided in conjunction with this Benefit are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

## **PREGNANCY AND MATERNITY CARE BENEFITS**

Benefits are provided for maternity Services, which include prenatal care, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy, Outpatient maternity Services, involuntary complications of pregnancy, and Inpatient Hospital maternity care including labor, delivery and post-delivery care. Involuntary complications of pregnancy include puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia. (Note: See the section on Outpatient X-ray, Pathology and Laboratory Benefits for information on coverage of other genetic testing and diagnostic procedures.) No benefits are provided for services after termination of coverage under this Plan unless the Participant qualifies for an extension of Benefits as described elsewhere in this booklet.

Note: The Newborns' and Mothers' Health Protection Act requires group 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.

## **PREVENTIVE HEALTH BENEFITS**

Preventive Health Services, as defined, are covered.

## **PROFESSIONAL (PHYSICIAN) BENEFITS**

**(Other than Infertility Benefits, Preventive Health Benefit, Mental Health Benefits, Hospice Program Benefits and Dialysis Center Benefits which are described elsewhere under Covered Services.)**

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 below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician 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 Preferred Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found in the Preferred Provider Directory or the Online Physician Directory located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal).

Benefits are provided for Services of Physicians for treatment of illness or injury, and for treatment of physical complications of a mastectomy, including lymphedemas, as indicated below.

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
4. Asthma self-management training and education to enable a Participant 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. When multiple surgical procedures are performed during the same operation, benefits for the secondary procedure(s) will be determined based on the Claims Administrator Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;
8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery 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 the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery or as authorized under the Enhanced Transgender benefit:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10. Extra time spent when a Physician is detained to treat a Participant in critical condition;
11. Necessary preoperative treatment;
12. Treatment of burns;
13. Outpatient routine newborn circumcisions.
14. Diagnostic audiometry examination.
15. Teladoc consultations. Teladoc consultation Services provide confidential consultations using a network of board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. by secure online video, 7 days a week. If your Personal Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 800-Teladoc (800-835-2362) or visit [www.teladoc.com/bsc](http://www.teladoc.com/bsc). The Teladoc Physician can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for 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 Personal Physician but are a supplemental service. You do not need to con-

tact your Personal Physician before using Teladoc consultation Services.

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

## PROSTHETIC APPLIANCES BENEFITS

Medically Necessary Prostheses for Activities of Daily Living are covered. 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 appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. See General Exclusions under the Principal Limitations, Exceptions, Exclusions and Reductions section for a listing of excluded speech and language assistance devices.

Benefits are provided for Medically Necessary Prostheses for Activities of Daily Living, including the following:

1. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy;
2. Artificial limbs and eyes;
3. Supplies necessary for the operation of Prostheses;
4. Initial fitting and replacement after the expected life of the item;
5. Repairs, even if due to damage.

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

Benefits are provided for eye glasses or contact lenses, if Medically Necessary to treat eye conditions such as keratoconus, keratitis sicca or aphakia following cataract surgery when no intraocular lens has been implanted.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see Reconstructive Surgery under Professional (Physician) Benefits. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

## RADIOLOGICAL AND NUCLEAR IMAGING BENEFITS

The following radiological procedures, when performed on an Outpatient, non-emergency basis, require prior authorization by the Claims Administrator under the Benefits Management Program. Failure to obtain this authorization may result in non-payment if the Claims Administrator determines the service was not a covered Services.

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. any cardiac diagnostic procedure utilizing Nuclear Medicine.

## **REHABILITATION BENEFITS (PHYSICAL, OCCUPATIONAL AND RESPIRATORY THERAPY)**

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan and when rendered in the provider's office or Outpatient department of a Hospital. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. The Claims Administrator reserves the right to periodically review the provider's treatment plan and records. If the Claims Administrator determines that continued treatment is not Medically Necessary, the Claims Administrator will notify the Participant of this determination and benefits will not be provided for services rendered after the date of the written notification.

Services provided by a chiropractor are not included in this Rehabilitation Benefit. See the section on Chiropractic Benefits.

Note: Outpatient Occupational and Physical Therapy Benefits are limited to a combined per Participant per Calendar Year Benefit maximum as shown on the Summary of Benefits. Additional visits may be allowed if Medically Necessary and prior authorized by the Claims Administrator.

Note: See the Home Health Care Benefits and Hospice Program Benefits sections for information on coverage for Rehabilitation Services rendered in the home.

Note: Covered lab and X-ray Services provided in conjunction with this Benefit are paid as shown under the Outpatient X-ray, Pathology and Laboratory Benefits section.

## **SKILLED NURSING FACILITY BENEFITS (Other than Hospice Program Benefits which are described elsewhere under Covered Services.)**

Benefits are provided for Medically Necessary Services provided by a Skilled Nursing Facility Unit of a Hospital or by a free-standing Skilled Nursing Facility.

Benefits are provided for confinement in a Skilled Nursing Facility or Skilled Nursing Facility Unit of a Hospital up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Participant per Calendar Year, except that room and board charges in excess of the facility's established semi-private room rate are excluded.

## **SPEECH THERAPY BENEFITS**

Benefits are provided for Medically Necessary outpatient Speech Therapy services when ordered by a Physician and

provided by a licensed speech therapist/pathologist, or other appropriately licensed or certified Health Care Provider pursuant to a written treatment plan to correct or improve (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, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records may be reviewed periodically for Medical Necessity. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist/pathologist, the Participant will be notified of this determination and benefits will not be provided for services rendered after the date of written notification.

Except as specified above and as stated under the Home Health Care Benefits and the Hospice Program Benefits sections, no Outpatient benefits are provided for Speech Therapy, speech correction, or speech pathology services.

Note: See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Speech Therapy Services rendered in the home. See the *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

## **TRANSGENDER BENEFITS**

### **Benefits**

Benefits are provided for the following Services and no others, for a physician diagnosis of gender identity disorder (gender dysphoria) to Members who meet recognized clinical criteria guidelines:

### **Transgender Surgical Services**

Subject to the Plan hospital and professional physician service copayments as shown on the Summary of Benefits and the lifetime maximum, Hospital and Professional Services are provided for transgender surgical services.

Benefits will be provided in accordance with guidelines established by the Claims Administrator. These services must be prior authorized by the Plan. Benefits are limited to a maximum per Participant per lifetime Benefit for Transgender Surgical Services as shown on the Summary of Benefits except for Medically Necessary services to treat medical complications of these surgeries.

Calculating this maximum lifetime allowance amount for the Transgender Surgical Services is determined by totaling the covered Hospital and Professional Transgender Surgical Services while covered under this Plan, or while covered under any prior or subsequent health plan.

You are responsible for the cost of any Transgender Surgical

Services which are in excess of this lifetime Benefit allowance.

The Claims Administrator has a Plan transgender network of contracted hospital and transgender surgery providers. Services received from a non-network provider are not covered unless prior authorized by the Claims Administrator. When authorized by the Claims Administrator, the non-network provider will be reimbursed at a rate determined by the Claims Administrator and the non-network provider.

### **Plan Principal Limitations, Exceptions, Exclusions and Reductions**

This Benefit is subject to the principal limitations, exceptions, exclusions and reductions listed in your booklet with the exception of the exclusions for transgender or gender dysphoria conditions, reconstructive surgery and penial implant devices and surgery and related services.

## **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 Participant 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 the Claims Administrator 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 the Claims Administrator, (2) prior authorization is obtained, in writing, from the Claims Administrator's Medical Director and (3) the recipient of the transplant is a Participant. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility may result in non-payment if the Claims Administrator determines the service was not a covered Service.

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.

## **TRAVEL AND UNRELATED DONOR SEARCH BENEFITS**

Benefits are provided for authorized travel expenses in connection with an organ transplant up to a per organ transplant Benefit maximum as shown on the Summary of Benefits.

Benefits are provided for unrelated donor searches for bone marrow/stem cell transplants up to a per transplant Benefit maximum as shown on the Summary of Benefits.

## **WIG BENEFITS**

Benefits are provided for wigs or other scalp prostheses when Medically Necessary due to hair loss. Benefits are limited to a per Participant Benefit maximum every two years as shown on the Summary of Benefits.

## **PRINCIPAL LIMITATIONS, EXCEPTIONS, EXCLUSIONS AND REDUCTIONS**

### **GENERAL EXCLUSIONS AND LIMITATIONS**

Unless exceptions to the following exclusions are specifically made elsewhere in this booklet, no benefits are provided for the following services or supplies which are:

1. 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 Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or domiciliary care, except as provided under Hospice Program Benefits;;
4. performed in a Hospital by house officers, residents, interns and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Participant's home;
6. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;



7. for hearing aids, except as specifically listed under Hearing Aid Benefits;
8. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
9. for 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;
10. for routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;
11. for or incident to acupuncture, except as may be provided under Acupuncture Benefits;
12. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;
13. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA); 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;
14. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to Medically Necessary Services which the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
15. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
16. 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 as specifically listed under Infertility Benefits and for Medically Necessary treatment of medical complications;
17. for 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; for 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; or muscle trauma due to exertion; or any type of massage procedure on the foot;
18. which are Experimental or Investigational in nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;
19. for 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 the Claims Administrator is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;
20. hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
21. 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 Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
22. for or incident to services and supplies for treatment of the teeth and gums (except for tumors 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, 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 Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
23. incident to organ transplant, except as explicitly listed under Transplant Benefits;
24. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the Claims Administrator consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
  - Lower eyelid blepharoplasty;

- Spider veins;
  - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures) except as specifically provided under the Enhanced Transgender Benefit;
  - Hair removal by electrolysis or other means except as specifically provided under the Enhanced Transgender Benefit; and
  - Reimplantation of breast implants originally provided for cosmetic augmentation except as specifically provided under the Enhanced Transgender Benefit; and
  - Voice modification surgery.
25. for Reconstructive Surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:
- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body.
  - Surgery to reform or reshape skin or bone.
  - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body.
  - Hair transplantation.
  - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.
- This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;
26. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;
27. for which the Participant is not legally obligated to pay, or for services for which no charge is made;
28. 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 workers' compensation law, occupational disease law or similar legislation. However, if the Claims Administrator provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Claims Administrator for the treatment of such injury or disease;
29. 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;
30. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefit and except as provided through a Participating Hospice Agency;
31. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;
32. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;
33. for 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 Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
34. for 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, except as specifically listed under Infertility Benefits, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy Benefits under the Claims Administrator health plan;
35. for services provided by an individual or entity that is not licensed, certified, or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification, or state authorization, except as specifically stated herein;
36. for massage therapy performed by a massage therapist;
37. for Outpatient prescription drugs;
38. for prescribed drugs and medicines for Outpatient care except as provided through a Participating Hospice Agency when the Participant is receiving Hospice Services and except as may be provided under the Outpatient Prescription Drugs Supplement or Home Infusion/Home Injectable Therapy Benefits in the Covered Services section;
39. for or incident to conditions that result from your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence;
40. for or incident to Services or supplies provided pursuant to a private contract between the member and a provider,

for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act;

41. for food items, nutritional supplements (unless they are the only source of nutrition in a life-sustaining situation), vitamins, medical foods and formulas, even if they are the sole source of nutrition. Note: the plans, however reimburse over-the-counter nutritional supplements for Phenylketonuria (PKU) when administered under a physician's direction;
42. not specifically listed as a Benefit.

## **MEDICAL NECESSITY EXCLUSION**

The Benefits of this Plan are intended 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. The Claims Administrator reserves the right to review all claims to determine if a service or supply is medically necessary. The Claims Administrator may use the services of Doctor of Medicine consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims. The Claims Administrator may limit or exclude benefits for services which are not necessary.

## **LIMITATIONS FOR DUPLICATE COVERAGE**

### **When a Participant is eligible for Medicare**

1. The Claims Administrator group plan will provide benefits before Medicare in the following situations:
  - a. When the Employee or his/her spouse is eligible for Medicare due to age, if the Employee is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
  - b. When the Participant is eligible for Medicare due to disability, if the Employee is actively working for a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
  - c. When a Participant is eligible for Medicare solely due to end-stage renal disease during the first 30 months that he or she is eligible to receive benefits for end-stage renal disease from Medicare.
2. Your Claims Administrator group plan will provide benefits after Medicare in the following situations:
  - a. When the Employee or his/her spouse is eligible for Medicare due to age, if the Employee is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
  - b. When the Participant is eligible for Medicare due to disability, if the Employee is covered by a group that

employs less than 100 employees (as defined by Medicare Secondary Payer laws).

- c. When the Employee 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 Employee is retired and the Employee or his/her spouse is age 65 years or older.

When your Claims Administrator group plan provides benefits after Medicare, the combined benefits from Medicare and your Claims Administrator group plan may be lower but will not exceed the Medicare allowed amount. Your Claims Administrator group plan Deductible and Copayments will be waived.

### **When you are eligible for Medicaid**

Medicaid always provides benefits last.

### **When you are a qualified veteran**

If you are a qualified veteran your Claims Administrator group plan will pay the reasonable value or the Claims Administrator's Allowable Amount for covered Services provided to you at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, your Claims Administrator group plan will pay the reasonable value or the Claims Administrator's Allowable Amount for covered Services provided to you at a Department of Defense facility, even if provided for conditions related to military service.

### **When you are covered by another government agency**

If you are also 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 your Claims Administrator group plan will equal, but not exceed, what the Claims Administrator would have paid if you were not eligible to receive benefits under that coverage (based on the reasonable value or the Claims Administrator's Allowable Amount).

Contact the Customer Service department at the telephone number shown at the end of this document if you have any questions about how the Claims Administrator coordinates your group plan benefits in the above situations.

## **EXCEPTION FOR OTHER COVERAGE**

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

## **CLAIMS REVIEW**

The Claims Administrator reserves the right to review all claims to determine if any exclusions or other limitations apply. The Claims Administrator may use the services of Physician consultants, peer review committees of profes-

sional societies or Hospitals and other consultants to evaluate claims.

## **REDUCTIONS – THIRD PARTY LIABILITY**

If a Participant is injured or becomes ill due to the act or omission of another person (a “third party”), the Plan shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover amounts the Claims Administrator paid for the Services provided to the Participant on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Participant, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

The Claims Administrator’s right to restitution, reimbursement or other available remedy is against any recovery the Participant receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the “Recovery”), without regard to whether the Participant has been “made whole” by the Recovery. The Claims Administrator’s right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due the Claims Administrator for the Benefits it paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The Participant is required to:

1. Notify the Claims Administrator in writing of any actual or potential claim or legal action which such Participant expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and
3. Agree in writing to reimburse the Claims Administrator for Benefits paid by the Claims Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and
4. Provide the Plan with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party’s agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Periodically respond to information requests regarding the claim against the third party, and notify the Claims Administrator, in writing, within 10 days after any Recovery has been obtained.

A Participant’s failure to comply with 1. through 5. above shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan or the Claims Administrator.

Further, if the Participant receives Services from a Participating Hospital for such injuries or illness, the Hospital has the right to collect from the Participant the difference between the amount paid by the Plan and the Hospital’s reasonable and necessary charges for such Services when payment or reimbursement is received by the Participant for medical expenses. The Hospital’s right to collect shall be in accordance with California Civil Code Section 3045.1.

## **THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”), THE FOLLOWING THIRD PARTY LIABILITY SECTION APPLIES.**

If a Participant’s injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable or paid under the Plan unless the Participant agrees in writing, in a form satisfactory to the Plan, to do all of the following:

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

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

“Recovery” includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any

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

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

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

## **COORDINATION OF BENEFITS**

When a Participant who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for Hospital or medical expenses, such Participant will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any Calendar Year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are Incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit value or amount payable by each plan separately.

If the covered Participant is also entitled to benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the Benefits of this Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the Participant as an employee will provide

its benefits before the plan covering the Participant as a Dependent.

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the Dependent child of a Participant whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, shall determine its benefits before a plan which covers the Dependent child of a Participant whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the patient for the longer period of time will determine its benefits first, provided that:
  - a. a plan covering a Participant as a laid-off or retired Employee, or as a Dependent of that Participant will determine its benefits after any other plan covering that Participant as an Employee, other than a laid-off or retired Employee, or such Dependent; and
  - b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

If this Plan is the primary carrier in the case of a covered Participant, then this Plan will provide its Benefits without making any reduction because of benefits available from any other plan, except that Physician Members and other Participating Providers may collect any difference between their billed charges and this Plan's payment, from the secondary carrier(s).

If this Plan is the secondary carrier in the order of payments, and the Claims Administrator is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Participant (1) assigns to the Claims Administrator the right to receive benefits from the

other plan to the extent of the difference between the benefits which the Claims Administrator actually pays and the value of the Benefits that the Claims Administrator would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, the Claims Administrator may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan. The Claims Administrator shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by the Claims Administrator in excess of the maximum amount of payment necessary to satisfy these provisions, the Claims Administrator shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

The Claims Administrator may release to or obtain from any organization or person any information which the Claims Administrator considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish the Claims Administrator with such information as may be necessary to implement these provisions.

## **TERMINATION OF BENEFITS**

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 for services provided following termination of this health Plan.

Coverage for Participants terminates at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Plan is discontinued, (2) the last day of the month in which the Employee's employment terminates, unless a different date has been agreed to between the Claims Administrator and your Employer, (3) the date as indicated in the Notice Confirming Termination of Coverage that is sent to the Employer; or (4) the last day of the month in which Participants become ineligible. A spouse also becomes ineligible following legal separation from the Employee, entry of a final decree of divorce, annulment or dissolution of marriage from the Employee. A Domestic Partner becomes ineligible upon termination of the domestic partnership.

If you cease work because of retirement, disability, leave of absence, temporary layoff, or termination, see your Employer about possibly continuing group coverage. Also see the Continuation of Group Coverage provision in this booklet for information on continuation of coverage.

If your 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), your payment of fees will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

The Claims Administrator may terminate a Participant's coverage for cause immediately upon written notice to the Participant and the Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to the Employer or the Claims Administrator;
2. Permitting use of your identification card by someone other than a Participant to obtain Services; or
3. Obtaining or attempting to obtain Services under the Plan by means of false, materially misleading, or fraudulent information, acts or omissions.

If a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by the Claims Administrator within the 31 days following that Dependent's effective date of coverage, Benefits under this Plan will be terminated on the 31<sup>st</sup> day at 11:59 p.m. Pacific Time.

## **EXTENSION OF BENEFITS**

If a Participant becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Plan terminates, the Claims Administrator will extend the Benefits of this Plan, 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) 12 months from the date coverage terminated; (2) the date the covered Participant is no longer Totally Disabled; (3) the date on which the covered Participant's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Participant. The time the Participant was covered under this Plan will apply toward the replacement plan's pre-existing condition exclusion.

No extension will be granted unless the Claims Administrator receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Claims Administrator.

## **GROUP CONTINUATION COVERAGE**

### **CONTINUATION OF GROUP COVERAGE**

Please examine your options carefully before declining this coverage. Participants should be aware that companies selling individual health insurance typically require a review of medical history that could result in a higher premium or denial of coverage entirely.

Applicable to Members when the Employer is subject to Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, a Participant will be entitled to elect to continue group coverage under this Plan if the Participant would otherwise lose coverage because of a Qualifying Event that occurs while the Employer is subject to the continuation of group coverage provisions of COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Participant if the Qualifying Event had not occurred (including any changes in such coverage).

Under COBRA, a Participant is entitled to benefits if at the time of the qualifying event such Participant 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 Participant:
  - 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 an Employee, spouse or Domestic Partner during a COBRA continuation period may be immediately added as Dependents, provided the Employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):

\*Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Participant elects to enroll.

- a. the death of the Employee; or
- b. the termination of the Employee's employment (other than by reason of such Employee's gross misconduct); or
- c. the reduction of the Employee's hours of employment to less than the number of hours required for eligibility; or
- d. the divorce or legal separation of the Employee from the Dependent spouse or termination of the domestic partnership; or
- e. the Employee'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.

3. With respect to an Employee 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.

### **Notification of a Qualifying Event**

The Employee 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 Employee's death, termination, or reduction of hours of employment, the Participant'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 Participant by first class mail of the Participant's right to continue group coverage under this Plan. The Participant must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Participant's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Participant does not notify the COBRA administrator within 60 days, the Participant's coverage will terminate on the date the Participant would have lost coverage because of the Qualifying Event.

### **Duration and Extension of Continuation of Group Coverage**

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

### **Payment of Dues**

Dues for the Participant continuing coverage shall be 102 percent of the applicable group dues rate, except for the Participant who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150 percent of the applicable group dues rate.

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

### **Effective Date of the Continuation of Coverage**

The continuation of coverage will begin on the date the Participant'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 dues are timely paid.

### **Termination of Continuation of Group 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 plan (if the Employer continues to provide any group benefit plan for employees, the Participant may be able to continue coverage with another plan);
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to the Claims Administrator as applicable. Coverage will end as of the end of the period for which dues were paid;
3. the Participant becomes covered under another group health plan;
4. the Participant becomes entitled to Medicare;
5. the Participant commits fraud or deception in the use of the Services of this Plan.

Continuation of group coverage in accordance with COBRA will not be terminated except as described in this provision.

### **CONTINUATION OF GROUP COVERAGE FOR MEMBERS ON MILITARY LEAVE**

Continuation of group coverage is available for Members on military leave if the Participant'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, and Labor Code requirements for Medical Disability.

## **GENERAL PROVISIONS**

### **LIABILITY OF PARTICIPANTS IN THE EVENT OF NON-PAYMENT BY THE CLAIMS ADMINISTRATOR**

In accordance with the Claims Administrator's established policies, and by statute, every contract between the Claims Administrator and its Participating Providers and Preferred Providers stipulates that the Participant shall not be responsi-

ble to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Participant's Plan. Participating Providers and Preferred Providers have agreed to accept the Plan's payment as payment-in-full for covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Participant is responsible for all amounts the Claims Administrator does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Participant is responsible for any charges above the Benefit maximums.

### **INDEPENDENT CONTRACTORS**

Providers are neither agents nor employees of the Plan or the Claims Administrator but are independent contractors. In no instance shall the Plan or the Claims Administrator 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.

### **NON-ASSIGNABILITY**

Coverage or any Benefits of this Plan may not be assigned without the written consent of the Plan and the Claims Administrator. Possession of an ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Participant must be a Participant who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment under the terms of this Plan.

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

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

### **PLAN INTERPRETATION**

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



## **CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION**

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

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

The Claims Administrator's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the number listed on the back of this booklet, or by accessing the Claims Administrator's internet site located at [www.blueshieldca.com/paypal](http://www.blueshieldca.com/paypal) and printing a copy.

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

### **Correspondence Address:**

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

### **Toll-Free Telephone:**

888-266-8080

### **Email Address:**

[blueshieldca\\_privacy@blueshieldca.com](mailto:blueshieldca_privacy@blueshieldca.com)

## **ACCESS TO INFORMATION**

The Claims Administrator may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Plan. You agree that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. You agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in your possession. Failure to assist the Claims Administrator in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by the Claims Administrator will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

## **RIGHT OF RECOVERY**

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

## **CUSTOMER SERVICE**

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

The hearing impaired may contact the Customer Service Department through the Claims Administrator's toll-free TTY number, 800-241-1823.

Customer Service can answer many questions over the telephone.

Note: The Claims Administrator has established a procedure for Participants to request an expedited decision. A Participant, Physician, or representative of a Participant may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Participant, or when the Participant is experiencing severe pain. The Claims Administrator shall make a decision and notify the Participant and Physician as soon as possible to accommodate the Participant'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. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number provided on the last page of this booklet.

## **SETTLEMENT OF DISPUTES**

### **INTERNAL APPEALS**

#### **Initial Internal Appeal**

If a claim has been denied in whole or in part by the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may request that the Claims Administrator give further consideration to the claim by contact-

ing the Customer Service Department via telephone or in writing including any additional information that would affect the processing of the claim. The Claims Administrator will acknowledge receipt of an appeal within 5 calendar days. Written requests for initial internal appeal may be submitted to the following address:

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

Appeals must be filed within 180 days after you receive notice of an adverse benefit decision. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator.

### **Final Internal Appeal**

If you are dissatisfied with the initial internal appeal determination by the Claims Administrator, the determination may be appealed in writing to the Claims Administrator within 60 days after the date of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefore. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse you for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator. Written requests for final internal appeals may be submitted to:

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

### **Expedited Appeal (Initial and Final)**

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

## **EXTERNAL REVIEW**

### **Standard External Review**

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment or a rescission of coverage, you, a designated representative, a provider or an attorney on your behalf may request an external review within four months after notice of the final internal appeal determination. Instructions for filing a request for external review will be outlined in the final internal appeal response letter.

### **Expedited External Review**

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the adverse benefit decision without participating in the initial or final internal appeal process. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may fax a request to (916) 350-7585, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

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

### **Other Resources to Help You**

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

## **DEFINITIONS**

### **PLAN PROVIDER DEFINITIONS**

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

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

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

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

**Hospital** —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and in-

jured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.

2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

**Non-Participating Home Health Care and Home Infusion Agency** — an agency which has not contracted with the Claims Administrator and whose services are not covered unless prior authorized by the Claims Administrator.

**Non-Participating/Non-Preferred Providers** — any provider who has not contracted with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Deductible, Copayment, or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider.

**Non-Preferred Hemophilia Infusion Provider** — a provider that has not contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has not been designated as a contracted hemophilia infusion product provider by the Claims Administrator. Note: Non-Preferred Hemophilia Infusion Providers may include Participating Home Health Care and Home Infusion Agency Providers if that provider does not also have an agreement with the Claims Administrator to furnish blood factor replacement products and services.

**Other Providers —**

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dietitians; certified nurse midwives; licensed occupational therapists; certificated acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech therapists or pathologists; 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; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

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

**Participating Ambulatory Surgery Center** — an Outpatient surgery facility 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; and,
3. has contracted with the Claims Administrator to provide Services on an Outpatient basis.

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

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

**Participating Physician** — a selected Physician or a Physician Participant that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

**Participating Provider** — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment in full for covered Services.

Note: This definition does not apply to Hospice Program Services. For Participating Providers for Hospice Program Services, see the Participating Hospice Agency definitions above.

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

**Physician Member** — a Doctor of Medicine who has enrolled with the Claims Administrator as a Physician Member.

**Preferred Dialysis Center** — a dialysis services facility which has contracted with the Claims Administrator to pro-

vide dialysis Services on an Outpatient basis and accept reimbursement at negotiated rates.

**Preferred Free-Standing Laboratory Facility (Laboratory Center)** — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide laboratory services on an Outpatient basis and accept reimbursement at negotiated rates.

**Preferred Free-Standing Radiology Facility (Radiology Center)** — a free-standing facility which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital, and which has contracted with the Claims Administrator to provide radiology services on an Outpatient basis and accept reimbursement at negotiated rates.

**Preferred Hemophilia Infusion Provider** — a provider that has contracted with the Claims Administrator to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia and accept reimbursement at negotiated rates, and that has been designated as a contracted Hemophilia Infusion Provider by the Claims Administrator.

**Preferred Hospital** — a Hospital under contract to the Claims Administrator which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Claims Administrator.

**Preferred Provider** — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider.

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

## ALL OTHER DEFINITIONS

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

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

**Activities of Daily Living (ADL)** — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

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

**Allowable Amount** — the Claims Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider's billed charge, whichever is less. The Claims

Administrator Allowance, unless otherwise specified for a particular service elsewhere in this booklet, is:

1. For a Participating Provider, the amount that the Provider and the Claims Administrator have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a Non-Participating/Non-Preferred provider (excluding a Hospital/ Outpatient Facility) in California who provides non-Emergency Services, the amount the Claims Administrator would have allowed for a Participating Provider performing the same service in the same geographical area.
3. For a Non-Participating/Non-Preferred Provider (excluding a Hospital/ Outpatient Facility) who provides Emergency Services, the Reasonable and Customary Charge.
4. For a Hospital/ Outpatient Facility that is a Non-Participating/Non-Preferred Provider in California who provides Emergency or non-Emergency Services, the amount negotiated by the Claims Administrator.
5. For a provider anywhere, other than in California, within or outside of the United States, which 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 service rendered; or
6. For a non-participating provider (i.e., that does not contract with the Claims Administrator or a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides non-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. If the local plan has no non-participating provider allowance, the Claims Administrator will assign the Allowable Amount used for a Non-Participating/Non-Preferred Provider in California.

**Behavioral Health Treatment** - professional Services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

**Benefits (Services)** — those Services which a Participant is entitled to receive pursuant to the Plan Document.

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

**Care Coordination** — Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

**Care Coordinator** — An individual within a provider organization who facilitates Care Coordination for patients.

**Care Coordinator Fee** — A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

**Claims Administrator** — the claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

**Close Relative** — the spouse, Domestic Partner, children, brothers, sisters, or parents of a covered Participant.

**Copayment** — the amount that a Participant is required to pay for specific 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 Services which a Participant is entitled to receive pursuant to the terms of the Plan Document.

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

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

**Deductible** — the Calendar Year amount which you must pay for specific Covered Services that are a Benefit of the Plan before you become entitled to receive certain Benefit payments from the Plan for those Services.

**Dependent** —

1. an Employee's legally married spouse who is:
    - a. not covered for Benefits as an Employee; and
    - b. not legally separated from the Employee;or,
  2. an Employee's Domestic Partner who is not covered for Benefits as a Participant;
- or,

3. a child of, adopted by, or in legal guardianship of the Employee, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Employee, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as an Employee who is 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)

and who has been enrolled and accepted by the Claims Administrator as a Dependent and has maintained participation in accordance with the Claims Administrator Plan.

Note: Children of Dependent children (i.e., grandchildren of the Participant, spouse, or Domestic Partner) are not Dependents unless the Participant, 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, Benefits for such Dependent will be continued upon the following conditions:
  - a. the child must be chiefly dependent upon the Employee, spouse, or Domestic Partner for support and maintenance;
  - b. the Employee, spouse, or Domestic Partner submits to the Claims Administrator a Physician's written certification of disability within 60 days from the date of the Employer's or the Claims Administrator's request; and
  - c. thereafter, certification of continuing disability and dependency from a Physician is submitted to the Claims Administrator on the following schedule:
    - (1) within 24 months after the month when the Dependent would otherwise have been terminated; and
    - (2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

**Domestic Partner** — For information regarding the definition of Domestic Partner, please see your Employer's Health and Welfare SPD.

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

**Durable Medical Equipment** — equipment designed for repeated use which is medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as wheelchairs, Hospital beds, respirators, and other items that the

Claims Administrator determines are Durable Medical Equipment.

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

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

**Employee** — an individual who meets the eligibility requirements set forth in the Plan Document.

**Employer** — is PayPal Holdings, Inc. and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for benefits under the Plan.

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

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

**Family** — the Employee and all enrolled Dependents.

**Family Coverage** — coverage provided for two or more Members, as defined herein.

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

**Individual (Self-only) Coverage** — Coverage provided for only one Participant, as defined herein.

**Infertility** — the Participant must actively be trying to conceive and has:

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
4. three or more pregnancy losses.

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

**Late Enrollee** — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent shall not be considered a Late Enrollee if any of the following paragraphs (1.), (2.), (3.), (4.), (5.), (6.) or (7.) is applicable:

1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
  - a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and
  - b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
  - c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
  - d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and

the eligible Employee elects this Plan during an open enrollment period; or

3. A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee's health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Employees or Dependents who were eligible for coverage under the Healthy Families Program or Medicaid and whose coverage is terminated as a result of the loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage; or
6. For eligible Employees or Dependents who are eligible for the Healthy Families Program or the Medicaid premium assistance program and who request enrollment within 60 days of the notice of eligibility for these premium assistance programs; or
7. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

#### **Medical Necessity (Medically Necessary) —**

The Benefits of this Plan are provided only for Services which are medically necessary.

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Claims Administrator, are:
  - a. consistent with the Claims Administrator 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, the Claims Administrator 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 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 Rehabilitation that can be provided on an Outpatient basis.
4. The Claims Administrator 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.

**Mental Health Condition** — mental disorders listed in the most current edition of the "Diagnostic & Statistical Manual of Mental Disorders" (DSM).

**Mental Health Service Administrator (MHSA)** — the Claims Administrator has contracted with the Plan's MHSA to manage the Claims Administrator's Mental Health and Substance Abuse Services as described under the Benefits Management Program.

**Mental Health Services** — Services provided to treat a Mental Health Condition.

**Negotiated Arrangement (Negotiated National Account Arrangement)** — An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the Blue-Card Program.

**Non-Routine Outpatient Mental Health Services** — Outpatient Facility and professional services for 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
- 5) Transcranial Magnetic Stimulation
- 6) Behavioral Health Treatment
- 7) Psychological Testing

These services may also be provided in the office, home, or other non-institutional setting.

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

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

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

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

**Partial Hospitalization Program (Day) Treatment** — an Outpatient treatment program that may be free-standing or Hospital-based and provides Services at least 5 hours per day, 4 days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following stabilization.

**Participant** — either an Employee or Dependent.

**Physical Therapy** — treatment provided by a Doctor of Medicine or under the direction of a Doctor of Medicine when provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. 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.

**Plan** — the Preferred Medical Benefit Plan for eligible Employees of the Employer.

**Plan Administrator** — is PayPal Holdings, Inc.

**Plan Document** — the document issued by the Plan that establishes the services that Employees and Dependents are entitled to receive from the Plan.

**Plan Sponsor** — is PayPal Holdings, Inc.

**Preventive Health Services** — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically listed below:

1. Evidence-based items 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.

Note: Diagnostic audiometry examinations are covered under the Professional (Physician) Benefits.

**Prosthesis (Prosthetics)** — an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

**Provider Incentive** — An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

**Reasonable and Customary Charge** — in California: The lower of (1) the provider's billed charge, or (2) the amount determined by the Claims Administrator to be the reasonable and customary value for the services rendered by a non-Plan 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; outside of California: The lower of (1) the provider's billed charge, or, (2) the amount, if any, established by the laws of the state to be paid for Emergency Services, if applicable.



**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 Reconstructive Surgery for cleft palate procedures.

**Rehabilitation** — Inpatient or Outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illnesses, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitation Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

**Residential Care** — services provided in a facility or a free-standing Residential Care Program that provides overnight/extended-stay services for Participants who do not qualify for Acute Care or Skilled Nursing Services. This definition does not apply to Services rendered under the Hospice Program Benefit.

**Residential Care Program for Mental Health Condition** - is provided in a licensed facility which operates in accordance with applicable California state law and provides 24-hour residential care, pursuant to written, specific and detailed treatment programs for full-time participating clients under the direction of an administrator and Physician for chronic mental health conditions. It includes diagnosis and treatment including ongoing evaluation and observation of the client for changes in physical, mental, emotional and social functioning and the consultation services of a dietitian, Physician, social worker, psychologist and other consultants when needed. The residential facility cannot accept or retain clients who require Inpatient Hospital level or acute psychiatric care.

**Residential Care Program for Substance Abuse Condition** - is provided in a licensed facility that provides structured 24-hour residential services designed to promote treatment and maintain recovery from the recurrent use of alcohol, drugs, and/or related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

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

**Routine Outpatient Mental Health Services** – professional office visits for the diagnosis and treatment of Mental Health Conditions including the individual, family, or group setting.

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

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a primary substance use disorder

or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and

2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
  - (a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;
  - (b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

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

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

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

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

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

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

**Substance Abuse Condition** — for the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

**Total Disability (or Totally Disabled)** —

1. in the case of an Employee or Participant 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.

**Value-Based Program (VBP)** — An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

For claims submission and information contact the Claims Administrator.

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

Participants may call Customer Service toll free:

1-844-462-9518

The hearing impaired may call Customer Service through the toll-free TTY number:  
1-800-241-1823

### Benefits Management Program Telephone Numbers

For Prior Authorization: Please call the Customer Service telephone number indicated on the back of the Participant's identification card

Please refer to the Benefits Management Program section of this booklet for information.





