HMO Benefit Guidelines

For IPAs/medical groups and their contracted providers

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blue california

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HMO Benefit Guidelines Revision Index

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Accidental Injury to Natural Teeth- Basic Plan

Benefit Coverage

Hospital and professional services provided for treatment of damage to the natural teeth, gums, and jaws caused solely by an accidental injury is limited to medically necessary services for initial, palliative stabilization of the member. This benefit does not include services for damage to the natural teeth that is not accidental; for example, resulting from chewing or biting.

Treatment of accidental injury to the natural teeth covered under the Basic Plan must be reviewed and authorized.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Inpatient Hospital Services

Outpatient Hospital Services

Accidental Injury to Natural Teeth- Basic Plan

Benefit Exclusions

The following services are excluded:

- Routine dental care including bridges, dentures, oral orthotics, periodontal treatment, and cosmetic treatment (bleaching of darkened tooth).
- Services customarily provided by dentists and oral surgeons, including hospitalization incidental to routine dental care and services.
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate symptoms as a result of TMJ conditions or abnormalities.
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures.
- Injury to dental implants (endosteal, subperiosteal, or transosteal).
- Treatment for damage to the natural teeth that is not accidental (e.g., damage to teeth resulting from chewing, biting, bruxing, clenching, natural erosion or attrition).
- Replacement of existing prosthesis, bridge or partial removable denture in case of accident.
- Dental services provided **after** the initial, palliative, stabilizing medical treatment for the injury.
- Cosmetic dental services to include replacement of dental veneers.
- Amalgam restorations, resin-based restorations, cement restorations, or full coverage cast (crowns) restorations.
- Periodontal or gingival services not caused by accident or trauma (e.g., “acute necrotizing ulcerative gingivitis,” diabetic gingivitis, “pregnancy gingivitis”).
- Tooth/teeth pain or oral swelling not caused by trauma or accident (e.g., tooth decay or from an unerupted tooth).

Accidental Injury to Natural Teeth- Basic Plan

Examples of Covered Services

- X-rays and other imaging studies of injured teeth, jawbones and/or affected area.
- Services in the Emergency Room to medically stabilize the acute-immediate dental or oral emergency.
- Limited problem focused oral evaluation (accidental injury).
- Palliative treatment of dental pain when related to accidental injury.
- Tooth removal, treatment for the avulsion of tooth/teeth, reimplantation of tooth/teeth, stabilization of teeth with closed reduction splinting, removal of foreign body, treatment of jaw fractures, treatment of alveolar fractures, reduction of dislocation of the jaw joints, and repair of traumatic wounds involving jaws or gum tissue.
- Removing sharp edges around a fractured tooth caused by an accident or trauma to the tooth/teeth.
- General anesthesia, when supporting above listed procedures (if medically required). General anesthesia is not a benefit if the dental emergency is normally treated with a local anesthetic and not simply because the patient is uncooperative or hysterical from the accident or trauma to the mouth or oral structures.

Examples of Non Covered Services

- Orthodontia.
- Preventive dental care.
- Routine dental care including dentures, bridges, oral orthotics, periodontal treatment, and cosmetic treatment (bleaching of darkened tooth).
- Treatment for damage resulting from chewing or biting.
- Replacement of existing prosthesis, fixed bridge or partial removable denture in case of accident.
- Prosthetic replacement of natural tooth/teeth (only) lost due to accidental injury.

Accidental Injury to Natural Teeth – Basic Plan

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code Section 1367.71

HMO Benefit Guidelines for:

Teeth, Jaws and Jawbones

Blue Shield HMO IPA/Medical Group Procedures Manual

Acupuncture

Benefit Coverage

Acupuncture with unlimited visits is included in IFP and Small Business HMO on and off exchange plans for treatment of nausea and as part of a chronic pain management program. These benefits are through American Specialty Health Plans (ASH Plans) when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. This benefit includes an initial examination and subsequent office visits and acupuncture services specifically for the treatment of nausea and as part of a chronic pain management program and must be determined as Medically Necessary by ASH Plans. A referral from the member's Blue Shield HMO Primary Care Physician is not required. The ASH Group provider will refer the member to the Primary Care Physician for evaluation of conditions not related to chronic pain or nausea and for evaluation of non-covered services such as diagnostic scanning (CAT scans or MRIs).

ASH Plans must determine all subsequent services as Medically Necessary following the initial examination and emergency services by an ASH Group provider.

The standard HMO Mid and Large Group plans do not include services for or incidental to acupuncture.

Some HMO Mid and Large Group plans have the optional chiropractic and acupuncture benefits through American Specialty Health Plans (ASH Plans) when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. The benefits are similar to the above with the exceptions that the optional chiropractic and acupuncture benefit visit limits and copayments vary and services for Acupuncture include treatment for neuromusculoskeletal disorders. Refer to the member's EOC for details or call ASH Plans at (800) 678-9133.

HMO members may receive discounted acupuncture and chiropractic and therapeutic massage services through the Alternative Care Discount Program on blueshieldca.com. Simply log on to blueshieldca.com, click on the *Be Well* tab at the top of the screen, then *Wellness Discount Programs*, then *Alternative Care*, or *Find a Doctor*, then *Alternative Medicine*, select *Alternative Care Discount Program* and click on *Visit American Specialty* tab.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Acupuncture

Benefit Exclusions

- Standard HMO Mid and Large plans, services for or incidental to acupuncture
- Massage therapy provided by a massage therapist
- Services administered by an acupuncturist or chiropractor not in the ASH Group

Examples of Covered Services

Initial examination and subsequent office visits and acupuncture services specifically for the treatment of nausea and as part of a chronic pain management program, when determined by American Specialty Health Plans (ASH Plans) as Medically Necessary.

Examples of Non-Covered Services

- Cupping
- Electroacupuncture
- Moxibustion

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

Alternative Care Discount Program on blueshieldca.com

HMO Optional Benefits: Chiropractic and Acupuncture rider offered by American Specialty Health Plans (ASH)

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Coverage

Medically necessary acupuncture services are covered up to the maximum visits* per calendar year when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. This benefit includes an initial examination and subsequent office visits and acupuncture services specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain, and must be determined as Medically Necessary by American Specialty Health Plans (ASH Plans).

Medically necessary chiropractic services are covered up to the maximum visits* per calendar year for routine chiropractic care when provided by an ASH Group participating provider. This benefit includes an initial examination and subsequent office visits, adjustments, and conjunctive therapy specifically for the treatment of neuromusculoskeletal disorders and must be determined as Medically Necessary by ASH Plans. Benefits are also provided for pre-authorized x-rays.

*Note: The two standard HMO plan designs are Acupuncture and Chiropractic Services with a combined maximum of 30 visits per calendar year with a $10 copay on standard HMO plans or a maximum of 30 chiropractic only visits per calendar year with a $10 copay. Some HMO Plans may have separate Acupuncture and Chiropractic maximum visit limits. The number of visits may vary. Refer to member's EOC for details or call American Specialty Health Plans at (800) 678-9133.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Exclusions

Covered services do not include:

- Services administered by an acupuncturist or chiropractor not in the ASH Group
- Acupuncture treatment for services for treatment of asthma
- Acupuncture treatment for addiction (including without limitation, smoking cessation)
- Vitamins, minerals, nutritional supplements (including herbal supplements) or similar products
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Treatment of service for pre-employment physicals
- Services, laboratory tests, x-rays, and other treatment classified as experimental or investigational, or in the research stage
- Services for examination and/or treatment of strictly non-musculoskeletal disorders
- Massage therapy provided by a massage therapist
- Vocational rehabilitation
- Thermography
- Air conditioners, air purifiers, mattresses, supplies or any other similar devices or appliances
- Transportation costs including local ambulance charges
- Education programs, non-medical self-care, or self-help training, or any related diagnostic testing
- Any treatment or service caused by or arising out of the course of employment or covered under any public liability insurance
- MRI, CAT scans, bone scans, nuclear radiology and/or other types of diagnostic radiology, other than plain film studies
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Limitations

- Refer to the member's EOC for benefit details including the copayment and if the member has chiropractic only, or chiropractic and acupuncture combined or chiropractic and acupuncture separate and the maximum number of annual visits or call American Specialty Health Plans at (800) 678-9133
- Chiropractic appliances are covered up to a maximum of $50.00 in a calendar year as authorized by ASH Plans
- Acupuncture services are limited to neuromusculoskeletal disorders, nausea, and pain as authorized by ASH Plans
- Chiropractic services are limited to neuromusculoskeletal disorders of the spine, neck and joints

Exceptions

Emergency services by non-ASH Network provider will be covered. Under certain circumstances in California counties without ASH Network providers, other services by non-ASH Network providers may be covered as well.

Examples of Covered Services

- Initial examination and office visits
- Acupuncture services for carpal tunnel syndrome or tennis elbow
- Acupuncture services for headaches
- Acupuncture services for menstrual cramps
- Acupuncture services for osteoarthritis or stroke rehabilitation
- Spinal manipulation or adjustments
- Adjunctive therapy
- Radiology procedures involving the spine and extremities
- Chiropractic appliances

Acupuncture and Chiropractic Services (Optional Benefits)

Examples of Non-Covered Services

- Vitamins, minerals, nutritional supplements (including herbal supplements)
- Acupuncture treatment for asthma or smoking addiction
- Treatment for cancer
- Hypnotherapy
- Diagnostic scanning (MRI or CAT scans) and diagnostic ultrasound

References

Combined Evidence of Coverage and Disclosure Form

HMO Access+ Evidence of Coverage

Local Access+ HMO Evidence of Coverage

Allergy

Benefit Coverage

Physician office visits for the purpose of routine allergy testing and treatment, including allergy immunotherapy and allergy serum (antigens), are covered.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

The forms of allergy testing and treatment excluded by Blue Shield Medical Policy. (See Examples of Non-Covered Services.)

Examples of Covered Services

- Allergy testing/skin testing
- Complete Blood Count (CBC) with differential
- Immunotherapy (excluding antigen) – CPT code for office visit; serum billed separately with its own CPT code
- Immunotherapy (including antigen) – office visit copay applies
- Allergy serum (also called allergy vaccine, antigen, or extract) – CPT code for serum copay (50% of allowed charges); office visit charged separately
- IP testing
- FAST
- Modified Allergosorbent Test (MAST)
- Paranasal sinus x-ray
- Radioallergosorbent Testing (RAST)
- Food allergy testing
- Respiratory emulsion therapy
- Skin end point titration
- Smear of nasal secretions
- Sputum exam
- Total eosinophil count
- Total gammaglobulins

Allergy

Examples of Non-Covered Services

- Non-medically necessary services, including:
    - Serum allergy (screening) testing
    - Sublingual administration of allergy extracts
- Provocative and neutralization testing, subcutaneous and sublingual
- Over-the-counter allergy medications, such as calamine lotion, Benadryl®, hydrocortisone
- Allergy Immunization Therapy (Urine)
- Bacterial antigens in the treatment of arthritis
- Cytotoxic testing

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield Medical Policy

Ambulance

Benefit Coverage

Medically necessary emergency air and ground transportation is covered to the nearest hospital, when there is an emergency condition present which requires immediate medical intervention at the hospital, or on the way to the hospital.

Transportation from one hospital facility to another hospital facility, rehabilitation facility, or skilled nursing facility is covered when the member's condition is such that transportation by ambulance is medically necessary and prior authorization is obtained.

The basic plan covers ambulance services as follows:

Emergency Ambulance Services

Services are a covered benefit if Blue Shield HMO determines that emergency transportation by ambulance is, or was, required for emergency services to the nearest hospital which can provide such emergency care. Medically necessary ambulance transportation is determined independently of medical necessity criteria for emergency room service.

Emergency ambulance services include those situations where a reasonable person would have believed that a medical emergency existed.

Non-Emergency Ambulance Services

Medically necessary authorized ambulance services to transfer the member from a non-plan hospital to a plan hospital or between plan facilities when in connection with authorized confinement/admission and use of the ambulance is authorized.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

Transportation services other than medically necessary ambulance transportation.

Ambulance

Benefit Limitations

Payment or denial of ambulance transport resulting from 911 calls will be determined based on medical necessity and a determination of the emergency nature of the services. For example, a reasonable person would believe it to be an emergency, based on the symptoms experienced.

A Primary Care Physician authorization for Emergency Services does not validate medical necessity for emergency transport. Dry run ambulance claims are not payable. This occurs when an ambulance responds to a call and the patient either did not need or refused medical care and/or transport to a hospital.

Paramedic services rendered at the scene where transport was not needed will require medical necessity review.

Examples of Covered Services

- Use of ambulance in a life-threatening emergency. Examples of a life-threatening emergency include:
    - Heart Attack
    - Loss of Consciousness
    - Major Burns
- Use of ambulance transportation when instructed to do so by emergency response personnel (e.g., police, paramedic, fire department, Coast Guard, etc.) in an emergency situation.
- Medically necessary life support and/or transport received from municipalities.
- Medically necessary transportation when prior authorization has been obtained, e.g., when a member requires professional medical care during a transfer from an acute setting to a skilled nursing facility.
- Air ambulance transportation from foreign countries to the U.S. when Blue Shield Medical Care Solutions authorizes a hospital to hospital transfer and determines that commercial airline transportation would be unsafe for the patient.

Examples of Non-Covered Services

- Commercial aircraft
- Taxi
- Wheelchair van, other non-ambulance assisted transportation

Ambulatory Surgeries/Procedures

Benefit Coverage

Services and supplies for certain surgeries or diagnostic procedures performed in an office setting, outpatient hospital setting, or ambulatory surgery center are covered.

Ambulatory surgeries/procedures are divided into two categories:

Facility-Based Ambulatory Surgeries/Procedures

Facility-based ambulatory surgeries/procedures should be performed in an ambulatory surgery center or in an acute care facility on an outpatient basis. Surgical diagnostic procedures are identified as facility-based ambulatory surgeries/procedures.

The IPA/medical group is responsible for authorizing facility-based surgeries/procedures, including inpatient services, and providing Blue Shield with the required notification of authorized and denied services. Authorization can only be given if the Ambulatory Surgery Center is a valid entity having the required licensure and/or accreditation in accordance with state and federal laws. The services should only be authorized in a contracted facility unless there are extenuating circumstances. No facility fee is allowed for facility-based ambulatory surgeries/procedures performed in an office setting unless authorized.

Office-Based Ambulatory Surgeries/Procedures

Office-based ambulatory surgeries/procedures should be performed in the physician's office setting unless it is medically necessary that they be performed in a facility setting, on an outpatient or inpatient basis. The IPA/medical group is responsible for authorizing office-based surgeries/procedures and providing Blue Shield with the required notification of such authorization. A list of Office-Based Ambulatory Surgeries/Procedures appears later in this document.

Questions about the appropriate setting for a surgery/procedure should be referred to Blue Shield Medical Care Solutions.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician – Outpatient/Surgery

Outpatient Hospital Services/Surgery

Ambulatory Surgeries/Procedures

Benefit Exclusion

Ambulatory surgeries/procedures that are not medically necessary, not appropriately authorized by the IPA/medical group, or excluded by Blue Shield Medical Policy.

Examples of Covered Services

Facility-Based

- Cataract Surgery
- Dilation and Curettage of uterus (D&C)
- Heart Catheterization
- Tubal Ligation by Laparoscopy
- Esophagogastroduodenoscopy

Office-Based

- Amniocentesis
- Removal of IUD
- Cryotherapy of warts

Examples of Non-Covered Services

- Cosmetic Procedures

References

Blue Shield HMO IPA/Medical Group Procedures Manual

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Office-Based Ambulatory Surgeries/Procedures

CPT	DESCRIPTION
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)

CPT	DESCRIPTION
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20600	Drain/inject, joint/bursa
20604	Drain/inject, joint/bursa w/US
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us

CPT	DESCRIPTION
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast

CPT	DESCRIPTION
29010	Application of body cast
29015	Application of body cast
29035	Application of body cast
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast

CPT	DESCRIPTION
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement

CPT	DESCRIPTION
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid

CPT	DESCRIPTION
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64455	N block inj, plantar digit
64611	Chemodenerv saliv glands
64616	Chemodenerv musc neck dyston
61617	Chemodenerv muscle larynx EMG
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas

CPT	DESCRIPTION
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0228T	Njx tfrml eprl w/us cer/thor
0230T	Njx tfrml eprl w/us lumb/sac
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0295T	Ext ecg complete
0296T	Ext ecg recording
0297T	Ext ecg scan w/report
0298T	Ext ecg review and interp
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rpt
0379T	Vis field assmnt tech supt
0380T	Comp animat ret image series
0419T	Dstrj Neurofibroma xtnsv
0420T	Dstrj Neurofibroma xtnsv
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0482T	Absolute quant myocardial bld flow
0525T	Insj/Rplcmt Compl IIMS
0529T	Interrog Dev Eval IIMS IP
0530T	Removal Complete IIMS
A4252	Blood ketone test or strip
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Blood and Blood Plasma

Benefit Coverage

Blood and blood plasma are covered when provided as part of covered and authorized services including inpatient hospital care, ambulatory surgery, and emergency services.

Blood and blood plasma are covered in full whether or not they are replaced.

The blood and blood plasma, administration and processing (including preparation, storage and transportation) of the blood and blood plasma are covered.

Copayment

See the member's *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for member copayments.

Examples of Covered Services

- Autologous Blood (The patient's own blood which is frozen and stored prior to need)
- Plasma
- Whole Blood

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

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BlueCard

Benefit Coverage

The Blue Shield HMO provides benefits for urgent services outside of California for members through the Plan's participation in the BlueCard Program.

When temporarily traveling within California but outside of the Personal Physician service area, a member who is unable to contact their Personal Physician should call Member Services at (800) 424-6521 for assistance in receiving urgent services.

For urgent mental health services within California, the member should contact the MHSA at (877) 263-8827.

The network of BlueCard participating health plans will provide urgent services when a member is temporarily traveling outside of California but within the United States, but members can also receive urgent care from non-participating providers. The member should call the 24-hour toll-free number at (800) 810-BLUE (2583) to obtain information about the nearest BlueCard participating provider.

Urgent care and emergency services are covered when received outside of the United States. The member may call the BlueCard Worldwide Network at (800) 810-BLUE (2583) for the nearest BlueCard participating provider, or when outside the country, call collect at (804) 673-1177.

If the member does not use the BlueCard Worldwide Network, and the claim is for services other than inpatient care, the member will need to pay the claim at the time the service is rendered. The member can obtain a BlueCard Worldwide International Claim Form (C14764) by calling the member services number on the front of their ID card. The member will then need to submit the claim form and a copy of the bill to the following address:

Blue Shield of California Foreign Claims Unit
P.O. Box 272550
Chico, California 95927-2550

Copayment

See the member's *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for member copayments for BlueCard.

BlueCard providers will request the member's copayment at the time services are rendered.

BlueCard

Benefit Exclusions

- Services provided outside of California, if the plan determines retrospectively that the services would not have been authorized as urgent care.
- Follow-up care to urgent or emergency services that is not medically necessary is not covered.

Benefit Limitations

Blue Shield HMO members who qualify for Away From Home Care will receive services through the local BCBS HMO where they reside. Their benefit plan will be one offered by the local HMO.

Authorization by Blue Shield HMO is required for more than two out of area follow-up outpatient visits or for care that involves a surgical or other procedure or inpatient stay. Blue Shield HMO may direct the patient to receive follow-up services from the Primary Care Physician.

Examples of Non-Covered Services

- Ongoing treatment, such as chemotherapy
- Routine services
- Out of area follow-up care that is not medically necessary to evaluate the member's progress after an initial emergency or urgent service
- Out of area follow-up care following an urgent or emergency visit in excess of two outpatient visits (except for non-marketed IFP plan members) and not authorized by Blue Shield HMO
- Out of area follow-up care following an urgent or emergency visit that involves any surgical procedure or inpatient stay unless authorized by Blue Shield HMO

Examples of Covered Services

- Evaluation of high or persistent fever
- Evaluation of symptoms of infection
- Evaluation of traumatic injury

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for *Emergency Services, Out-of-Area Services,* and *Urgent Care Services.*

Chemotherapy

Benefit Coverage

Chemotherapy is a covered benefit when medically necessary for appropriate treatment of disease or illness and can be provided in a physician's office, facility, or other outpatient or home setting.

Chemotherapy services require authorization.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Inpatient Hospital Services

Outpatient Hospital Services

Chemotherapy/Radiation Therapy

Physician - Outpatient/Office Visit

Benefit Exclusions

- Experimental/investigational chemotherapy drugs or services. Prescribed drugs and medicines for outpatient care and over-the-counter medications not requiring a prescription.
- Drugs packaged in combination kits that include other non-prescription products or non- prescription drugs unless the drug is not otherwise available without the non-prescription components.

Chemotherapy

Exceptions

See the *HMO Benefit Guideline* on *Clinical Trials for Cancer or Life-Threatening Illnesses* for information about use of experimental/investigational chemotherapy drugs or services while enrolled in an eligible Cancer Clinical Trial.

Examples of Covered Services

- FDA Approved Chemotherapy Drugs

Examples of Non-Covered Services

- Oral or topically self-administered medications (may be available under the *Outpatient Prescription Drug* benefit)
- Laetrile
- Chymotrypsin
- Experimental/Investigational Treatment(s)

References

Blue Shield Medical Policy

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

Blue Shield HMO IPA/Medical Group Procedures Manual

Chiropractic Services (Optional Benefit)

Benefit Coverage

Medically necessary chiropractic services, for example, are covered up to 30 visits per calendar year* for routine chiropractic care when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. An initial examination and subsequent office visits are covered as well as adjustments and conjunctive therapy specifically for the treatment of neuromusculoskeletal disorders. X-rays are also covered and must be determined as Medically Necessary by ASH Plans.

A referral from the member's Blue Shield HMO Personal Physician is not required. The ASH Group provider will refer the member to the Personal Physician for evaluation of conditions not related to neuromusculoskeletal disorders and for evaluation of non-covered services such as diagnostic scanning (CAT scans or MRIs).

American Specialty Health Plans, Inc. (ASH Plans) must determine all subsequent services as Medically Necessary except the initial examination and emergency services by an ASH Group provider.

One brief re-examination is covered for each treatment program.

* Some plan visit limits may vary. Refer to the member's EOC for details or call American Specialty Health Plans at (800) 678-9133.

Copayment

See the member's *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for member copayments.

Chiropractic Services (Optional Benefit)

Benefit Exclusions

- Services administered by a chiropractor not in the ASH Group
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Treatment or service for pre-employment physicals
- Services, laboratory tests, x-rays, and other treatment classified as experimental or investigational, or in the research stage
- Services for examination and/or treatment of strictly non-musculoskeletal disorders
- Massage therapy provided by a massage therapist.
- Vocational rehabilitation
- Thermography
- Air conditioners, air purifiers, mattresses, supplies, or any other similar devices or appliances
- Transportation costs including local ambulance charges
- Vitamin, minerals, nutritional supplements, or other similar products
- Education programs, non-medical self-care, or self-help training, or any related diagnostic testing
- Any treatment or service caused by or arising out of the course of employment, or covered under any public liability insurance
- MRI, CAT scans, bone scans, nuclear radiology and/or other types of diagnostic radiology, other than plain film studies
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services

Chiropractic Services (Optional Benefit)

Benefit Limitations

- One examination for each treatment program may be provided by an ASH Plan provider.
- Services are provided up to a maximum of 30 visits per calendar year*
- Chiropractic appliances are covered up to a maximum of $50.00 in a calendar year as authorized by ASH Plans
- One brief re-examination is covered for each treatment program
- Covered Services are limited to musculoskeletal disorders of the spine, neck, and joints

* Some plan visit limits may vary. Refer to the member's EOC for details or call American Specialty Health Plans at (800) 678-9133.

Exceptions

Emergency services by non-ASH Group provider will be covered. Under certain circumstances, in California counties without ASH Group providers, other services by non-ASH Group providers may be covered as well.

Examples of Covered Services

- Initial Examination and Office Visits
- Spinal Manipulations or Adjustments
- Adjunctive therapy
- Radiology procedures involving the spine and extremities
- Chiropractic Appliances

Chiropractic Services (Optional Benefit)

Examples of Non-Covered Services

- Treatment of Cancer
- Hypnotherapy
- Diagnostic Ultrasound
- Thermography
- Nutritional and digestive supplements
- Vitamins and minerals

References

Supplement to the *Blue Shield HMO Evidence of Coverage for Chiropractic Services.*

Clinical Trials for Cancer or Life-Threatening Conditions

Purpose

This Policy describes the guidelines used to approve Clinical Trials for Cancer and/or Life-Threatening conditions. It also delineates the services covered and non-covered which are provided during a clinical trial.

Policy

Clinical Trials are covered under the Affordable Care Act, (ACA) when it meets the definition of "life-threatening." The ACA defines life-threatening as a "disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted." (See 42 U.S.C.A. § 300gg-8(e))

An approved clinical trial is limited to a trial that:

1) Is federally funded and approved by one of the following:

- One of the National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities above; or the federal Departments of Defense or Veterans Administration;
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
    - 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

    - 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.

Clinical Trials for Cancer or Life-Threatening Conditions

Benefit Coverage

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

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

2. The Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

The hospital or provider conducting the clinical trial must be in the Blue Shield network unless the protocol is not available through a network provider.

Copayment

See the member's *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

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

- The investigational item, device, or service, itself;
- Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
- Services customarily provided by the research sponsor free of charge for any enrollee in the trial; or Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Clinical Trials for Cancer or Life-Threatening Conditions

Exceptions

If the clinical trial recommended by the member's physician is only available out of network, Blue Shield will approve coverage of routine patient services related to that clinical trial if the member is accepted as a participant.

Examples of Covered Services

- Professional office visits for examination, diagnosis, or consultation
- Radiology and clinical laboratory services
- Hospital outpatient care
- Inpatient care when appropriately authorized
- Diagnosis or treatment of any complications arising from the clinical trial

Examples of Non-Covered Services

- Drugs or devices not approved by FDA
- Airline, hotel, and other expenses incurred because provider of clinical trial services is in another geographic area
- Office visit solely for data collection purposes
- Services customarily provided by the research sponsor free of charge for any enrollee in the trial (e.g., drugs provided as part of clinical trial, as described in the clinical trial protocol)
- Research costs associated with conducting the trial, such as data collection and management, research physician and nurse time, analysis of results or tests performed solely for research purposes

References

Evidence of Coverage

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Consultations

Benefit Coverage

Consultations with physicians or other qualified licensed health care professionals on an inpatient and outpatient basis for the additional evaluation of a medical condition or for the initial consultation to establish diagnosis are covered.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Physician-Inpatient

Visits/Consultations

Benefit Exclusion

Consultations for infertility are excluded for HMO Individual and Family Plan (IFP) members.

Consultations for in vitro fertilization, GIFT, artificial insemination, or any other form of induced fertilization are excluded. (They may be covered under Optional Benefits for Infertility for group members whose employers have purchased this option.)

Consultations

Benefit Limitations

Services must be referred by the member's Personal Physician and authorized by the medical group. Consultations are not limited as long as they are determined to be medically necessary by the Personal Physician and appropriately referred and authorized, except as excluded.

Exceptions

- See the *HMO Benefit Guideline* on *Second Opinion Consultations*.
- For Access+ consultations, see the *HMO Benefit Guideline* on *Physician Services.*

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Second Opinion Consultations

Physician Services

Contact Lenses

Benefit Coverage

Contact lenses are covered only if medically necessary to treat medical eye conditions such as keratoconus, keratitis sicca, or aphakia following cataract surgery when no intraocular lens has been implanted. The following medical necessity criteria are used by Blue Shield HMO to determine coverage:

- Keratoconus when visual acuity cannot be corrected to 20/40 with eyeglasses
- Anisometropia when 3 diopters or more, provided visual acuity improves to 20/40 in weaker eye
- Astigmatism of 3 diopters or more
- Aphakia (after cataract surgery), contacts in lieu of glasses
- Myopia when more than 12 diopters
- Hyperopia when more than 7 diopters
- Following cataract surgery when no intraocular lens has been implanted

Coverage is provided for medically necessary contact lenses when the member does not have supplemental benefits for vision care through a Blue Shield vision plan (administered by the vision plan administrator (VPA)) or another vision plan for contact lenses.

Contact Lenses

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Orthotics, Prosthetics (external)

Benefit Exclusion

Contact lenses needed for routine vision correction, cosmetic purposes, or other purposes not specifically listed above.

Benefit Limitations

Medically necessary contact lenses (except when used as an optical bandage) will not be covered under the Access+ HMO plan if the employer provides supplemental benefits for vision care that cover contact lenses through a Blue Shield vision plan administered by the VPA or another vision plan. There is no coordination of benefits between the health plan and the vision plan for these benefits.

Exceptions

Contact lenses used as medically necessary corneal bandages following a surgical procedure and not used solely for vision correction, when authorized.

CalPERS: Eyeglasses following cataract surgery are a benefit.

Contact Lenses

Examples of Covered Services

Medically necessary contact lenses are covered:

1. Following cataract surgery when no intraocular lens has been implanted
2. To treat the following eye conditions such as:
    - Keratoconus
    - Keratitis Sicca
    - Aphakia
    - Amblyopia
    - Severe Anisometropia
    - Strabismus

Examples of Non-Covered Services

- All contact lenses used solely for the purpose of routine vision correction, or for cosmetic purposes
- Replacement of contact lenses due to loss
- Contact lenses in lieu of other eyewear
- Accommodative Intraocular implants (e.g., Crystalens)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guideline for:

Vision Care – Optional Benefits

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Custodial Care

Benefit Coverage

Not applicable.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

Services for or incident to custodial, maintenance, or domiciliary care are excluded from coverage.

Custodial or maintenance care furnished in the home primarily for supervisory care or supportive services or in a facility primarily to provide room and board or meet the activities of daily living, which may include:

- Training in personal hygiene and other forms of self-care or care furnished to a member who is mentally or physically disabled, and
    - who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care, or
    - when despite such treatment there is no reasonable likelihood that the disability will be so reduced.

Benefit Limitations

Not applicable.

Exceptions

Not applicable.

Custodial Care

Examples of Non-Covered Services

- Administration of routine oral medications and ointments
- Board and care home residential fees
- General maintenance care of colostomy or ileostomy
- Housekeeping services
- Supervisory care in the home

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Dental - Blue Shield HMO Plans (DHMO)

Benefit Coverage

Blue Shield of California Dental HMO (DHMO) covers diagnostic and preventive services, restorative services, oral surgery, periodontics, endodontics, prosthetics, and orthodontics.

DHMO plans are administered by Blue Shield's Dental Plan Administrator (DPA). Blue Shield contracts with the Dental Plan Administrator to provide services to members. The Dental Plan Administrator manages all covered services, provided by the Dental Provider or other plan providers, to members in an appropriate manner consistent with the contract. Each member is required to select a Primary Care Dentist within their dental center. The Primary Dental Provider will:

- Help the member to decide on actions to maintain and improve dental health.
- Provide, coordinate, and direct all necessary covered dental care services.
- Arrange referrals to plan specialists when required, including required prior authorization.
- Authorize emergency services when necessary.

All services must be medically or dentally necessary. The fact that a dentist or other plan provider may prescribe, order, recommend, or approve a service, procedure or dental material does not, in-of-itself, constitute or determine dental necessity even though it is not specifically listed as an exclusion or limitation. Blue Shield **may** limit or exclude benefits for services which are not dentally or medically necessary to restore the function of the teeth and oral cavity.

The Dental Provider for each member must be located sufficiently close to the member's home or work address to ensure reasonable access to care, as determined by the DPA. A Primary Dental Provider must also be selected for a newborn or child placed for adoption.

Dental - Blue Shield HMO Plans (DHMO)

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

When the member and dentist elect(s) a more complicated or personalized procedure that is more expensive than the covered benefit, the member will be responsible for the copayment of the covered benefit plus the difference between the dentist's usual and customary fee for the covered service and the selected procedure. If no dental service appearing on the schedule of benefits is related to the procedure selected, the service is excluded.

Benefit Exclusions

General Exclusions:

Unless otherwise specifically mentioned elsewhere in the contract DHMO dental plans do not provide benefits with respect to:

- Dental services not appearing on the schedule of benefits.
- Dental treatment that has been previously started by another dentist prior to the participant's eligibility to receive benefits under this plan.
- Dental services for cosmetic purposes (e.g., bleaching, veneer facings, crowns; porcelain on molar crowns, or brides and/or dentures).
- Dental services performed in a hospital and/or any related hospital fee(s).
- Treatment to correct congenital and developmental malformations including but not limited to: cleft palate/lip, anodontia, mandibular prognathism, retrognathia, overjet/overbite issues, enamel hypoplasia, enamel dysplasia, enamel discolorations, and malocclusions caused by skeletal jaw discrepancies.
- Treatments which, in the professional judgement of the DPA, have a poor prognosis when an alternative treatment with a more favorable prognosis is available.
- Treatment to correct or restore teeth, oral soft tissues, the alveolus, or jaws as the result of naturally occurring attrition or erosion of the oral or dental structures to include atrophy of the jaws from edentulism and/or clenching or grinding of the teeth.

Benefit Exclusions *(cont'd.)*

- Reimbursement to the member or another dental office for the cost of services secured from dentists, other than the Dental Provider or other DHMO plan authorized provider, except;
    - When such reimbursement is expressly by the DHMO plan; or
    - As cited under the Emergency Services and Emergency Claims provision (thorough documentation must be provided to the DPA).

Treatment for any condition for which benefits could be recovered under any worker's compensation, accident insurance, occupational disease law or when no claim is made for such benefits.

- Treatment for which payment is made by any governmental agency, including any foreign government.
- Treatment from dentists outside the United States of America except when emergency services are medically necessary to medically stabilize the oral or dental structures due to accidental injury or trauma to the mouth and associated structures. Pre-accident or pre-trauma radiographs **MUST** be submitted for review when making a dental claim of this nature (there are no exceptions to this policy).
- Temporomandibular Joint (TMJ) disorder or dysfunction to include any referred pain to the jaw joints, trismus, discomfort to the muscles of mastication to include any joint discomfort from using an oral appliance to manage obstructive sleep apnea or from/ during active or passive orthodontic treatment.
- Any oral-myofacial pain, headaches, cervicalgia, head position-postural issues, or migraines as the result of or associated with clenching, grinding of teeth (bruxism), orthodontic treatment, sudden traumatic insult to the jaws or joints, or from the use of an oral appliance to manage obstructive sleep apnea.
- Dental implants, transplants, ridge augmentations, bone grafts to the dental implant site or to the implant, periodontal procedures to the implant, or the implant site or teeth adjacent to the implant site, surgical implant guides, temporary crowns on implants as part of the immediate loading technique for an implant, diagnostic casts or working casts, 3-dimensional radiographs, rendering of the 3-dimensional radiographs, or removal of implants.

  NOTE: Some Plans provide a dental implant benefit.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- General anesthesia including intravenous, conscious (oral route) and inhalation sedation (any medications used to alter mood, the perception of reality, calms patient anxiety will be referred to as "sedation") is considered medically necessary when its use is (a) in accordance with generally accepted professional standards, (b) due to the existence of a specific medical or developmental condition and (c) not furnished primarily for the convenience of the patient, the parents, the attending dentist or other provider, and not provided because of dental phobias, combativeness, and non-cooperation of the patient (e.g., general anesthesia requests are not a benefit because the child requires "lots of dental treatment" and it is more convenient to place the child to sleep and do all the treatments in one appointment; general anesthesia is not a benefit simply because the parents cannot "afford to take time off from work" to bring their child in for their dental appointments; general anesthesia is not a benefit because the provider will not or is unwilling to make multiple treatment appointments for the child).
- The site/office/physical location where general anesthesia, et.al., is administered must meet the minimal requirements/regulations set-forth for the administration of a general anesthetic in an outpatient facility and have the proper license and/or permit allowing for such procedures from the California Dental Board (this is a State of California Regulation). The use of a mobile dental anesthesia service DOES NOT MEET THIS REQUIREMENT.
- Written documentation of the medical condition necessitating use of general anesthesia or intravenous or inhalation sedation must be provided by a **physician** (M.D.) to the Dental Center. Written documentation on the medical condition of a patient from a dentist or dentist- anesthesiologist requesting medically necessary sedation services are not acceptable.
- Patient apprehension or patient anxiety will not constitute medical necessity when requesting intravenous sedation, general anesthesia, or inhalation analgesia (nitrous oxide gas)
- Mental retardation is an acceptable medical condition to justify use of general anesthesia. Autism is not necessarily a medical condition requiring the use of a general anesthetic for routine dental procedures. Documentation of a patient's degree of autism must come from the patient's medical doctor addressing the level of patient cooperation and not from a dentist or parents.
- The DHMO plan reserves the right to review the use of general anesthesia to determine dental or medical necessity.
- Charges for broken or missed appointments.

Benefit Exclusions *(cont'd.)*

- Dental prophylaxis more than twice per calendar year.
- Precious metals (gold and gold alloy) will be charged to the patient at the dentist's cost.
- The use of titanium metal or titanium alloy for cast metal restorations will be charged to the patient at the dentist's cost for the material.
- Replacement of an existing, lost, or stolen prosthetic appliance more than once in the five-year period commencing on the date the appliance was last supplied, whether under this contract or any prior dental care policy, unless of dental necessity.
- Removal of 3rd molar (wisdom teeth) other than for dental necessity (pain, swelling, infection, causing decay to adjacent tooth). Removal of asymptomatic impacted, partially or fully erupted 3rd impacted molars because of possibility of dental crowding or for pre or post orthodontic treatment is considered not medically necessary by the DPA.
- Referral of a dependent child age 6 and over to a pedodontist (specialist in children's dentistry), unless for medical or dental necessity, or the child is uncooperative and will not allow the general dentist to treat after two attempts (thorough documentation must be provided to the DPA to include treatment attempts, behavioral management techniques employed, and level of uncooperativeness; there are no exceptions to this policy). All such exceptions must be approved by the DPA.
- Treatment as a result of accidental injury shall only be covered secondary to medical insurance, or any other primary insurance with accident coverage (thorough documentation must be provided to the DPA).
- Services, procedures, or supplies which are not reasonably necessary for the care and maintenance of the member's dental condition according to the broadly accepted standards of professional care in the United States or Canada, or which are experimental or investigational in nature or which do not have consistent-uniform professional endorsement.
- Dental treatment that does not meet Plan "utilization" guidelines, frequency limitations, and/or when the mandatory "waiting period" for specified dental services have not been met.
- Any manner of prosthesis used to prevent a tempro-mandibular joint problem from developing (e.g., such as "morning aligners" used in conjunction with oral appliance to manage obstructive sleep apnea or during any phase of orthodontic treatment).

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Any manner of oral or facial prosthesis constructed to mask facial or jaw deformities/defects as the result of surgery, congenital or developmental issues.
- Any dental treatment not provided by a California Dental Board licensed dentist or a dentist not licensed to practice in the United States of America or Canada (except for EMERGENCY dental treatment to MEDICALLY STABLIZE teeth and associated oral structures when the member is outside the United States; thorough documentation must be provided).
- Any self- administered, self-prescribed dental treatment, dental therapies, or oral treatments (drug store purchased "nightguards, teething medications, self-administered teeth bleaching kits, self-administered orthodontic appliances, snore guards, appliances for obstructive sleep apnea, dental restoration kits, medications prescribed by a medical doctor for a dental problem, etc.).

Orthodontic Exclusions:

- Treatment in progress (after banding) at inception of eligibility. After "banding" is defined as the initial treatment taken by an orthodontist to prepare and place orthodontic bands on a patient's teeth to include the placement of orthodontic separators.
- Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment to include the surgical placement of implant anchors or "bollard plates" to "distract" the growth or trajectory (direction) of the upper or lower jaws, exposing teeth, exposing the crowns of teeth, removing remaining deciduous teeth in the dental arches, up-righting a tooth or teeth, and etc. . The DPA will make the final determination on what constitutes "surgical orthodontics."
- Surgically assisted rapid palatal expansion (SARPE) procedures to treat transverse jaw issues or a high-narrow palate if the maxilla does not meet the criteria outlined under the orthognathic surgery **MEDICAL POLICY** of Blue Shield of California for transverse discrepancies.
- Surgical treatment to expose impacted teeth, surgical placement of tooth collars, or procedures to direct the eruption of teeth.
- Treatment to remove orthodontic cement from teeth, discoloration of teeth and periodontal or gingival surgery to expose the clinical crown(s) of teeth for the purpose of attaching an orthodontic bracket to the tooth.
- Treatment for myofunctional therapy as part of an orthodontic treatment program.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Changes in treatment necessitated by an accident.
- Re-treatment of orthodontic cases when the DPA concurs with the professional judgment of the attending dentist that there is a poor prognosis.
- Relapse of the occlusion or movement of teeth to their original position after primary orthodontic treatment is completed.
- Treatment for Temporomandibular joint (TMJ) disorder (or dysfunction), bruxism or clenching of the teeth as the result of orthodontic treatment.
- Special orthodontic appliances, including but not limited to, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic.
- X-rays for orthodontic purposes (to include full mouth screen, 3-dimensional radiographs, rendering of 3-dimensionl images, and cephalometrics) - Dental - Blue Shield HMO Plans (DHMO).
- Replacement of lost, broken, or stolen appliances (e.g., orthodontic retainers) or repair of the same if broken.
- Charges for records fee to include but not limited to cephalometric tracing, photos, models, radiographs (initial, progressive, and final, as deemed necessary), 3-dimensional cone beam computerized tomography (CBCT), and computerized-digital modeling of the jaws and face.
- Interceptive orthodontics or "preventive-orthodontics" of any sort (sometimes referred to as "PHASE ONE" orthodontic treatment) to the deciduous and/or transitional dentition.
- Orthodontic treatment for patients with deciduous and or transitional dentition retained in the patient's mouth.
- Orthodontic treatment using a removable or fixed orthodontic appliance to achieve a limited cosmetic result (for example moving a single anterior tooth because it is positioned too far back in the mouth).
- Charges for broken or missed appointments.
- Appliances constructed to prevent a future malocclusion from developing. For example, a "thumb-sucking" device to prevent the patient from sucking the thumb and causing flaring of the front teeth.
- Treatment which is received in more than one course of treatment, or which is not received in consecutive months or treatment exceeding 24 months.
- Any self-prescribed orthodontic treatment (orthodontic aligners that can be purchased from the Internet).

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

Prosthodontics: Existing, lost, or stolen prosthetic devices will be replaced once in the five-year period commencing on the date the appliance was last supplied, whether under this contract or any prior dental care policy, unless of dental necessity. An "immediate," "remote," "temporary," or "provisional" dentures are viewed as a "denture" (partial, complete, full) and subject to the 5-year replacement guidelines. For example, if a patient elects to have an immediate denture made by the attending dentist and then returns to have the immediate denture replaced with a remote denture, Blue Shield will view the immediate denture as the patient's final denture and there will be no replacement of the denture with another denture.

Partial Dentures: If a satisfactory result can be achieved by a standard cast chrome-resin partial denture, but the member and dentist select a more complicated precision appliance, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the obligation of the DHMO plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the member.

Complete ("full") Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, and the member and the Dental Provider select a personalized appliance or one involving specialized techniques, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the obligation of the DHMO plan will be any of the procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the member.

Dental prophylaxis: Dental prophylaxis (dental cleanings) are available not more than once in any period of 6 consecutive months. Prophylaxes performed in conjunction with fluoridation or any other periodontal procedure (e.g. gross debridement of tartar from teeth) shall be considered a dental prophylaxis for the purpose of applying this limitation. A dental prophylaxis should not be confused with a periodontal prophylaxis (also known as a "deep cleaning" or subgingival curettage and root planning procedure) which as a different treatment goal.

Benefit Limitations *(cont'd.)*

Endodontics: Root canal (endodontic) treatment includes pulp capping; therapeutic pulpotomy on deciduous teeth only (in addition to restoration); apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays, and apicoectomy (including apical curettage), but excluding the final restoration of the tooth. Documentation requires the submission of pre- and post-operative radiographs clearly showing the APEX of the treated tooth. The endodontic filling must meet current endodontic treatment guidelines (a three-dimensional root canal filling that is +/- 1.5 mm of the apex per UCSF-School of Dentistry Guidelines).

Palliative: This is emergency treatment for immediate relief of acute, intractable (severe) oral or tooth pain or the medical stabilization of the teeth or oral structures (not the definitive treatment or restoration of the dentition). For example, if a cusp is fractured on a tooth and there are "sharp edges that lacerate the soft tissues of the mouth, the "palliative" treatment is to smooth off the sharp edges of the tooth, not requesting a crown for the tooth (this is definitive treatment). Documentation requires submission of necessary pre- and post-radiographs and written documentation.

Periodontics: Periodontal (gum) treatment is available to treat emergency periodontal problems, periodontal abscess, acute/chronic periodontitis; root planning (not dental prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits). All periodontal surgery must meet BSC guidelines of gingival pocket depths, root exposure, jawbone recession around the teeth, and a fair to good long-term prognosis. There must be radiographic evidence there is sufficient exposed root surfaces AND root calculus to accomplish the treatment goals associated with "root planning" of the roots of the tooth/teeth. A "periodontal prophylaxis" ("deep cleaning" or subgingival curettage-root planning) is limited to once in 24 months per quadrant of teeth. Periodontal prophylaxis should not be confused with routine "dental prophylaxis" or "dental cleaning" which has a very limited treatment goal.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

NOTE: The so-called "deep cleaning" (subgingival curettage and root planning or periodontal prophylaxis) is considered a definitive surgical treatment modality for moderate to severe periodontal conditions (CPITN levels III, IV). It is recommended the member **direct** the participating dentist to obtain pre-certification for such a procedure by submitting a full set of current radiographs, bitewing radiographs, a complete periodontal pocket charting and any intra-oral photographs, as needed, to document the dental necessity for a "deep cleaning" to the DPA. Per utilization management guidelines, only 2 quadrants of the mouth can be treated in one (1) appointment and a local anesthesia must be utilized. For a "deep cleaning" to be authorized, the DPA will determine if there is sufficient exposed root surface of the teeth to allow for the planning of the root surfaces per the code definition AND if there is radiographic calculus visible on the root surfaces. A deep cleaning should not be confused with a "dental cleaning (dental prophylaxis)." The treatment goals of a "dental cleaning" are to remove stains and supragingival tartar (calculus) from the teeth primarily for cosmetic considerations and not necessarily to treat "gum disease" (CPITN 0, I, II). If the attending dentist makes a diagnose the member has "healthy gums," a "deep cleaning" is NOT NEEDED and payment will be denied.

Restorative Dentistry: Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling). Stainless steel crowns are used when the tooth cannot be restored with a direct filling material (stainless steel crowns, when properly prepared, are considered permanent restorations per the United States Department of Veterans Administration and subject to the 5 (five) year frequency limitations).

Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (SEVERE) dental or oral pain may be requested when the PROVIDER submits clinical information as the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment WAIVER is justified. A member calling a "customer service representative" stating that they are "in pain," is INSUFFICENT clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment GOAL, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to **medically** or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

Indirect Restorations: Non-precious metal crowns are generally specified for posterior teeth; porcelain fused to nonprecious metal restorations (crowns) are generally reserved for anterior teeth or when dental esthetics is a consideration. For crowns, a five-year period will be measured from the date the existing crown was last seated on the tooth or supplied, whether under this contract or under any prior dental care policy or Plan. Full ceramic, porcelain, ceramic-porcelain crowns are considered cosmetic procedures for anterior and posterior teeth; reimbursement will be at the same level as the appropriate metal crown for the tooth. The balance of the cost for such crowns will remain the responsibility of the member.

NOTE: Cast "inlays" (metal, ceramic, resin) will be reimbursed for the equivalent direct restoration.

Direct Restorations: Amalgam material is generally specified to restore posterior teeth; composite or plastic materials are used to restore anterior teeth. Judgement for materials used will be the responsibility of the Dental Provider providing the covered service. The use of composite or plastic materials on posterior teeth will be paid at the same level as the comparable amalgam restoration; the balance of the cost will remain the responsibility of the member.

Full Mouth Rehabilitation: If the member and the Dental Center select a course of mouth rehabilitation, the obligation of the DHMO plan will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth. The balance of the treatment, including costs to increase vertical dimension of the occlusion, improve esthetics or cosmetics, or to restore tooth loss by attrition or erosion, will remain the responsibility of the member.

Pedodontics: Referral of dependent children to a pedodontist will be covered by the DHMO plan for children up to, but not beyond 6 years old, with prior approval. Benefits are not applicable for pediatric dental care provided by a plan specialist for children age 6 and over unless of dental or medical necessity, or the child will not allow the general dentist to treat after two attempts (the provider must provide thorough clinical documentation, not just a note that states the "patient is uncooperative.") All such exceptions must be approved by the DPA (the DPA will adjudicate the treatment request for pediatric dental specialist services based on the training and reasonable treatment expectations of the scope of practice provided by general dentists practicing in the United States and Canada).

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

NOTE: Requests to obtain treatment from an "out-of-network" pediatric (or any) dental specialist because of personality or logistical issues (i.e., the parents do not "like" the "in-network" pediatric dental specialist or because the "drive is too far" to the "in-network" specialist) are not considered sufficient clinical rationale to allow the member to request services of a specialist outside the network.

Implants: Single cylinder implants are a benefit only when Plan criteria are met. Not a benefit are implants used to directly or indirectly support dentures, implants used as an abutment for a fixed dental bridge, when there are empty (edentulous) teeth spaces on both sides of the same dental arch ("bilateral edentulous spaces"), lower anterior teeth (teeth 22, 23, 24, 25, 26, 27), second molars (teeth 2, 15, 18, 31), third molars (teeth 1, 16, 17 and 32), when there is no opposing tooth/teeth, the tooth space is too small to accommodate a normal size tooth, and when the implant is **NOT** the initial replacement for a missing tooth. Depending on the Plan, the abutment for an implant is considered an INTEGRAL part of the implant screw and not a separate billable item or procedure. Implant procedures such as mounting diagnostic casts on an articulator, special implant surgical guides, uncovering the implant, temporary crowns utilized in the "immediate loading" technique, special manipulation or renderings of radiographs, extra or intra oral photographs, and three-dimensional radiographs are generally not a benefit of this Plan.

Emergency Claims: The DHMO plan's liability for emergency services rendered outside of the service area will be limited to $50 in palliative treatment services only. If emergency services outside of the service area were received and expenses were incurred by the member, the member must submit a complete claim with the emergency service record, to include pre-accident or pre-trauma radiographs, (a copy of the dentist's bill) for payment to the DPA within one year after the treatment date. Claims should be sent to:

Dental Benefit Providers of California, Inc.
425 Market Street, 12th Floor
San Francisco, CA 94105

If the claim is not submitted within this period, the DHMO plan will not pay for those emergency services unless the claim was submitted as soon as reasonably possible as determined by the plan. If the services are not pre-authorized, the DPA will review the claim retrospectively.

Dental - Blue Shield HMO Plans (DHMO)

References

Combined Evidence of Coverage and Disclosure Form Blue Shield of California Dental HMO Supplement.

Blue Shield of California Utilization Management Matrix

Dental - Blue Shield HMO Plans (DHMO)

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Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage

Benefits are provided for services performed by California licensed dentists and oral surgeons for treatment of teeth, jaws, and their dependent tissues.

The member is solely responsible for assuring that the dentist chosen is a participating dentist. The member is also solely responsible for following the Precertification of Dental Benefits Program which includes directing the participating or non-participating dentist to request and OBTAIN Precertification of ALL Benefits prior to the initiation of any dental treatment.

Before any course of treatment expected to cost more than $250 is started, the member should obtain Precertification of Benefits. The dentist should submit the recommended treatment plan and fees together with appropriate diagnostic x-rays to Blue Shield's Dental Plan Administrator (DPA) at:

Dental Benefits Providers of California, Inc.
425 Market Street, 12th Floor
San Francisco, CA 94105

The dental plan provides benefits for covered services at the most cost-effective level of care that is consistent with professionally recognized standards of care (in the United States and Canada). If there are two or more professionally recognized procedures for treatment of a dental condition, this Plan will generally provide benefits based on the most cost-effective procedure to restore the function of the tooth, teeth and oral cavity. The benefits provided under this plan are based on these considerations but the member and the attending dentist makes the final decision regarding treatment.

Services exceeding $250 are subject to pre-certification by Blue Shield.

Failure to obtain pre-certification of benefits will not necessarily result in denial of benefits. If the pre-certification process is not followed, the DPA will still determine payment by taking into account alternative procedures, services or materials for the dental condition based upon professionally recognized standards of practice. The covered dental expense will be limited to the allowed amount for the procedures which meets professionally recognized standards and is the most cost effective as determined by the DPA.

Principal Benefits and Coverages:

The following services are benefits when provided by a dentist and when necessary and customary as determined by the standards of generally accepted dental practice. These benefits are subject to the terms, conditions, limitations and exclusions of the plan.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

Diagnostic and Preventive Services:

- Clinical oral examinations: Oral examinations including consultations by a specialist (if diagnostic service is provided by a dentist or physician other than the practitioner providing treatment), not more than once in any period of 6 consecutive months.

- Dental prophylaxis: Dental prophylaxis (dental cleanings) are available not more than once in any period of 6 consecutive months. Prophylaxes performed in conjunction with fluoridation or any other periodontal procedure (e.g. gross debridement of tartar from teeth) shall be considered a dental prophylaxis for the purpose of applying this limitation. A dental prophylaxis should not be confused with a periodontal prophylaxis (also known as a "deep cleaning" or subgingival curettage and root planning procedure).

- Topical application of fluoride: not more frequently than once in any period of 12 consecutive months and only for eligible persons under the age of 18 except when dental necessity is established with submission of the "caries management by risk assessment" (CAMBRA) protocol tool available from the American Dental Association Website.

- Periodontal Services: Periodontal (gum) treatments are available for emergency periodontal problems, including but not limited to, periodontal abscess, acute periodontitis; root planning-subgingival curettage, periodontal debridement for certain medical problems or medication usage, gingival and osseous surgery (including post-surgical visits). All periodontal surgery must meet BSC guidelines of gingival pocket depths, root exposure, jaw bone recession around the teeth, and a fair to good long-term prognosis. There must be radiographic evidence there is sufficient exposed root surfaces AND root calculus to accomplish the treatment goals associated with "root planning" of the roots of the tooth/teeth. Periodontal prophylaxis" ("deep cleaning" or subgingival curettage-root planning) is limited to once in 24 months.

- NOTE: The so-called "deep cleaning" (subgingival curettage and root planning or periodontal prophylaxis) is considered a definitive surgical treatment modality for moderate to severe periodontal conditions (CPITN levels III, IV). It is recommended the member direct the participating dentist to obtain pre-certification for such a procedure by submitting a full set of current radiographs, bitewing radiographs, a complete periodontal pocket charting and any intra-oral photographs, as needed, to document the dental necessity for a "deep cleaning" to the DPA. Per utilization management guidelines, only 2 quadrants of the mouth can be treated in one (1) appointment and a local anesthesia must be utilized. For a "deep cleaning" to be authorized, the DPA will determine if there is sufficient exposed root surface of the teeth to allow for the planning of the root surfaces per the code definition AND if there is radiographic calculus visible on the root surfaces. A deep cleaning should not be confused with a "dental cleaning (dental prophylaxis)." The treatment goals of a "dental cleaning" is to remove stains and supragingival tartar (calculus) from the teeth primarily for cosmetic considerations and not necessarily to treat "gum disease" (CPITN 0, I, II). If the attending dentist makes a diagnose the member has "healthy gums," a "deep cleaning" is NOT NEEDED and payment will be denied.

- X-rays:

  - Bitewing film not more than once in any period of 6 consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of 24 consecutive months. In applying this 24-month limitation, a panoramic (pantomograph) x-ray shall be considered a full mouth series.

  - X-rays required to diagnose a specific condition that needs treatment are not subject to limitations stated above.

  - Three dimensional radiographs or rendering of a 3-dimensional radiograph ("cone beam computerized tomographic radiographs") are not a benefit.

- Diagnostic casts: Diagnostic cast are a benefit not more than once in any period of 24 consecutive months to evaluate the occlusion (bite). If the diagnostic casts are taken as part of the records preparing for orthodontic treatment, the casts will be covered under the lifetime orthodontic benefit. Working models taken in conjunction with a prosthetic, sleep apnea, temporomandibular joint, dental implants, malocclusion, or other appliance(s) are not considered to be diagnostic casts and are not a benefit.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

Basic Services:

- Anesthesia: General anesthesia, intravenous sedation, oral conscious sedation, and nitrous oxide analgesia (any medications used to alter mood, the perception of reality and calms patient anxiety will be referred to as "sedation") are/is provided only in conjunction with a covered oral surgical (not routine dental procedures) procedure(s) and consistent with the Blue Shield Basic Dental Plan and the State of California regulations pertaining to the appropriate use of general anesthesia in conjunction with oral surgery treatment. Local anesthesia is considered integral to any dental or oral surgery procedure and is not a separate billable procedure.

- NOTE: Per State of California Regulations, offices employing any manner of sedation must have a facility permit from the California Dental Board indicating the office is medically equipped to provide sedation services, has available emergency medications to manage any sedation emergency and the dental staff are fully trained in sedation procedures. Itinerate (mobile) dental anesthesia teams do not meet the California Regulations for the use of sedative agents in an office not licensed by the State Dental Board for general anesthesia or any sedation services.

- Endodontics: Pulp capping; therapeutic pulpotomy on deciduous teeth only (in addition to restoration); apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays and culture; and apicoectomy (including apical curettage), but excluding the final restoration of the tooth. Documentation requires the submission of pre- and post-operative radiographs clearly showing the APEX of the treated tooth. The endodontic filling must meet current endodontic treatment guidelines (a three-dimensional root canal filling that is +/- 1.5 mm of the apex per UCSF-School of Dentistry Guidelines).

- Oral Surgery: Extractions; removal of symptomatic (painful, infected) impacted teeth (not for any orthodontic considerations), radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre- and post-operative care. Removal of deciduous teeth that are within 6 months of natural exfoliation are not a covered benefit (adjudication by the Dental Plan Administrator). All oral surgery must be medically necessary. All ancillary procedures associated with the initial surgery are considered integral to the surgery and not separate billable procedures (sutures, follow-up treatments, removal of sutures, treatment for surgical complications, insertion of drains, prescriptions, bone fillers, post treatment materials, local anesthesia, etc.).

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

- Palliative: This is emergency treatment for immediate relief of acute, intractable (severe) oral or tooth pain or the medical-dental stabilization of the teeth or oral structures (not the definitive treatment or restoration of the dentition). For example, if a cusp is fractured on a tooth and there are "sharp edges that lacerate the soft tissues of the mouth, the "palliative" treatment is to smooth off the sharp edges of the tooth, not requesting a crown for the tooth (this is definitive treatment). Documentation requires submission of necessary pre- and post-radiographs and written documentation.

  Restorative Dentistry: Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling). Stainless steel crowns are used when the tooth cannot be restored with a direct filling material (stainless steel crowns, when properly prepared, are considered permanent restorations per the United States Department of Veterans Administration and subject to the 5 (five) year frequency limitations) .

- Sealants: One treatment in any period of 24 consecutive months per each permanent molar, and only for patients under age 18.

- Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (SEVERE) dental or oral pain may be requested when the PROVIDER submits clinical information as the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment WAIVER is justified. A member calling a "customer service representative" stating that they are "in pain," is INSUFFICENT clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment GOAL, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to **medically** or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

- Space Maintainers: Includes all adjustments within 6 months after the installation. Benefits for space maintainers are limited to eligible dependent children under age 16. Removal of a space maintainer is integral to the placement of the appliance.

Major Services:

- Cast Restorations – Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a direct filling material. Cast restorations consists of full cast metal crowns, inlays, veneers or onlays constructed of precious metal, dental casting metal, acrylic, composite-glass, porcelain, and porcelain-fused to metal inlays. Post-cores and crown build-ups are used on vital or non-vital teeth when functionally necessary to help to retain a crown. There is no coverage for replacement of an existing crown, inlay or onlay, or other cast restoration which is less than 5 years old and/or can be repaired. Repair or re-cementing on inlays, onlays and crowns is covered for 6 months after installation.

- Prosthetics – Bridges, dentures, partials and relining or rebasing dentures, adding teeth to an existing partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one course of treatment per 6-month period), and denture duplication (jump case). Fees for appliances include adjustments, repairs, and relines for a 6-month period following installation. An additional benefit for one reline per immediate denture is payable during the first 6 months following installation. Replacement of an existing partial denture which is more than 5 years old and cannot be repaired will normally be limited to a new partial denture. Upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture. A removable dental prosthesis, regardless of type, (immediate, remote, provisional, temporary, complete or partial), is regarded as a "denture" and subject to the 5-year replacement provision.

- Dental Implants: Depending on the Plan, dental implants may be a benefit; if a Plan authorizes implants as a benefit, then strict adherence to Plan utilization management guidelines and criteria must be met.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Coverage *(cont'd.)*

- Pedodontics: Referral of dependent children to a pedodontist will be covered by the Dental Plan for children up to, but beyond 6 years of age, with prior approval. Benefits are not applicable for pediatric dental care provided by a Plan specialist for children age 6 and over unless of dental necessity, or the child will not allow the general dentist to treat after two attempts (the provider must provide clinical documentation to include behavioral management techniques employed or attempted, not just a note that states the "patient is uncooperative.") All such exceptions must be approved by the DPA (the DPA will adjudicate the treatment request for pediatric dental specialist services based on the reasonable expectations of the scope of practice and training for general dentists practicing in the United States and Canada).

- Requests to obtain treatment from an "out-of-network" pediatric (or any) dental specialist because of personality or logistical issues (the parents/patient does not "like" the "in-network" pediatric dental specialist or because the "drive is too far" to the "in-network" specialist) are considered to be insufficient clinical rationale to allow members to request treatment outside the provider network.

All services for covered benefits are administered by Blue Shield's Dental Plan Administrator (DPA). Participating Dentists have agreed to accept the DPA's payment, plus any applicable deductible and copayment, as payment in full for covered services. This is not true of non-participating dentists who are not contracted to accept DPA payments as "payment in full" for dental services; any monetary balances for dental treatment by "out of network" dentists are the responsibility of the member.

The Blue Shield of California Smile *Basic* Dental Plan reduces coverage for services provided by non-participating dentists. Assignment of benefits to non-participating dentists is not allowed.

Applicable deductibles, copayments and charges in excess of the Allowable Amount by non-participating providers are the responsibility of the member.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Financial Responsibility

The allowable amount is the DPA's allowance for the service(s) rendered, or the provider's billed charge, whichever is less. Payments are based on the allowable amount as defined, and are subject to the dental benefit deductible, the indicated copayment percentages, and all benefit maximums as specified.

Participating Dentists:

- Services rendered for the procedures listed under Diagnostic and Preventive Services are paid at 100% of the allowable amount.
- Services rendered for the procedures listed under Basic Services are paid at 80% of the allowable amount. Subscribers are responsible for the remaining 20% of this amount.
- Services rendered for the procedures listed under Major Services are paid at 50% of the allowable amount. Subscribers are responsible for the remaining 50% of this amount.

Non-Participating Dentists:

- Services rendered for procedures listed under Diagnostic and Preventive Services are paid at 80% of the allowable amount. Subscribers are responsible for the remaining 20% of this amount as well as any charges above the allowable amount.
- Services rendered for procedures listed under Basic Services are paid at 70% of the allowable amount. Subscribers are responsible for the remaining 30% of this amount as well as any charges above the allowable amount.
- Services rendered for procedures listed under Major Services are paid at 50% of the allowable amount. Subscribers are responsible for the remaining 50% of this amount as well as any charges above the allowable amount.

Requests for payment by participating dentists, non-participating dentists, or the subscriber must be submitted to the DPA within 6 months after the month in which services were provided.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Copayment and Deductible Amounts

A calendar year deductible of $75 per person is applied as follows:

- The deductible applies to all covered services and supplies furnished by participating and non-participating dentists. The deductible applies separately to each covered person each calendar year.
- The maximum deductible required for services by any combination of participating and non-participating dentists is $50 per person, not to exceed $150 per family, each calendar year.
- Diagnostic and preventive services provided by participating dentists are not subject to deductible.

The Blue Shield of California Smile Basic Dental Plan pays up to a maximum of $1000 per person each calendar year for covered services and supplies provided by participating dentists, and a maximum of $750 per person per calendar year for covered services and supplies provided by non-participating dentists. The maximum payment each calendar year for covered services and supplies by any combination of participating and non-participating dentists is $1000 per person. (This maximum is not applicable to Orthodontic Services if a benefit.)

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Limitations

- Implants – Dental implants including any artificial materials, natural or synthetic bone grafting materials or soft tissue grafting materials which are implanted into, onto, or under bone or soft tissue, or the removal of implants (surgically or otherwise) are not a benefit unless specified in the Plan. Depending on the Plan, the implant abutment is generally considered an integral part of the implant screw and not a separate billable procedure. If an implant procedure is performed, without prior authorization from Blue Shield of California, the DPA or Blue Shield of California may pay the benefit available for any conventional restorative prosthetic procedure (if any) which could have been used to correct the subscriber's condition in a professionally satisfactory and/or least cost alternative manner. If the DPA or Blue Shield of California makes an allowance toward the cost of an implant procedure(s), benefits will not be available for any replacement prosthesis placed within the immediately following 5 years.

- Regardless if a Plan has dental implants as a benefit, dental implants are not provided under the following criteria: 1) Lower anterior teeth (teeth 22, 23, 24, 25, 26, 27), second molars (teeth 2, 15, 18, 31), 3) third molars (teeth 1, 16, 17, 18), 4) when there are empty tooth/teeth spaces on both sides of the same dental arch (jaw), 5) when there is no opposing tooth/teeth, 6) when the tooth space is too small to accommodate a normal size tooth, 7) to support (directly or indirectly) any sort of denture, 8) serve as an abutment for a fixed dental bridge, and 9) when the dental implant is NOT the initial replacement for the missing tooth.

- If the Plan allows for implants, the restoration of the implant with a permanent restoration is a benefit except if the implant screw was paid by the member without authorization from Blue Shield of California (self paid) or paid entirely by another dental plan not associated with Blue Shield of California.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Limitations *(cont'd.)*

- Crowns/Inlays – Benefits are not provided for crowns, inlays or onlays, laminate veneers, or other cast or laboratory prepared restorations if the tooth can be restored with a direct filling material (e.g., amalgam, composite resin, or silicate cement). Typically, a tooth must be missing 2 cusps and 3 surfaces to warrant a crown. Cracks visible in the enamel of the tooth, defective fillings, or large "cavities," are, in-of- themselves, insufficient clinical rationale for a crown.
- General Anesthesia – Benefits are not provided for general anesthesia or intravenous sedation except as administered by a licensed dentist in connection with a covered oral surgical procedure (not routine dental procedures) per Plan utilization guidelines.
- General anesthesia including intravenous, conscious (oral route) and inhalation sedation is considered medically necessary when its use is (a) in accordance with generally accepted professional standards, (b) due to the existence of a specific medical condition, and (c) not furnished primarily for the convenience of the patient, the parents, the attending dentist or other provider, and not provided because of dental phobias, combativeness, and non-cooperation of the patient (e.g., general anesthesia request are not a benefit because the patient requires "lots of dental treatment" and it is more convenient to place the child to sleep and do all the treatments in one appointment; general anesthesia is not a benefit simply because the parents or patient cannot "afford to take time off from work for their dental appointments; general anesthesia is not a benefit because the provider will not or is unwilling to make multiple treatment appointments for the patient or child).
- The site/office/physical location where general anesthesia, et.al., is administered must meet the minimal requirements/regulations set-forth for the administration of a general anesthetic in an outpatient facility and have the proper license and/or permit allowing for such procedures from the California Dental Board. The use of a mobile dental anesthesia service DOES NOT MEET THIS REQUIREMENT.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

- Written documentation of the medical condition necessitating use of general anesthesia or intravenous or inhalation sedation must be provided by a physician (M.D.) to the Dental Center. Written documentation on the medical condition of a patient from a dentist requesting medically necessary sedation services is not acceptable.
- Patient apprehension or patient anxiety will not constitute medical necessity when requesting intravenous sedation, general anesthesia, or inhalation analgesia (nitrous oxide gas)
- Mental retardation is an acceptable medical condition to justify use of general anesthesia. Autism is not necessarily a medical condition requiring the use of a general anesthetic for routine dental procedures.
- The Dental Plan reserves the right to review the use of general anesthesia to determine dental necessity.

Benefit Exclusions

Unless exceptions to the following general exclusions are specifically made elsewhere under these plans, Blue Shield of California Smile Basic Dental Plan does not provide benefits with respect to:

- Charges for services in connection with any treatment to the gums (gum surgery) or hard tissues for tumors, cysts and neoplasms.
- Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the DPA or Blue Shield of California provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the DPA or Blue Shield of California for the treatment of such injury or disease.
- Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums, and adjacent tissues) in preparation to construct a denture.
- Any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural or skeletal disorder, dysfunction, or disease of the temporomandibular (jaw hinge) joint and its associated structures, including but not limited to myo-facial pain dysfunction syndrome.
- Charges for treatments to augment the dental ridges due to the natural aging process (jaw atrophy) in preparation for a denture (partial or full) or implant.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Exclusions *(cont'd.)*

- Any surgery in preparation to place a dental implant (e.g., "sinus lift" procedure).
- Charges for services performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home.
- Any services or supplies provided in connection with a congenital anomaly (an abnormality present at birth) or developmental malformation (an abnormality which develops after birth). Congenital anomalies and developmental malformation include but are not limited to cleft palate/lip, cleft lip, upper or lower jaw malformations (e.g., prognathism), enamel hypoplasia (defective development), fluorosis (a type of enamel discoloration), treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth).
- Charges related to prescribed drugs or locally delivered drugs, pre-medication, analgesia, local anesthetics, sedatives, or periodontal pocket irrigation.
- Dental treatment when the mandatory "waiting period" has not been met for a dental treatment. An exception to the mandatory "waiting period" for a bonified dental emergency and/or when there is intractable (SEVERE) oral-dental pain may be requested when the PROVIDER submits clinical evidence (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) that such a treatment WAIVER is justified. A member calling a "customer service representative" stating that they are "in pain," is INSUFFICENT clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment GOAL, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to medically stabilize an emergency dental condition; it is not to restore the dentition.
- Dental treatment that does not meet Plan "utilization" guidelines (solely determined by the Dental Plan Administrator).
- Any dental treatment not provided by a California Dental Board licensed dentist or a dentist not licensed to practice in the United States of America or Canada (except for EMERGENCY dental treatment to MEDICALLY STABLIZE teeth and associated oral structures when the member is outside the United States; thorough documentation must be provided to the Pan).
- Services, procedures, or supplies which are not reasonably necessary for the care of the person's dental condition according to broadly accepted standards of professional care or which are investigational in nature or which do not have uniform professional endorsement.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Appliances, restorations or services, including but not limited to occlusal equilibration required solely to change, maintain or restore the vertical dimension of occlusion.
- Re-positioning the temporomandibular joints (jaw joints) or "re-capturing" the articulating disc of the TMJ fossa with an oral appliance.
- Splinting loose teeth (i.e., stabilizing periodontally loose teeth).
- Services, procedures or supplies which are purely cosmetic in nature. White facings on crowns or pontics posterior to the second bicuspid, and composite restorations on posterior teeth, shall always be considered cosmetic. If "white fillings" are placed on posterior teeth, most Plans will reimburse the provider for the equivalent "silver filling."
- The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been lost, damaged or stolen.
- Myofunctional therapy, athletic mouthguards, precision or semi-precision attachments, denture duplication, oral hygiene instruction, treatment of jaw fractures, sealants (over age 18), enameloplasty to prevent caries (cavities), oral habit devices, and charges for acid etching.
- Charges for saliva testing, caries testing, blood tests, diabetes tests, virus testing, and testing for the bacterial content of saliva.
- Charges for three dimensional radiographs.
- Any manner of prosthesis used to prevent a temporo-mandibular joint problem from developing (e.g., such as "morning aligners" used in conjunction with oral appliance to manage obstructive sleep apnea).
- Any manner of oral or facial prosthesis constructed to mask facial or jaw deformities/defects as the result of surgery, congenital or developmental issues.

Dental - Blue Shield Smile Basic Dental Plan (DPPO)

Benefit Exclusions *(cont'd.)*

- Orthognathic surgery, including but not limited to osteotomy, ostectomy, and other services or supplies to augment, re-position or reduce the upper or lower jaw to correct a skeletal discrepancy or occlusion.
- Charges for surgical services in connection with orthodontia, except those listed under covered services (e.g., removal of third molars prior to placing orthodontic appliances, gingivectomies to expose tooth/root surfaces, removal of teeth to manage the crowding of teeth, and etc.).
- Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable.
- Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues).
- Bone or soft tissue grafts to fill-in a tooth socket after an extraction or as a result of iatrogenic issues or complications associated with an oral surgical procedure.
- Bone grafts around dental implants.
- Hospital costs and any additional fees charged by the dentist for hospital treatment.
- Surgical services, treatments and/or oral appliances constructed by a dentist for the treatment and/or management of obstructive sleep apnea to include "morning aligners."
- Any service, procedure, or supply for which the prognosis for long-term success is not reasonably favorable, as determined by the DPA and its dental consultants.
- Any dental service for which the person is not legally obligated to pay as specified in the Provider Contract or for services for which no charge is made to the person.
- Any self- administered, self-prescribed dental treatment, dental therapies, or oral treatments (drug store purchased "nightguards, teething medications, self-administered teeth bleaching kits, self-administered orthodontic appliances, snore guards, appliances for obstructive sleep apnea, dental restoration kits, medications prescribed by a medical doctor for a dental problem, etc.).

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:
  - For full dentures or partial dentures: on the date the final impression is taken;
  - For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
  - For root canal therapy: on the date the pulp chamber is opened;
  - For periodontal surgery: on the date the surgery is actually performed;
  - For all other services: on the date the service is initially performed.

References

Blue Shield Smile Basic Dental Plan

Blue Shield of California Utilization Management Matrix

Diabetes Care

Benefit Coverage

The following medically necessary services for the treatment and management of diabetes and diabetes-related complications are covered when authorized:

- Diabetic equipment and devices, including glucometers (See list of covered items in Examples of Covered Services.)
- Professional office visits for examination and diagnosis, including specialist office visits, consultations, and office surgery
- Diabetic outpatient self-management training, education and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications
- Hospital outpatient care for services and supplies for treatments, diagnostic tests, emergency care, surgeries, and procedures performed in a hospital outpatient setting when appropriately authorized
- Inpatient care for services customarily furnished by a hospital when appropriately authorized
- Drugs and supplies (insulin, glucagon, disposable insulin needles and syringes, pen delivery systems, diabetic testing supplies including lancets, lancet puncture devices, and blood and urine testing strips and test tablets). For glucometers obtained at the pharmacy, coverage is limited to specific manufacturer brands. Preferred blood glucose test strips do not require prior authorization.

  Note: These drugs and supplies are covered by the Outpatient Prescription Drug benefit. No prescription is required by law for pen delivery systems (prior authorization required) or diabetic supplies; however, in order to be covered by the Outpatient Prescription Drug benefit, the member's physician must order them. For plans without an Outpatient Prescription Drug benefit, diabetic supplies and equipment are covered as basic plan benefits. However, insulin, prescription medications for treatment of diabetes, and glucagon are not covered unless the plan has Outpatient Prescription Drug coverage.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Diabetes Care

Benefit Exclusion

- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin)
- Video-assisted visual aid devices
- Routine foot care

Examples of Covered Services:

- Diabetic daycare and diabetic outpatient self-management training, education and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications
- Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes
- Visual aids (excluding eyewear) needed to assist the visually impaired when measuring (or dosing) their own insulin (excluding video-assisted devices)
- When authorized, blood glucose monitors for self-management of diabetes
- Insulin pumps (including needles and tubing) per Blue Shield Medical Policy
- Dosing devices such as dosing devices for syringes, insulin gauges, measuring devices, insulin-measuring devices, needle guides and syringe/vial holders, syringe loading devices with magnifier
- Magnifiers such as aspherical magnifiers with stand, dome magnifiers, fixed stand magnifiers, folding pocket magnifiers, hand held magnifiers, illuminated magnifiers, insulin syringe magnifiers, magnifying lamps or rules, visor magnifiers
- Transparent film dressings are covered if used with an insulin pump

Examples of Non-Covered Services:

- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin)
- Binoculars and other visual aid devices that only assist with distance vision
- Video-assisted visual aid devices
- Alcohol swabs

References

Evidence of Coverage

HMO Benefit Guidelines for:

Durable Medical Equipment (DME)

Rehabilitation and Habilitation Services

Orthoses

Outpatient Prescription Drugs

Blue Shield HMO IPA/Medical Group Procedures Manual

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Drugs-Basic Plan

Benefit Coverage

Benefits are provided for drugs, medications and biologicals administered in an inpatient, outpatient, or home setting as follows:

- Administered in the hospital
- Administered by a physician in an outpatient setting
- Administered by a home health agency in conjunction with an approved home health treatment plan
- Prescription drugs supplied upon discharge from a hospital inpatient stay for the purposes of transition from hospital to home, limited to a 3 day supply

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Medical Supplies/IV Solutions

Benefit Exclusion

Outpatient prescription drugs (covered if the member has the Outpatient Prescription Drug benefit).

Drugs-Basic Plan

Exceptions

Drugs and medications provided upon discharge from an inpatient setting (up to a 3 day supply) for the purpose of transition from hospital to home.

Examples of Covered Services

- Medically necessary drugs administered by a plan provider
- Immunizations (see the *HMO Benefit Guideline* for *Immunizations and Vaccinations*)

Examples of Non-Covered Services

- Over-the-counter medications
- Outpatient prescription drugs unless covered in the Outpatient Prescription Drug benefit
- Drugs administered for investigational purposes

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Immunizations and Vaccinations

Injectable Medications

Outpatient Prescription Drugs

Durable Medical Equipment (DME)

Benefit Coverage

Medically necessary and authorized durable medical equipment (DME) and supplies needed to operate DME, oxygen and its administration, ostomy supplies, and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function are covered. Visual aids (excluding eyewear) needed to assist the visually impaired when measuring (or dosing) their own insulin are also covered. DME, previously referred to as Home Medical Equipment (HME), is defined as:

> *Equipment designed for repeated use, which is medically necessary to treat illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition.*

Delivery charges are covered. Rental of DME is covered up to the purchase price unless the HMO authorizes purchase of the equipment instead of rental.

If an emergency room visit is authorized, no additional authorization is needed for the related DME given to the member at the emergency room. For instance, if a member has a fracture and is given crutches, a separate authorization for the crutches is not needed. The DME given must match services on the ER claim.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Medical Supplies

Durable Medical Equipment (DME)/Prosthetics

Orthotics

Diabetes Care

Durable Medical Equipment (DME)

Benefit Exclusions

Services are excluded for the following:

- Comfort items
- Over-the-counter disposable medical supplies
- Environmental control and hygienic equipment
- Exercise equipment
- Devices to perform medical tests on blood or other body substances in the home
- Home monitoring equipment and monitoring supplies (see Exceptions)
- Rental charges in excess of the purchase price (except rental charges for ventilators for long term use, and DME which are considered continuous rentals (e.g., oxygen & oxygen administration equipment)). Provider-specific Agreements as well as Blue Shield payment and/or medical policy may also dictate DME which is eligible for continuous rental status.
- Routine maintenance, repair or replacement of DME due to damage of any type, including loss resulting from fire or other accidents (see Exceptions)
- Self-help/educational devices
- Speech/language assistance devices
- Wigs
- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin)
- Video-assisted visual aids for diabetics
- Generators
- Backup or alternate equipment

Benefit Limitations

Limited to the least costly item to meet the patient's medical needs.

Durable Medical Equipment (DME)

Exceptions

When authorized as DME, other covered items include peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, and the home prothrombin monitor for specific conditions as determined by Blue Shield. Rental charges for ventilators for long term use are covered when authorized.

When authorized, visual aids (excluding eyewear) designed to assist the visually impaired with proper dosing of insulin (excluding video-assisted visual aids) are covered.

When authorized, replacement parts to extend the lifetime of Durable Medical Equipment are covered as a cost-effective measure.

When authorized, replacement of DME is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item.

A patient who requires a power wheelchair (PWC) usually is totally non-ambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease/condition. Power-operated wheelchairs/ vehicles are covered when prescribed by an MD or DO and when all of the following criteria are met:

- A mobility limitation exists that significantly impairs ability to participate in one or more mobility-related activities of daily living (MRADLs) in customary locations.
- The mobility limitation cannot be resolved by the use of an appropriately fitted cane, crutch, or optimally configured manual wheelchair.
- The patient does not have sufficient upper extremity function to self-propel a manual wheelchair to perform MRADLs.
- The patient's mental and physical capabilities are sufficient to safely operate a PWC that is provided.
- If the patient is unable to safely operate a PWC, the patient has a caregiver who is available, willing, and able to safely operate a PWC for the patient, but is otherwise NOT physically able to adequately propel a manual wheelchair.
- The patient's weight does not exceed the weight capacity of the requested PWC.
- The use of a PWC is expected to significantly improve or restore the patient's ability to perform or participate in MRADLs. For patients with severe cognitive and or physical impairments, participation in MRADLs may require the assistance of a caregiver.

Durable Medical Equipment (DME)

Examples of Covered Services

Covered Services include, but are not limited to:

- Elastic, compression, or custom high-pressure support stockings knee length or thigh length for the treatment of chronic venous insufficiency and edema (e.g., Jobst, Juzo, Sidvaris)
- Canes
- Colostomy/Ostomy supplies (See the *HMO Benefit Guideline* for *Medical Supplies*)
- Crutches
- Hospital beds
- Traction equipment
- Walkers
- Wheelchairs
- Positive Airway Pressure Devices and supplies (for treatment of sleep apnea)
- Hydraulic patient lifts (e.g., Hoyer Lift)
- Insulin pumps (including needles and tubing) per Blue Shield Medical Policy
- Dosing devices, such as dosing devices for syringes, insulin gauges, measuring devices, insulin measuring devices, needle guides and syringe/vial holders, syringe loading devices with magnifier
- Magnifiers, such as aspherical magnifiers with stand, dome magnifiers, fixed stand magnifiers, folding pocket magnifiers, hand held magnifiers, illuminated magnifiers, insulin syringe magnifiers, magnifying lamps or rules, and visor magnifiers
- Transcutaneous Electrical Nerve Stimulation (TENS) for the treatment of pain

Durable Medical Equipment (DME)

Examples of Non-Covered Services

Non-Covered Services include, but are not limited to:

- Over-the-counter disposable medical supplies for home use, purchased by the member; for example, support stockings and disposable/ thromboembolic deterrent stockings such as TED stockings, bandages, splints, etc. (See the *HMO Benefit Guideline* for *Medical Supplies*)
- Bandages
- Diapers
- Exercise equipment
- Spa
- Binoculars and other visual aid devices which only assist with distance vision
- Video-assisted visual aid devices
- Repair or replacement of DME due to damage of any type, including loss resulting from fire or other accidents
- Coverage for equipment that is not medically necessary, is predominantly for the convenience or comfort of the member, or is not primarily for a medical purpose
- Electric, elevator, stairwell-mounted, truck-mounted or ceiling-mounted patient lifts
- Power operated wheelchairs for patients who are capable of ambulation within the home but require a power vehicle for movement outside the home; power operated wheelchairs/vehicles generally intended for use outdoors; custom or heavy-duty wheelchairs, unless required to accommodate a patient's physical needs

Durable Medical Equipment (DME)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Home Health Care

Orthotics

Prostheses

Medical Supplies

Blue Shield HMO IPA/Medical Group Procedures Manual

Out of state DME claims should be processed by the local plan as with any out of state service. However, the local plan is not necessarily the state where the supplier resides. The local plan is defined as the plan in whose service area the ancillary services are rendered. For DME, the local plan would be the plan in whose service area the equipment was shipped to or purchased at a retail store.

Emergency

Benefit Coverage

Blue Shield and Blue Shield Life cover emergency services necessary to screen and stabilize members, without prior authorization, in cases where an enrollee reasonably believed he/she had an emergency medical condition given the enrollee's age, personality, education, background and other similar factors. Blue Shield and Blue Shield Life will also cover ambulance transportation services provided to an enrollee due to a "911" call for assistance.

California Health & Safety (H&S) Code 1317.1(a) defines "emergency services and care" as medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

The same section of the H&S Code also includes in the definition of "emergency services and care" an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

For emergency services, members 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. The member should notify the Primary Care Physician by phone within 24 hours after care is received unless it was not reasonably possible to communicate with the Primary Care Physician within this time limit. In such case, notice should be given as soon as possible.

Members should go to the closest plan hospital for emergency services whenever possible.

Blue Shield HMO will provide care in a non-plan hospital only for as long as the member's medical condition prevents transfer to a plan hospital.

Coverage is provided for a screening exam to determine if a psychiatric medical emergency condition exists and for care and treatment to stabilize the patient.

Emergency

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Care

Hospital ER Care

Physician Office Emergency Care

Durable Medical Equipment (DME)

Benefit Exclusion

Unauthorized emergency services rendered at an emergency facility are not covered if retrospective review determines that a reasonable person would not have believed that they had an emergency medical condition.

Unauthorized continuing or follow-up care after the initial emergency has been treated in a non-plan hospital or by a non-plan provider is not covered.

Examples of Non-Covered Services

- Prescribed drugs and medicines
- Over-the-counter medications
- Emergency room visits that are for non-emergency or routine problems, even if the visit is "after hours" or on the weekend. The member is to call the Primary Care Physician or physician-on-call for instructions or make an appointment with his/her Primary Care Physician.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Family Planning Counseling

Benefit Coverage

Family planning benefits include counseling and consulting services, physician office visits for diaphragm fitting, injectable contraceptives or implantable contraceptives, diaphragm fitting procedures, injectable contraceptives, implantable contraceptives, intrauterine device (IUD), insertion and/or removal of an IUD, infertility services to diagnose and treat the cause of Infertility, tubal ligation, and vasectomy.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Family Planning

Benefit Exclusion

Contraceptive drugs and devices that are covered under the Outpatient Prescription Drug benefit.

Benefit Limitations

No benefits are provided for infertility services related to the harvesting or stimulation of the human ovum (including medications, laboratory, and radiology service).

No benefits are provided for the insertion or removal of an IUD when used for non-contraceptive reasons, except the medically necessary removal of the IUD to treat related complications.

See *HMO Benefit Guidelines* for:

Infertility Services - Basic/Optional Benefit

Sterilizations

Family Planning Counseling

Examples of Covered Services

- Physician office visits for injectable contraceptives, implantable contraceptives, or diaphragm fitting
- IUD and the insertion or removal of the device
- Contraceptive education and counseling

Examples of Non-Covered Services

- Male Condoms
- Contraceptive drugs and devices, including diaphragms (covered under the Outpatient Prescription Drug benefit)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for*:*

Infertility Services-Basic & Optional Benefits

Sterilizations

Gynecological Examinations

Benefit Coverage

Routine breast and pelvic exams, Pap tests, or other Food and Drug Administration (FDA) approved cervical cancer and human papilloma virus (HPV) screening tests are covered annually for women.

A Blue Shield HMO female member may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or family practice physician (who is not their designated Personal Physician) without referral from her Personal Physician. The OB/GYN or family practice physician must be in the same medical group as the Personal Physician. Obstetrical and gynecological services are defined as follows:

- Physician services related to prenatal, perinatal, and postnatal (pregnancy) care
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia
- Physician services for treatment of disorders of the breast
- Routine annual gynecological examinations/annual well-woman examinations

The OB/GYN or family practice physician will notify the Personal Physician of the results of the examination. If the examination results identify the need for specialty services (for example, mammography, surgery, ultrasound, etc.), the member's Personal Physician must provide or arrange for the additional services.

Additional medically necessary mammograms for screening and diagnostic purposes are covered without limitation when done upon the referral of the patient's Personal Physician.

The benefit for a routine annual gynecological exam is in addition to the benefit for routine physical examinations, according to schedule, when performed by two different physicians.

Gynecological Examinations

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Preventive Services/Routine physical exams

Physician - Outpatient/office visits

Outpatient Hospital Services/Lab/X-Ray/Ancillary Services

Benefit Exclusion

Physical examinations required for licensure, employment, insurance, etc., unless the examination corresponds to the schedule of routine physical examinations.

Benefit Limitations

The following are general minimum guidelines for breast cancer detection for healthy persons as recommended by Blue Shield's Preventive Health Guidelines. The Personal Physician will determine the need for mammography based on individual risk factors.

Screening for breast cancer is a covered service for patients who meet the following criteria:

- Women must be 40 years and older, and
- The exam is performed every one to two years.

Gynecological Examinations

Benefit Limitations *(cont'd.)*

BRCA

Referral for genetic risk assessment and evaluation for BRCA mutation testing for breast and ovarian cancer susceptibility is a covered service for patients who meet **all** of the following criteria (medical policy applies for BRCA testing):

- Women
- Family history associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes

These services are considered inclusive in the preventive care visit, and therefore not separately reimbursable.

Examples of Covered Services

- Mammography
- Pap tests or other FDA approved cervical cancer screening tests
- Pelvic and breast examinations
- Urinalysis

Gynecological Examinations

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guideline for:

Physician Services

Preventive Health Services

US Preventive Services Task Force, Guide to Clinical Preventive Services

Health & Safety Code Section 1367.695

Home Health Care (HHC) Services - CalPERS

Benefit Coverage

Home health care services are a covered benefit when medically necessary and authorized by the Personal Physician and Blue Shield HMO. See the separate guidelines for Hospice Services and for PKU-Related Formulas and Special Food Products. Covered home health care services include:

1. Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) by any of the following professional providers:

    - Registered Nurse (RN)
    - Licensed Vocational Nurse (LVN)
    - Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), or Respiratory Therapist (RT)
    - Certified Home Health Aide (CHHA) in conjunction with services of an RN or LVN
    - Licensed Medical Social Worker (LMSW) for consultation and evaluation of the home health care treatment plan

    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).

2. In conjunction with the professional services rendered by a home health care or home infusion agency, medical supplies, disposable medical supplies, and medications administered by the home infusion agency necessary for the home health treatment plan are also a covered benefit. Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Health Care and Home Infusion agency.

3. Related pharmaceutical and laboratory services to the extent the services would have been provided had the member remained in the hospital or skilled nursing facility.

4. Medically necessary home visits by a physician.

5. Home infusion therapy including parenteral and enteral nutrition services for tube feedings and associated supplies and solutions.

6. Medically necessary FDA-approved self-injectable medications when prescribed by the Personal Physician and prior authorized by Blue Shield. Self-injectable medications may be obtained from a home infusion agency through the medical benefit or from a Blue Shield participating Specialty Pharmacy under their outpatient prescription benefit. Refer to the *HMO Benefit Guideline* for Medical Benefit Drugs for additional details.

Home Health Care (HHC) Services - CalPERS

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Physician Home Visit
Agency visit

Medical Supplies/IV Solutions

Durable Medical Equipment

Prosthetics/Orthotics

Home Health Care (HHC) Services - CalPERS

Benefit Exclusion

The following services are excluded:

- Services for private duty nursing
- Services for custodial, maintenance, or domiciliary care, services for rest, or services to control, or to change a person's environment

Benefit Limitations

IFP: The combined visit limitation for home health care includes visits by providers from a home health care agency, home infusion agency, or hospice agency (RN, LVN, PT, OT, ST, RT, CHHA, or LMSW). See the separate guideline for hospice services for group members.

Home self-injectable medications are limited to a quantity not to exceed a 30-day supply. Prescriptions may be refilled at a frequency that is considered to be medically necessary.

Examples of Covered Services

- Intermittent nursing visits for wound care, IV medication treatments
- Intermittent physical therapy visits for home traction treatment

Home Health Care (HHC) Services - CalPERS

References

Evidence of Coverage

HMO Benefits Guidelines for:

Chemotherapy
Custodial Care
DME
Hospice Care
Medical Benefit Drugs
Orthoses
Oxygen
Parenteral/Enteral Nutrition
Prostheses

Blue Shield HMO IPA/Medical Group Procedures Manual

Home Health Care (HHC) Services

Benefit Coverage

Home health care services are a covered benefit when medically necessary and authorized by the Personal Physician and Blue Shield HMO. Hospice services to an Individual and Family Plan (IFP) member are covered under this benefit. See the separate guideline for hospice services for group members for information on the separate benefit for those members.

Covered home health care services include:

1. Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) by any of the following professional providers:

    - Registered Nurse (RN)
    - Licensed Vocational Nurse (LVN)
    - Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), or Respiratory Therapist (RT)
    - Certified Home Health Aide (CHHA)
    - Medical Social Worker (MSW) for consultation and evaluation of the home health care treatment plan

    Home health care visits by a RN, LVN, PT, OT, ST, RT, CHHA or MSW are limited to a combined 100 visits per calendar year.

    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).

2. In conjunction with the professional services rendered by a home health care or home infusion agency, medical supplies, disposable medical supplies, and medications administered by the home infusion agency necessary for the home health treatment plan are also a covered benefit.

3. Related pharmaceutical and laboratory services to the extent the services would have been provided had the member remained in the hospital or skilled nursing facility.

4. Home infusion therapy including parenteral and enteral nutrition services for tube feedings and associated supplies and solutions. Benefits are also provided for infusion therapy provided in infusion suites associated with a participating Home Infusion agency.

Home Health Care (HHC) Services

Benefit Coverage *(cont'd.)*

5. Medically necessary FDA-approved self-injectable medications, also known as Specialty Drugs, when prescribed by the Personal Physician and prior authorized by Blue Shield. Self-injectable medications or Specialty Drugs may be obtained from a home infusion agency under the medical benefit or from a Blue Shield participating pharmacy under the outpatient pharmacy benefit.

   Specialty Drugs are defined as specific drugs used to treat complex or chronic conditions that usually require close monitoring. Specialty Drugs may be self-administered by injection, inhalation, orally or topically. These drugs may also require special handing, special manufacturing processes, have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy and Therapeutics Committee, prior authorized for medical necessity by Blue Shield and obtained from a Blue Shield Specialty Pharmacy. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary.

   Refer to the Medical Benefit Drugs guideline.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Agency visit

Durable Medical Equipment

Prosthetics/Orthotics

Physician Services

Physician Home Visit

Home Health Care (HHC) Services

Benefit Exclusion

The following services are excluded:

- Services for private duty nursing
- Services for custodial, maintenance, or domiciliary care, services for rest, or services to control, or to change a person's environment

Benefit Limitations

Group: The home health care services benefit is limited to a combined total of visits per calendar year by the following home health care agency professional providers: RN, LVN, PT, OT, ST, RT, CHHA, and MSW.

IFP: The combined visit limitation for home health care includes visits by providers from a home health care agency, home infusion agency, or hospice agency (RN, LVN, PT, OT, ST, RT, CHHA, or MSW). See the separate guideline for hospice services for group members.

Home self-injectable medications are limited to a quantity not to exceed a 30-day supply. Prescriptions may be refilled at a frequency that is considered to be medically necessary.

Examples of Covered Services

- Intermittent nursing visits for wound care, IV medication treatments
- Intermittent physical therapy visits for home traction treatment
- Home infusion therapy, visits for chemotherapy for cancer catheterization, medical supplies used during a covered visit, and pharmaceuticals administered intravenously
- Parenteral/enteral nutritional services and associated supplies and solutions provided by a home health agency or by a home infusion agency
- Hemophilia home infusion services prior authorized and provided by a Hemophilia Infusion Provider or home infusion nurse

Home Health Care (HHC) Services

Examples of Non-Covered Services

- Homemaker services
- Custodial care in the home setting

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefits Guidelines for:

Chemotherapy
Custodial Care
DME
Hospice Care
Medical Benefit Drugs
Orthoses
Oxygen
Parenteral/Enteral Nutrition
Physician Services
Prostheses

Blue Shield HMO IPA/Medical Group Procedures Manual

Hospice Care

Benefit Coverage

Hospice services by a participating hospice agency contracted with Blue Shield are covered for a member with a terminal illness as determined by the treating physician. The member must request and be formally admitted to an approved hospice program. Blue Shield's Medical Care Solutions department and the delegated IPA/medical group's utilization management department must approve admission to the hospice program through the prior authorization process.

Terminal illness is defined as medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

The following covered services are available on a 24 hour basis to the extent necessary to meet the needs of the member for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions:

1. Pre-hospice consultative visit by Hospice provider regarding pain and symptom management, hospice and other care options including care planning. Note: Members do not have to be enrolled in a 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 counseling.

5. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling by a qualified provider, when needed.

6. Medical direction with the hospice medical director being also responsible for meeting the general medical needs for the terminal illness of the members to the extent that these needs are not met by the Primary Care Physician.

7. Volunteer services.

Hospice Care

Benefit Coverage *(cont'd.)*

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. Respiratory therapy.

12. Nursing care services on a continuous basis for as much as 24-hours a day during periods of crisis as necessary to maintain a member at home and achieve palliation or management of acute medical symptoms. 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.

13. Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.

14. Occasional respite care services (no more than five consecutive days at a time). Respite care services are short-term inpatient services covered only when necessary to relieve the family members or other caregivers.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits* for member copayments.

Benefit Exclusion

Hospice services provided by a non-participating hospice agency are not covered. See exceptions below.

Benefit Limitations

Members are allowed to change their participating hospice agency only once during each period of care. Members may receive care for either a 30 or 60-day period, depending on their diagnosis. The care continues through another period of care if the Primary Care Physician recertifies that the member is terminally ill.

Hospice care received out of the IPA/medical group service area (e.g., member moves to a relative's household in another part of California or out of state) will not be covered unless authorized in advance by Blue Shield's Medical Care Solutions Department. Contact Blue Shield for more information.

Exceptions

Hospice services provided by a non-participating hospice agency are not covered except in certain circumstances in counties in California in which there are no participating hospice agencies. Such services must be approved in advance by the Blue Shield Medical Care Solutions Department. Contact Blue Shield for more information.

Hospice Care

Examples of Covered Services

- Pre-hospice consultative visit by Hospice providers
- Continuous home care provided during a period of crisis
- Short-term inpatient care arrangements
- Inpatient respite care to relieve the family or other caregivers for no more than five consecutive days at a time
- Interdisciplinary home care plan

Examples of Non-Covered Services

- Respite care for more than five consecutive days
- Services by the hospice agency to treat conditions not related to the terminal illness
- Treatment by the hospice agency intended to cure a terminal illness rather than provide palliative care
- Care received from a non-hospice agency provider that duplicates care received from the hospice

References

Evidence of Coverage – Group

Evidence of Coverage and Health Service Agreement – IFP

Blue Shield HMO IPA/Medical Group Procedures Manual

Hospital – Inpatient Care

Benefit Coverage

Inpatient services customarily furnished by a hospital for a member who is admitted to a hospital as a registered bed patient who requires an acute bed-patient (overnight) setting when services are medically necessary and appropriately authorized are covered.

For hospital admissions for mastectomies or lymph node dissections, the length of a hospital stay will be determined solely by the member's physician in consultation with the member.

Inpatient psychiatric hospitalization, professional services related to psychiatric hospitalization, daycare and psychological testing for mental illness (including severe mental illness and serious emotional disturbances of a child) are covered when authorized and provided by a Mental Health Services Administrator (MHSA) under contract with Blue Shield.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Infertility Services

Maternity Care

Normal Delivery/C-Sections

Mental Health

Physician Services

Rehabilitation and Habilitation Services

Substance Abuse

Hospital – Inpatient Care

Benefit Exclusions

The following inpatient services are excluded:

- Inpatient hospitalization for monitoring, testing, or diagnostic studies that could have been provided on an outpatient basis.
- Hospitalization in pain management center to treat or cure chronic pain.
- Hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, domiciliary care, residential care, or for personal comfort.
- Psychiatric hospitalization and daycare, psychiatric professional services, delivered in conjunction with inpatient hospitalization and daycare not authorized or provided by the MHSA.
- Testing for intelligence or learning disabilities.
- Services performed in a hospital by hospital officers, residents, interns or others in training.

Benefit Limitations

See the *HMO Benefit Guidelines* Benefit Limitations for:

Maternity Care

Mental Health - Basic Plan Core/Basic Plan Small Business and IFP

Infertility Services - Basic Plan/Additional Benefits

Rehabilitation and Habilitation Services

Skilled Nursing Facility (SNF)

Substance Abuse - Basic Plan

Substance Abuse - Optional Benefit

Examples of Covered Services

- Semiprivate room and board, unless a private room is medically necessary.
- General nursing care.
- Operating room, newborn nursery.
- Hospital ancillary services including diagnostic laboratory and X-ray services
- Medications and biologicals administered in the hospital, and up to a 3-day supply of drugs supplied upon discharge by the Plan physician for the transition from the hospital to the home.
- Authorized Surgical procedures and supplies.
- Blood and blood products.
- Radiation therapy, chemotherapy and renal dialysis.

Examples of Non-Covered Services

See Benefit Exclusions.

Hospital – Inpatient Care

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Mental Health

Substance Abuse - Basic Plan

Substance Abuse - Optional Benefits

Blue Shield HMO IPA/Medical Group Procedures Manual

Hospital – Outpatient Care

Benefit Coverage

Hospital outpatient care is covered for medically necessary services and supplies for treatments, diagnostic tests, and emergency care, surgeries, and procedures performed in a hospital outpatient setting when appropriately authorized.

Any questions about the appropriate setting for a surgery/procedure should be referred to Blue Shield HMO Medical Care Solutions.

For mental health and substance abuse services, outpatient care must be authorized and provided by the Mental Health Services Administrator (MHSA) under contract with Blue Shield.

Members may call MHSA directly at (877) 263-8827 to arrange for mental health and substance abuse services. Members may also ask their Personal Physicians to contact MHSA to arrange for these services for them.

Note: The Optional Plan benefit for Substance Abuse allows for a substitution of two (2) day care days for one (1) inpatient day. Claims for day care are the responsibility of the MHSA.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Care

Optional Benefits

Infertility Services

Substance Abuse

Outpatient Hospital Services

Hospital – Outpatient Care

Benefit Limitations

Refer to the Benefit Limitation sections of the *HMO Benefit Guidelines* for:

Ambulatory Surgeries/Procedures

Chemotherapy

Emergency Services

Infertility - Basic Plan/Optional Benefit

Mental Health

Rehabilitation and Habilitation Services

Substance Abuse - Basic Plan/Optional Benefit

Examples of Covered Services

Outpatient care is covered for:

- Computerized Axial Tomography (CAT) Scan
- Chemotherapy
- Lymph Node Biopsy
- Magnetic Resonance Imaging (MRI)
- Treadmill tests

Hospital – Outpatient Care

Examples of Non-Covered Services

Outpatient psychiatric or substance abuse services not authorized or provided by the MHSA.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Facility Based Ambulatory Surgery/Procedures List

HMO Benefit Guidelines for*:*

Ambulatory Surgery/Procedures

Chemotherapy

Emergency Services

Infertility - Basic Plan/Optional Benefits

Rehabilitation and Habilitation Services

Substance-Abuse - Basic Plan

Blue Shield HMO IPA/Medical Group Procedures Manual

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Immunizations and Vaccinations

Benefit Coverage

Benefits for pediatric and adult immunizations, vaccinations, and immunizing agents are provided based on Blue Shield's Preventive Health Guidelines. The guidelines regarding immunizations and vaccinations are derived from the most recent recommendations of the American Academy of Pediatrics and United States Public Health Service through its U.S. Preventive Services Task Force and/or under the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) including their frequency and patient age recommendations.

To view the guidelines, log on to Provider Connection at blueshieldca.com/provider and click on the *Guidelines & Resources* tab at the top. Next, click on *Guidelines and Standards*, then *Preventive Health Guidelines*.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Immunizations and Vaccinations

Examples of Covered Vaccinations

Vaccinations that are recommended by the American Academy of Pediatrics or the United States Public Health Service through its U.S. Preventive Services Task Force and/or under the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC).

Note: This is not a comprehensive list of vaccines covered by Blue Shield.

- Pediatrix (a combination of DTaP, IPV, and HepB)
- Diphtheria, Tetanus, Pertussis (DTaP) vaccination
- Haemophilus influenzae type b4
- Influenza vaccination (seasonal)
- HPV Gardasil (Quadrivalent Human Papillomavirus (Types 6, 11, 16, 18) Recombinant Vaccine
- Varicella (Chickenpox) (Var) vaccination
- Polio vaccination (IPV)
- Measles, Mumps, Rubella (MMR) vaccination
- Rotavirus (RV) vaccination
- Tetanus and diphtheria booster (Td)
- Tetanus, diphtheria toxoids, and acellular pertussis vaccine (TdaP)
- Pneumococcal vaccination (Prevnar-13)
- Meningitis vaccination (MCV4)
- Zoster (shingles)

Immunizations and Vaccinations

Examples of Non-Covered Vaccinations

- Vaccinations that are not recommended by the American Academy of Pediatrics or the United States Public Health Service through its U.S. Preventive Services Task Force and/or under the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC).
- Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel. This applies to employer groups, Individual Family Plan (IFP) members, and FEHBP members (this exclusion does not apply to CalPERS). Please see the *Evidence of Coverage* for details.
- Anthrax Vaccination
- Smallpox Vaccination

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Advisory Committee on Immunizations Practices (ACIP)

US Preventive Services Task Force, Guide to Clinical Preventive Services; 2nd edition, Baltimore: Williams & Wilkins, 1996

American Academy of Pediatrics (AAP)

California Code of Regulations, Title 10, Section 1300.67 (f) (5)

Centers for Disease Control (CDC)

HMO Benefit Guidelines for*:*

Preventive Health Services

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Infertility - Additional Benefits

Benefit Coverage

Additional infertility services are covered when defined as a benefit on the member's Blue Shield Health Plan. (The basic plan has limited benefits for the diagnosis and treatment of the cause of infertility.)

These additional services must be provided to a covered member with conception in the member as the intended result of the services. Procedures must be consistent with established medical practice in the treatment of infertility and induced fertilization.

Additional benefits include prescribed injectable drugs to stimulate fertility, including needles and syringes and the following procedures up to a lifetime benefit maximum see members EOC for coverage limitations:

- Natural artificial inseminations supervised by a physician (without ovum [egg] stimulation).
- Stimulated artificial inseminations (with ovum [egg] stimulation).
- Gamete intrafallopian transfer (GIFT) is covered even though it is performed in association with the excluded service, intracytoplasmic sperm injection (ICSI).
- Cryopreservation of sperm/eggs/embryos when retrieved from a subscriber, spouse or covered domestic partner. Benefits include cryopreservation services 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). See member's EOC for benefits limits.

Infertility - Additional Benefits

Benefit Coverage *(cont'd.)*

For the purpose of this optional benefit, infertility is defined as:

The member must be actively trying to conceive and has either:

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. Failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician. (The initial six cycles of artificial insemination are not a benefit of this plan); or
5. Three or more pregnancy losses.

Infertility optional benefits are not available for IFP members.

Note: When services are prior authorized by Blue Shield, within 5 days before the actual date of service, providers MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke their authorization prior to services being rendered based on cancellation of the member's eligibility.

Covered for this benefit, the following injectables are generally administered by the patient in the home. These injectables can be provided by a Blue Shield specialty pharmacy who will deliver them to the patient's home. They are not considered to be under the home self-administration benefit category.

Brand Name	**Generic Name**
Pergonal, Humagon	Menotropins
Metrodin	Urofollitropin
Profasi HIP, APL, Pregnyl, Choron	Chorionic Gonadrotropin (HCG)
Gonal-F	Follitropin

Consult the Blue Shield HMO for a complete list of covered medications that are provided in the physician's office or for home self-administration.

Infertility - Additional Benefits

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Infertility services are not provided for:

- Sexual dysfunction or sexual inadequacies
- Services incident to or resulting from procedures for a surrogate mother; however, if the surrogate mother is an enrolled member of a Blue Shield health plan, covered pregnancy and maternity care will be provided to her under her own plan
- Collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the subscriber or enrolled spouse or domestic partner (if domestic partners are covered by the plan)
- Intracytoplastmic sperm injection (ICSI)
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Oral drugs for the treatment of infertility

Benefit Limitations

See member's EOC for benefit/coverage limits.

Infertility - Additional Benefits

Examples of Covered Services

- Artificial insemination and supporting procedures
- Gamete Intrafallopian Transfer/G.I.F.T.

Examples of Non-Covered Services

- Services for sexual dysfunction and sexual inadequacies
- Services incident to or resulting from procedures for a surrogate mother who is not covered for maternity services under her own Blue Shield health plan.
- Services for collection, purchase, or storage of sperm/eggs from donors other than the subscriber, enrolled spouse or domestic partner (if domestic partners are covered by the plan).
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Intracytoplasmic sperm injection (ICSIO are excluded as a benefit)
- Infertility services for an individual who is not a member
- Sterilization reversals are excluded as a benefit

References

Additional Infertility Services, Supplement to the *Evidence of Coverage* and *Disclosure Form*.

Infertility – Basic Plan

Benefit Coverage

Inpatient, outpatient, professional and ancillary services prescribed or administered by the provider to diagnose and treat the cause of infertility are covered services for group members. In addition, Depo Lupron is an office-administered injectable and currently the only injectable medication covered when provided for the treatment of endometriosis as a cause of infertility, which is defined as:

The member must be actively trying to conceive and has either:

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. Failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician. (The initial six cycles of artificial insemination are not a benefit of this plan); or

5. Three or more pregnancy losses.

The treatment of the cause of infertility does not include pregnancy by artificial means.

Services to diagnose and treat the cause of infertility are not covered for IFP members.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Infertility – Basic Plan

Benefit Exclusions

- Services for or incident to non-organic based sexual dysfunction or sexual inadequacies, services related to assisted reproductive technology, including but not limited to in vitro fertilization (I.V.F.), Gamete Intrafallopian Transfer (G.I.F.T.) procedure, artificial insemination, services or medications to treat low sperm count, any other form of assisted fertilization (including related medications, laboratory, and radiological services), or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan.
- Medications and drugs that may be covered under the basic benefit for treating the medical cause of infertility are not covered when used in conjunction with, or to enhance assisted reproduction, or any form of induced fertilization. (Injectable medications may be covered under optional Infertility-Additional Benefits.)
- Services for, or incident to, the treatment of infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation are not covered, or complications of any such procedures.
- Services for IFP members are not covered.
- Services related to harvesting or stimulation of the human ovum, including medications, laboratory, and radiology services.

Exceptions

See *HMO Benefit Guidelines* for:

Infertility – Additional Benefits

Outpatient Prescription Drugs

Infertility – Basic Plan

Examples of Covered Services

The diagnosis and treatment of infertility includes:

- Office visits (medical history and physical exams)
- Depo Lupron used for the treatment of endometriosis as a cause of infertility
- Diagnostic tests and surgical procedures specific to infertility

Male

- Epididymovasostomy, anastomosis of epididymis to vas deferens
- Semen analysis, sperm antibodies, sperm evaluation

Female

- Laparoscopy with lysis of adhesions or with aspiration
- Hysteroscopy
- Injection procedure for hysterosalpingography
- Transcervical introduction of fallopian tube catheter for diagnosis and establishing potency, with or without hysterosalpingography
- Hydrotubation of oviduct
- Lysis of adhesions
- Fimbrioplasty
- Salpingostomy
- Hysterosalpingography
- Echography, pelvic
- Ultrasonic guidance for aspiration of ova

Infertility – Basic Plan

Examples of Non-Covered Services

- Artificial insemination
- Gamete Intrafallopian Transfer (G.I.F.T.)
- In vitro fertilization (I.V.F.)
- Intracytoplasmic sperm injection (I.C.S.I.)
- Other forms of induced fertilization
- Any service related to the harvesting or stimulation of human ovaries in conjunction with or to enhance any form of assisted reproduction or induced fertilization (which includes laboratory services, radiology services, or medications such as Gonal F, Follistin, Lupron, Fertinex, Pergonal, Humagon)
- Penile implant devices and surgery, except as covered under Reconstructive Surgery Benefits
- Services for or incident to sexual dysfunction and sexual inadequacy, except as provided for treatment of organic-based conditions
- Services incident to or resulting from procedures for a surrogate mother
- Services for collection, purchase, or storage of sperm/eggs
- Other services (semen analysis, other urological testing) for male spouse who is not also a member
- Services for, or incident to, the reversal of a vasectomy or tubal ligation (for example, vasovasostomy, vasovasorrhaphy, tubotubal anastomosis)
- Services or medication to treat low sperm count
- Sterilization reversals are excluded as a benefit

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Infertility – Additional Benefits

Infertility – CalPERS & FEHBP

Outpatient Prescription Drugs

Infertility - CalPERS/FEHBP

Benefit Coverage

For the purpose of this benefit, infertility is defined as:

- The presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of infertility, or
- Because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or
- The inability to conceive a pregnancy after six cycles of artificial insemination. These initial six cycles are not a benefit of this Plan.*

* Note: That portion of the definition which recognizes infertility as the inability to conceive a pregnancy after six cycles of artificial insemination does not apply to FEHBP.

Services to Diagnose and Treat the Cause of Infertility

Inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider to diagnose and treat the cause of infertility are covered. Depo Lupron is currently the only injectable medication covered when provided for the treatment of endometriosis as a cause of infertility.

Services to Treat Infertility

When authorized by Blue Shield, some inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider for the treatment of infertility are covered. These additional services must be provided to a covered member with conception in the member as the intended result of the services. Procedures must be consistent with established medical practice in the treatment of infertility and induced fertilization.

Services to treat infertility include prescribed home self-administered injectable drugs, including needles and syringes, and artificial insemination (with and without egg stimulation). (See “Benefit Exclusions” below for services that are specifically excluded.)

When the following injectables are approved for home self-administration, the member must purchase the injectable, needles, and syringes at a Blue Shield participating pharmacy and submit a receipt to Blue Shield HMO for reimbursement under the Family Planning benefit of the CalPERS HMO Plan.

Brand Name	**Generic Name**
Pergonal, Humagon	Menotropins
Metrodin	Urofollitropin
Profasi, APL, Pregnyl, Choron	Chorionic Gonadrotropin (HCG)
Gonal F	Follitropin

Infertility – CalPERS/FEHBP

Benefit Coverage *(cont'd.)*

Consult Blue Shield HMO for a complete list of covered medications that are provided in the physician's office or for home self-administration.
See the member's EOC for benefit coverage.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Infertility services are not provided for:

- Sexual dysfunction or sexual inadequacies
- Services incident to or resulting from procedures for a surrogate mother; however, if the surrogate mother is an enrolled member of a Blue Shield health plan, covered pregnancy and maternity care will be provided to her under her own plan.

  Note: If a child resulting from a surrogate parenting arrangement meets the requirements and is enrolled as a "Dependent" (as defined by Blue Shield) of a Blue Shield subscriber, all covered services are available to such child from the first date of coverage.
- Collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the enrolled spouse or domestic partner
- Gamete intrafallopian transfer (GIFT)
- Intracytoplastmic sperm injection (ICSI)
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Ovum transplant
- Any form of induced fertilization except for artificial insemination
- For or incident to the reversal of a vasectomy or tubal ligation or repeat vasectomy or tubal ligation
- Services or medications to treat low sperm count
- Sterilization reversals are excluded as a benefit

Examples of Covered Services

Services to diagnose and treat the cause of infertility

- Office visits (medical history and physical exams)
- Depo Lupron used for the treatment of endometriosis as a cause of infertility
- Diagnostic tests and surgical procedures specific to infertility

Male

- Epididymovasostomy, anastomosis of epididymis to vas deferens
- Semen analysis, sperm antibodies, sperm evaluation

Female

- Laparoscopy with lysis of adhesions or with aspiration
- Hysteroscopy
- Injection procedure for hysterosalpingography
- Transcervical introduction of fallopian tube catheter for diagnosis and establishing potency, with or without hysterosalpingography
- Hydrotubation of oviduct
- Lysis of adhesions
- Fimbrioplasty
- Salpingostomy
- Hysterosalpingography
- Echography, pelvic
- Ultrasonic guidance for aspiration of ova

Services to treat infertility

- Artificial insemination and supporting procedures

Infertility – CalPERS/FEHBP

Examples of Non-Covered Services

- Services for sexual dysfunction and sexual inadequacies, except as provided for organically based conditions
- Services incident to or resulting from procedures for a surrogate mother who is not covered for maternity services under her own Blue Shield health plan
- Services for collection, purchase, or storage of sperm/eggs from donors other than enrolled spouse or domestic partner
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Infertility services for an individual who is not a member

References

CalPERS Access+ HMO Combined Evidence of Coverage and Disclosure Form

Blue Shield Access+ HMO FEHBP Plan Brochure

HMO Benefit Guidelines for:

Outpatient Prescription Drugs

Blue Shield HMO IPA/Medical Group Procedures Manual

Maternity Care

Benefit Coverage

Prenatal and postnatal physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. All necessary inpatient hospital services for normal delivery, Cesarean section, complications of pregnancy and routine newborn circumcision.

The Newborns and Mothers Health Protection Act of 1997 requires health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal vaginal delivery. A minimum hospital stay for the mother and newborn child of 96 hours is required after a C-section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

Note: If the mother is not covered as a subscriber or spouse by the Blue Shield HMO plan, and the newborn qualifies as a dependent of the subscriber, newborn nursery charges are eligible for coverage for the first 31 days under the subscriber's inpatient hospital benefits, subject to standard Coordination of Benefit rules as applicable. This coverage applies regardless of whether the newborn is added to the subscriber's plan.

California law requires coverage for a follow-up visit for the mother and newborn within 48 hours of discharge when prescribed by the treating physician, if the hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section. 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 if the visit shall occur at home, the contracted facility, or the physician's office.

Members may arrange for maternity physician services directly from an OB/GYN who is in the same IPA/medical group as her Primary Care Physician.

OB Checks (Facility-Based)

Non-Emergent

The member is not responsible for any copayment, as these services are considered diagnostic.

Emergent

The member is responsible for an emergency room copayment unless admitted within twelve hours.

Maternity Care

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Pregnancy and Maternity Care

Benefit Exclusions

Services incident to or resulting from procedures for a surrogate mother who is not eligible under a Blue Shield health plan.

Services for a newborn of a dependent unless legally adopted by the subscriber and added to the plan.

Benefit Limitations

Certified nurse midwife services are covered only when available within the IPA/medical group network.

Examples of Covered Services

- Newborn screening for metabolic disorders and Alpha Fetoprotein Screening (AFP)
- Services provided by a certified nurse midwife when available within the IPA/medical group network
- Diagnostic testing
  - Amniocentesis
  - Blood test to determine pregnancy
  - Chorionic Villus Sampling/CVS
  - Fetal contraction stress test (a.k.a. fetal monitoring)
  - Fetal non-stress test (a.k.a. fetal monitoring)
- Genetic counseling
- Lactation counseling by a licensed provider
- Ultrasound
- Diagnostic procedures

Examples of Non-Covered Services

- Ambulatory fetal monitors such as Tokos or Term Guard
- Amniocentesis that is not medically necessary or that is performed solely for sex determination
- Blood tests to determine paternity
- Experimental/Investigational services

Maternity Care

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Newborns

Preventive Health Services

Health & Safety Code Section 1367.62

Medical Benefit Drugs

Benefit Coverage

Drugs approved by the Food and Drug Administration (FDA) and covered under a Blue Shield member's medical benefit are generally those that are incident to a medical service, administered by a healthcare professional in a provider office, outpatient facility, infusion center, or by home health/home infusion (not self-administered by the patient). Some medical benefit drugs may require prior authorization for coverage based on medical necessity.

The Blue Shield Pharmacy and Therapeutics Committee (P&T) reviews drugs quarterly and determines medication coverage policies and requirements for drugs requiring prior authorization. Medication coverage policies for medical benefit drugs can be found on Provider Connection at blueshieldca.com/provider. Once you have logged on, select *Authorizations*, *Clinical Policies and Guidelines*, *Medication Policy,* then *Medication Policy List.*

Medical benefit drugs are typically covered under capitation, unless contracted differently. When delegated for utilization management, Blue Shield requires the IPA/medical group to follow Blue Shield's medication coverage policies including step therapy requirements for Blue Shield members when administering prior authorizations. Refer to Section 2.8 - Pharmaceutical Benefits of the *HMO IPA/Medical Group Procedures Manual* for more details.

See also the *HMO Benefit Guidelines* for Allergy, Infertility-Basic Plan and Infertility-Additional Services for information on separate coverage for subcutaneous allergen immunotherapy and infertility injectable medications.

Medications self-administered by a patient at home are covered in the member's outpatient prescription drug benefit. See the *HMO Benefit Guidelines* for Outpatient Prescription Drugs for more information.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Allergy

Infertility-Additional Benefits

Infertility-Basic Plan

Outpatient Prescription Drugs

Physician – Outpatient/Office Visits

Medical Benefit Drugs

Benefit Exclusions

Benefits are excluded for medications not approved by the FDA, and for uses (indications) not approved by the FDA or recognized in clinical compendia approved under federal or California law.

Benefit Limitations

See the *HMO Benefit Guidelines* for Allergy, Infertility-Basic and Infertility-Additional Services.

Examples of Covered Services

- Medically necessary medications administered by a licensed healthcare provider
- Lupron Depot administered by a licensed healthcare provider in the office
- Contraceptive devices inserted by a licensed healthcare provider in the office

Examples of Non-Covered Services

- Lupron Depot self-administered by the patient at home
- Insulin (Covered under the Outpatient Prescription Drug Benefit)

References

Blue Shield Medical Policy

HMO Benefit Guidelines for*:*

Allergy

Infertility-Additional Benefits

Infertility-Basic Plan

Outpatient Prescription Drugs

Blue Shield HMO IPA/Medical Group Procedures Manual

Medical Supplies

Benefit Coverage

Ostomy and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function, and medical supplies needed to operate home medical equipment, prostheses, and orthoses are covered when appropriately authorized.

Note: Disposable insulin needles and syringes, pen delivery systems, diabetic testing supplies including lancets, lancet puncture devices, blood and urine testing strips, and test tablets are covered by the Outpatient Prescription Drug benefit. No prescription is required by law for pen delivery systems (prior authorization required) or diabetic supplies; however, in order to be covered by the Outpatient Prescription Drug benefit, the member's physician must order them. For plans without an Outpatient Prescription Drug benefit, diabetic supplies and equipment are covered as basic plan benefits.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and coverage* for member copayments for:

Home Health Care

Other Services

Durable Medical Equipment (DME)

Medical Supplies

Orthoses, Prostheses (external)

Benefit Exclusion

Non-prescription (over-the-counter) medical equipment or supplies 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 Services, Hospice Program Services, Diabetes Care, Durable Medical Equipment, and Prostheses.

Medical Supplies

Examples of Covered Services

HCPC Code	Description
A4320	Irrigation tray
A4323	Saline for bladder irrigation
A4351-A4353	Intermittent catheters
A4361	Ostomy face plate
A4362	Ostomy skin barrier
A4363	Ostomy liquid barrier
A4364	Ostomy skin bond or cement, adhesive
A4366	Ostomy bag reusable or drainable
A4367	Ostomy belt
A4368	Stoma filter
A4400	Irrigation set for ostomy
A4402	Ostomy lubricant
A4404	Ostomy rings
A4623	Tracheostomy inner cannula
A4624	Tracheal suction
A4625	Tracheostomy care kit (for new patient)
A4611-A4613	Battery for ventilator
A4615	Nasal cannula
A4616	Oxygen tubing
A4619	Face tent (for children)
A5051-A5055	Ostomy pouches
A5071-A5073 A5081-A5082	Urostomy supplies

Medical Supplies

Examples of Non-Covered Services

The following over-the-counter medical supplies are not covered:

- Adhesive remover
- Alcohol and Peroxide solution
- Alcohol wipes/towelettes
- Band-Aids
- Betadine and Iodine wipes/ towelettes
- Composite dressings
- Hydrocolloid dressings
- Hydrogel dressing
- Iodine/Betadine solutions
- Parrafin
- Rib belts
- Skin sealants, protectants, moisturizers, ointments
- Slings
- Conductive paste/gel
- Deodorant
- Elastic bandage/Ace wraps
- Face masks (not including CPAP)
- Gauze dressings (sterile/non-sterile)
- Gloves
- Splints
- Standard 4V, 6V, 9V batteries
- Sterile saline
- Tape
- Thermometers
- Transparent film dressings (covered if used with an insulin pump)
- Underpad/Chux/Depends

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Diabetes Care

Durable Medical Equipment

Home Health Care

Hospice Care

Orthoses

Prostheses

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Mental Health – Core Accounts

Benefit Coverage

The diagnosis and medically necessary treatment of mental health conditions are a covered benefit for all Blue Shield large group plans according to the federal Mental Health Parity and Addiction Equity Act. The Act mandates if a health plan provides mental health or substance abuse benefits, coverage must be at parity with or at a level equal to, the plan's existing medical benefit coverage.

Blue Shield has contracted with a mental health service administrator (MHSA) to administer the treatment of mental health conditions.

No benefits are provided for substance abuse conditions, unless substance abuse coverage has been selected as an optional benefit by the member's employer.

> Note: Inpatient services which are medically necessary to treat the acute medical complications of detoxification are covered as part of the medical benefits and are not considered to be treatment of the substance abuse condition itself.

Members must utilize the MHSA provider network and not the network of the IPA/medical group to which they are assigned. The member can self-refer to the MHSA by calling the Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health provider and receive an authorization for services and/or crisis intervention services. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Primary care physicians can contact Blue Shield's MHSA at (877) 263-9870 to consult with a psychiatrist or allied mental health professional about clinical issues related to mental health or to discuss issues related to a particular member.

Mental Health – Core Accounts

Benefit Coverage *(cont'd.)*

Benefits are provided for the following medically necessary covered mental health conditions, subject to applicable deductible/copayments.

Inpatient Services

Benefits are provided for inpatient hospital and professional services in connection with hospitalization for the treatment of mental health conditions. All non-emergency mental health services must be prior authorized by the MHSA and obtained from MHSA participating providers.

Outpatient Services

Benefits are provided for outpatient facility and office visits for mental health conditions.

Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

Benefits are provided for hospital and professional services in connection with partial hospitalization, intensive outpatient care and ECT for the treatment of mental health conditions. ECT is a covered benefit when the procedure is prior authorized by the mental health service administrator (MHSA) and obtained from MHSA Participating Providers.

Psychological Testing

Psychological testing is a covered benefit when the member is referred by an MHSA provider and the procedure is prior authorized by the MHSA.

Pre-surgical Evaluations

When required, a pre-surgical evaluation is a covered benefit when the member is referred to a Blue Shield mental health service administrator (MHSA) provider and the evaluation is prior authorized by the MHSA.

Behavioral Health Treatment for Pervasive Developmental Disorders, including applied behavior analysis (ABA)

Behavioral Health Treatment (BHT) is covered when prescribed by a physician or licensed psychologist within the IPA/medical group and the treatment is provided under a treatment plan prescribed by a Blue Shield mental health service administrator (MHSA) Participating Provider. BHT must be prior authorized by the MHSA and obtained from MHSA Participating Providers.

Mental Health – Core Accounts

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Mental Health

Hospital Inpatient Care

Hospital Outpatient Care

Outpatient Visits

Benefit Exclusions

Benefits are not provided for:

- Testing for intelligence or learning disabilities except medically services that Blue Shield is required by law to cover for the treatment of severe mental illness or serious emotional disturbances of a child.
- Learning disabilities, or behavioral problems or social skills training/therapy except medically services that Blue Shield is required by law to cover for the treatment of severe mental illness or serious emotional disturbances of a child.
- Any non-emergency mental health service not authorized by the Blue Shield MHSA.
- Behavior Health Treatment used to provide respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Benefit Limitations

- No benefits are provided for substance abuse conditions, unless substance abuse coverage has been selected as an optional benefit by the member's employer.

Mental Health – Core Accounts

Examples of Covered Services

- Family counseling
- Crisis intervention
- Outpatient psychotherapy
- Treatment for ADHD as emotional disturbance of a child
- ABA when prescribed and authorized according to *Evidence of Coverage* guidelines.
- Telebehavioral health services with participating therapists and psychiatrists contracted with Blue Shield's mental health service administrator (MHSA)

Examples of Non-Covered Services

- Marital counseling
- Chemical dependency and substance abuse services

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Substance Abuse-Optional Benefits – Large Group

Blue Shield HMO IPA/Medical Group Procedures Manual

Blue Shield Medical Policy

Behavioral Health Treatment for Pervasive Developmental Disorders

Mental Health – Small Business and IFP

Benefit Coverage

The diagnosis and medically necessary treatment of mental health conditions are a covered benefit for Blue Shield's Small Business (groups of 1-100 employees) and IFP plans according to the federal Mental Health Parity and Addiction Equity Act. The Act mandates if a health plan provides mental health or substance abuse benefits, coverage must be at parity with or at a level equal to, the plan's existing medical benefit coverage.

Blue Shield has contracted with a mental health service administrator (MHSA) to administer these benefits.

In order to be considered a covered benefit, members must utilize the MHSA provider network and not the network of the IPA/medical group to which they are assigned. The member can self-refer to the MHSA by calling the Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health provider and receive an authorization for services and/or crisis intervention services. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Primary care physicians can contact Blue Shield's MHSA at (877) 263-9870 to consult with a psychiatrist or allied mental health professional about clinical issues related to mental health or to discuss issues related to a particular member.

Benefits are provided for the following medically necessary covered mental health conditions, subject to applicable deductible/copayments.

Behavioral Health Treatment (BHT) for Pervasive Developmental Disorders includes applied behavior analysis (ABA)

Behavioral Health Treatment is covered when prescribed by a physician or licensed psychologist within the IPA/medical group and the treatment is provided under a treatment plan prescribed by a Blue Shield mental health service administrator (MHSA) Participating Provider. Behavioral Health Treatment must be prior authorized by the MHSA and obtained from MHSA Participating Providers.

Inpatient Services

Benefits are provided for inpatient hospital and professional services in connection with hospitalization for the treatment of mental health conditions. All non-emergency mental health services must be prior authorized by the MHSA and obtained from MHSA participating providers.

Mental Health – Small Business and IFP

Benefit Coverage *(cont'd.)*

Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

Benefits are provided for hospital and professional services in connection with partial hospitalization, intensive outpatient care and ECT for the treatment of mental health conditions. ECT is a covered benefit when the procedure is prior authorized by the mental health service administrator (MHSA) and obtained from MHSA Participating Providers.

Outpatient Services

Benefits are provided for outpatient facility and office visits for mental health conditions.

Psychological Testing

Psychological testing is a covered benefit when the member is referred by an MHSA provider and the procedure is prior authorized by the MHSA.

Pre-surgical Evaluations

When required, a pre-surgical evaluation is a covered benefit when the member is referred to a Blue Shield mental health service administrator (MHSA) provider and the evaluation is prior authorized by the MHSA.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Hospital Inpatient Care

Hospital Outpatient Care

Mental Health

Outpatient Visits

Substance Abuse

Benefit Exclusions

Benefits are not provided for:

- Testing for intelligence or learning disabilities except medically necessary services that Blue Shield is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- Learning disabilities, behavioral problems, or social skills training/therapy except medically necessary services that Blue Shield is required by law to cover for the treatment of severe mental illness or serious emotional disturbances of a child.
- Any non-emergency mental health service not authorized by the Blue Shield MHSA.
- Behavioral Health Treatment used to provide respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Mental Health – Small Business and IFP

Examples of Covered Services

- Family counseling
- Crisis intervention
- Outpatient psychotherapy
- Treatment for ADHD as emotional disturbance of a child
- Applied behavior analysis (ABA) when prescribed and authorized according to *Evidence of Coverage* guidelines
- Residential care
- Telebehavioral health services with participating therapists and psychiatrists contracted with Blue Shield's mental health service administrator (MHSA)

Examples of Non-Covered Services

- Marital counseling

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Substance Abuse-Optional Benefits – Small Group and IFP

Blue Shield HMO IPA/Medical Group Procedures Manual

Blue Shield Medical Policy

Behavioral Health Treatment for Pervasive Developmental Disorders

Newborns

Benefit Coverage

Immediate accident and sickness coverage from and after the moment of birth of each newborn infant of any enrolled subscriber or spouse is provided, as required by the Health and Safety Code (Knox-Keene Act). Benefits are provided for the first 31 days regardless of whether the newborn has been added to the subscriber's health plan. This immediate accident and sickness coverage include newborn of enrolled member who is a surrogate mother until the adoptive parents have the right to control the newborn's health care. All other provisions and rules of the plan apply. Newborn must be added as a dependent within the first 31 days to avoid a gap in coverage. Exception: FEHBP, CalPERS, and Small Group plans as members have 60 days from the date of birth/placement for adoption.

IFP: If the parents fail to put in a request to add the child within the first 31 days they will be able to submit an application between the 32nd and 63rd days as this would be a qualifying event under California law for late enrollees who are under age 19.

Note: If the mother is not covered as a subscriber or spouse by the Blue Shield HMO plan, and the newborn qualifies as a dependent of the subscriber, newborn nursery charges are eligible for coverage under the subscriber's inpatient hospital benefits, Coordination of Benefit rules will apply if applicable. This coverage applies regardless of whether the newborn is added to the subscriber's plan.

The primary care physician (PCP) selected for a newborn must be in the same IPA or medical group as the mother's PCP during the calendar month of birth. If the mother of the newborn is not enrolled as a subscriber or spouse, the PCP selected must be a physician in the same IPA or medical group as the subscriber during the calendar month of birth. If the child has been placed with the subscriber for adoption, the PCP selected must be a physician in the same IPA or medical group as the subscriber or covered spouse during the calendar month the subscriber has the right to control health care of the child.

The primary care physician for a newborn may be changed after the birth month. If the newborn is ill or hospitalized during the birth month, the effective date of the new PCP will be the first of the month following discharge from the hospital, or the date it is medically appropriate to transfer care to the new PCP. Exceptions must be approved by the Blue Shield Medical Director.

Retinal Screening exams for infants with low birth weight (<1500g) or < 32 gestational weeks and infants weighing between 1500 and 2000g or > 32 gestational weeks with an unstable clinic course are covered.

Newborns

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Services

Inpatient Hospital Services

Physician-Outpatient

Benefit Exclusion

- Well baby services not provided by the primary care physician

Examples of Covered Benefits

- Well baby services provided by the primary care physician. These services are available to enrolled newborns and to newborns that are not enrolled for the first 31 days.
- Routine circumcision performed within 18 months of birth. The newborn must be enrolled to access these services after the first 31 days of life.
- Treatment for illness or injury (active or non-active).

Examples of Non-Covered Services

- Medical care after 31 days if the newborn is not enrolled
- Well baby services provided by non-plan providers
- Infant nutritional formulas such as Enfamil, and Similac. (See guidelines on PKU and Home Health Services for possible coverage under Medical Benefits.)

References

Evidence of Coverage

Health & Safety Code (Knox-Keene Act), Section 1373

HMO Benefit Guidelines for *Maternity Care*

IFP Evidence of Coverage and Health Service Agreement

Original Date: 08/01/1995
Revision Date: 01/01/2010
Effective Date: 01/01/2010

Nursing - Private Duty

Benefit Coverage

Not applicable.

Copayment

Not applicable.

Benefit Exclusion

To exclude coverage for the services of a nurse who attends an individual patient, usually on a fee-for-service per 8 hour shift basis, and is not acting as a staff member of an institution.

Benefit Limitations

Not applicable.

Exceptions

If special duty nursing is medically necessary for inpatient hospital care, when authorized by the HMO, such nursing is covered under the Hospital Services benefit.

For intermittent and part time home nursing visits, see benefits for Home Health Care services.

Examples of Covered Services

Not applicable.

Nursing - Private Duty

Examples of Non-Covered Services

- Private duty nursing in patient's hospital room that is not medically necessary or provided by staff employees.
- Private duty nursing at home, in a skilled nursing facility, or in any other services setting.

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Home Health Care Services

Hospital – Inpatient Care

Skilled Nursing Facility

Orthoses

Benefit Coverage

Medically necessary orthoses and related services for maintaining normal Activities of Daily Living, defined as, “Mobility skills required for independence and normal everyday living. Recreational, leisure, or sports activities are not included.” The following services are covered:

- Initial fitting and replacement after expected life of the item
- Repairs, even if due to damage
- Supplies necessary for the operation or function of orthoses
- Special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, or by accident or developmental disability
- Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes
- 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. They are usually made of high-impact thermal plastic. (See list of covered diagnoses under Examples of Covered Services below.)

Routine maintenance of orthoses is not covered. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. Orthoses must be authorized.

Copayment

See the member’s *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services - Orthoses, Prostheses (external)

Orthoses

Benefit Exclusions

- External accommodative, digital, and supportive foot orthoses, including services associated with fitting. Accommodative, digital, or supportive orthotics are flexible or semi-rigid devices and are used to ease foot pain. Since they do not correct the condition, they are considered comfort and convenience items and are excluded from coverage. Orthopedic shoes are not covered except extra-depth orthopedic shoes used to prevent or treat diabetes-related complications.
- External foot orthoses not authorized and prescribed by a physician.
- Non-custom made or over-the-counter shoe inserts or arch supports.
- Routine maintenance.
- No benefits are provided for backup or alternate items.

Benefit Limitations

Limited to least costly item to meet patient's medical needs.

Exceptions

- Orthopedic shoes are covered when attached to a leg brace.
- Special footwear required for foot disfigurement as a result of, but not limited to, cerebral palsy, arthritis, polio, spina bifida, diabetes, and for foot disfigurements caused by accident or developmental disability are covered.
- Functional foot orthoses (custom-made rigid inserts for shoes) when used to treat specific diagnoses (See Examples of Covered Services below).

Examples of Covered Services

- Back brace
- Cervical halo
- Knee brace
- Orthopedic shoes (with leg brace)
- Functional foot orthoses for foot disfigurement
- Arch supports, foot orthotics, toe separators, custom built shoes, and extra-depth orthopedic shoes to prevent or treat diabetes-related conditions
- Functional foot orthoses used to treat one of the following diagnoses when improvement has not occurred with a trial of strapping or of an over-the-counter stabilizing device (except that a trial of strapping or of an over-the-counter stabilizing device is not required for the management of genu varum/ valgum*):
    - Abnormal pronation of the foot
    - Apophysitis in children
    - Calcaneal spur
    - Diabetes
    - Femoral torsion antetorsion
    - Genu varum/valgum*
    - Hallux valgus
    - Lateral ankle instability
    - Metatarsalgia
    - Patellofemoral dysfunction
    - Pescavus/planus/planovalgus
    - Plantar fasciitis
    - Tarsal tunnel syndrome
    - Tendonitis
    - Tibial torsion
- Foot orthotic every two years, except for children under age 18 who are allowed a new foot orthotic every 6 months if their provider has documented that the child has outgrown his or her previous foot orthotic

Orthoses

Examples of Non-Covered Services

- Functional foot orthoses for a non-covered diagnosis
- External accommodative, digital, and supportive foot orthoses except those used to prevent or treat diabetes-related conditions
- Orthopedic shoes (without leg brace), including any associated professional services except for extra-depth orthopedic shoes used to prevent or treat diabetes-related complications
- Over-the-counter shoe inserts or arch supports

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Out-of-Area Services

Benefit Coverage

The subscriber, spouse and dependents are covered for the following types of services while outside the Primary Care Physician's service area:

- Non-emergency services referred out-of-area and authorized by the IPA/medical group and/or Blue Shield HMO
- Emergency services (Refer to the *HMO Benefit Guidelines* on *Emergency*)
- Urgent services (Refer to *HMO Benefit Guidelines* on *BlueCard* and *Urgent Services*)
- Services provided through the Away From Home Care℠ Program

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Unauthorized treatment outside the Primary Care Physician's service area when it is determined by the Plan that emergency services were not required, or urgent services received were obtained and retrospective review indicated the services would not have been authorized as urgent services, is not covered.

Benefit Limitations

Authorization by Blue Shield HMO is required for more than two out of area follow-up outpatient visits following an urgent or emergency visit or for care that involves a surgical or other procedure or inpatient stay. Blue Shield HMO may direct the patient to receive follow-up services from the Primary Care Physician.

Exceptions

Out-of-area treatment for renal failure is covered while the member is temporarily traveling **only** when prior authorized by the IPA/medical group or Blue Shield HMO.

Out-of-Area Services

Examples of Covered Services

- Emergency services
- Non-emergency/non-urgent services rendered out-of-area and authorized by the IPA/medical group and/or Blue Shield HMO
- Urgent services received through the Blue Shield network, a non-network provider, the Away From Home Care Program, or BlueCard network

Examples of Non-Covered Services

- Non-emergency/non-urgent self referrals
- Out-of-area follow-up care for an urgent or emergency visit that is not medically necessary
- Out-of-area follow-up care for an urgent or emergency visit in excess of two outpatient visits (except for non-marketed IFP plan members) that was not authorized by Blue Shield HMO
- Out-of-area follow-up care for an urgent or emergency visit that involves any procedure or facility component unless prior authorized by Blue Shield HMO

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for*:*

BlueCard

Emergency

Urgent Services

Blue Shield HMO IPA/Medical Group Procedures Manual

Outpatient Prescription Drugs

Benefit Coverage

Drugs eligible for coverage under a Blue Shield member's outpatient prescription drug benefit are those that meet all of the requirements specified in this guideline, are prescribed by participating licensed prescriber and, except as noted below, are obtained from a Participating Pharmacy.

The list of covered drugs maintained by the Blue Shield of California Pharmacy and Therapeutics (P&T) Committee, is designed to assist physicians in prescribing medically-appropriate, cost-effective drug therapy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which have been reviewed for safety, efficacy, bio-equivalency, and cost. The P&T Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to formulary management, drug utilization, pharmacy-related quality improvement, educational programs and utilization management programs, and other drug issues related to patient care. The committee determines clinical drug preference for formulary inclusion, medication coverage policies and clinical coverage requirements based on the medical evidence for comparative safety, efficacy and cost when safety & efficacy are similar. The voting members of the P&T Committee are practicing physicians and pharmacists in the Blue Shield network who are not employees of Blue Shield. The P&T Committee reviews drugs on a quarterly basis.

Drugs and associated supplies eligible for coverage are defined as:

- Drugs approved by the Food and Drug Administration (FDA), requiring a prescription either by federal or California law, and prescribed for treatment of a medically necessary condition according to the FDA label, or for off-label uses and doses when:
    - supported by clinical compendia defined in federal and California law, or
    - supported in two articles from major peer reviewed medical journals with data demonstrating use or uses as safe and effective unless there is contradictory evidence presented in a major peer reviewed medical journal.
- Contraceptive drugs and devices, including female OTC contraceptives (commercial plans only).
- Over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B (commercial plans only).
- Insulin and disposable hypodermic insulin syringes and needles for administration of insulin.

Outpatient Prescription Drugs

Benefit Coverage *(cont'd.)*

- Pen delivery systems for the administration of insulin as medically necessary.
- Diabetic testing supplies, including lancets, lancet puncture devices, blood and urine testing strips, and test tablets. For blood glucose test strips obtained at the pharmacy, coverage is limited to specific manufacturer brands.
- Inhalers and inhaler spacers for the management and treatment of asthma.

Note: Coverage of listed supplies requires a prescription.

When the Blue Shield P&T Committee removes a drug from formulary (i.e. non-formulary), and ongoing use of that drug is required to treat a chronic condition or to maintain health, the drug will continue to be covered for the member as long the member remains eligible and the medication continues to be prescribed for that member.

Maintenance Medication: When a member's medication dosage is stabilized and taken on an ongoing, regular basis to maintain health, the member may obtain the prescription through the Mail Service Prescription Drug Program for up to a 90-day supply. In order for a prescription to be filled by a mail service pharmacy, or to be transferred from a retail pharmacy to a mail service pharmacy, a new prescription with a quantity sufficient to cover up to a 90-day supply is required.

Specialty Drugs: Specialty drugs are drugs that may require special handling or manufacturing processes, coordination of care, close monitoring, or extensive patient training for safe self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty drugs may also be drugs restricted by the FDA or drug manufacturer to prescribing by certain physicians or dispensing at certain pharmacies. A Network Specialty Pharmacy provides Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup.

- The list of specialty drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com/pharmacy.
- New prescriptions for specialty drugs should be sent to a Network Specialty Pharmacy.
- Medicare Part D plans may receive Specialty drugs from any willing pharmacy within the plan's network.

Outpatient Prescription Drugs

Prior Authorizations and Exceptions

Prior Authorization: Many medications are covered without prior authorization. However, some medications require the patient's prescription and medical history to establish medical necessity and/or to evaluate use of preferred, formulary alternatives prior to coverage.

Exceptions: Medications not covered under a member's benefit or that are prescribed outside of coverage rules require an exception for coverage based on medical necessity. Types of exceptions include:

- Formulary exceptions. Coverage of a non-formulary (non-listed) drug when formulary alternatives are not appropriate for the individual patient.
- Waiver of coverage restrictions or limits, such as prescription quantity limits or step therapy protocols for prior use of preferred drugs.
- Drugs obtained from a non-participating pharmacy due to a covered emergency

Prior authorization or step therapy exception requests may be submitted electronically through the electronic health record, if available. If electronic prior authorization capability is not available, then complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) (available at blueshieldca.com/provider) to (888) 697-8122 or online at blueshieldca.com/provider under Authorization, then *Submit a Pharmacy Prior Authorization*. Evidence of medical necessity may include submission of studies published in major peer reviewed medical journals and/or a patient's medical records.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

If a brand name drug is dispensed when a generic is available upon request of the member or prescriber, the member may be responsible for paying the difference between the cost of the brand name drug and its generic equivalent, in addition to the generic copayment. Exceptions may be granted to cover the brand name drug at a plan copayment if medically necessary and use of the generic equivalent is not clinically appropriate for the individual patient.

Blue Shield members are responsible for paying 100% of the cost of the drug(s) if it is not a covered benefit unless a prior authorization or exception is obtained.

Outpatient Prescription Drugs

Benefit Exclusions

No benefits are provided for:

- Prescription drugs dispensed by non-participating pharmacies, except for emergency coverage.
- Non-formulary drugs for members with a benefit only for formulary drugs, unless coverage is granted subsequent to an exception request.
- Any drug covered under the member's medical benefit, including:
    - drugs provided or administered by a healthcare provider in a hospital, physician's office, Skilled Nursing Facility, Outpatient Facility, or infusion center
    - take-home drugs received from a hospital, skilled nursing facility, or similar facility
    - drugs provided as part of the home health benefit or by home infusion service
    - blood or blood products
- Drugs that are only available without a prescription (over-the counter) and prescription drugs that have a non-prescription version that is an identical chemical equivalent (i.e., same active ingredient and dosage).
- Drugs that are considered to be experimental or investigational.
- Medical devices or supplies unless specifically listed as covered.
- Topically applied prescription preparations that are approved by the FDA as medical devices.
- Drugs when prescribed for cosmetic purposes, including but not limited to drugs used to slow or reverse the effects of skin aging or to treat hair loss.
- Dietary or nutritional products (see the *HMO Benefit Guidelines* on PKU and Home Health Services for possible coverage under the medical benefit).
- All drugs for the treatment of infertility.
- Appetite suppressants or drugs for body weight reduction except when medically necessary for the treatment of morbid obesity. In such cases the drug will be subject to prior authorization from Blue Shield.

Outpatient Prescription Drugs

Benefit Exclusions *(cont'd.)*

- Contraceptive drugs or devices covered under the medical benefit (IUDs, injections or implants).
- Compounded medications that: (1) do not include at least one drug ingredient, (2) do not have an FDA-approved, commercially available alternative(s) that is medically appropriate for the patient for self-administration, and (3) are not used to treat a medically accepted indication as described in the FDA label or supported in clinical compendia defined in federal and state law or supported in the medical literature.
- Replacement of lost, stolen or destroyed prescription drugs.
- Pharmaceuticals that are reasonable and necessary for the palliation and management of terminal illness and related conditions if they are provided to a member enrolled in a hospice program through a participating hospice agency.
- Drugs prescribed for treatment of dental conditions. (This exclusion shall not apply to antibiotics prescribed to treat infection or to medications prescribed to treat pain.)
- Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list, except for a covered emergency.
- Immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel.
- Drugs packaged in convenience kits that include non-prescription convenience items, unless the drug is not available without the non-prescription components. This exclusion shall not apply to items used for the administration of diabetes or asthma drugs.

Benefit Limitations

- Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).
- Outpatient Prescription Drugs obtained at a Participating Pharmacy are limited to a 30-day supply for commercial plans.

Outpatient Prescription Drugs

Benefit Limitations *(cont'd.)*

- Medicare Part D plans provide 90-day supplies with reduced cost sharing when dispensed by a preferred cost-sharing pharmacy for most maintenance medications. This does not apply to Specialty Tier drugs and controlled substances.
- Outpatient Prescription Drugs obtained at mail service pharmacy according to the Mail Service Prescription Drugs Program may fill up to a 90-day supply of maintenance medication.
- Dispensing limits as described in the drug formulary.

Examples of Covered Services

- Blue Shield of California Formulary Drugs. (Select drugs and drug dosages require prior authorization or an exception by Blue Shield.)

Examples of Non-Covered Services

- Hypodermic needles/syringes used with drugs other than insulin
- Support garments and similar items
- Bevacizumab (Avastin) infused in the provider office or infusion center
- Retin A for members over 40 years of age
- Antifungal drugs prescribed for cosmetic purposes

References

Outpatient Prescription Drug Benefit Supplement to Evidence of Coverage

HMO Benefit Guidelines for:

Drugs-Basic Plan
Hospice Care
Infertility-Additional Benefits
Infertility-Basic
Infertility-CalPERS
Medical Benefit Drugs

Blue Shield Pharmacy Customer Service and Drug Prior Authorization Units

Blue Shield Drug Formularies – Plus, Standard and Medicare

Oxygen

Benefit Coverage

Oxygen and the administration of oxygen are covered when medically necessary including professional respiratory therapy services to monitor use of oxygen in the home and supplies needed to administer oxygen.

The oxygen, flow rate, concentration and tank type, as well as the Home Health Care visits must be appropriately authorized.

Professional services associated with administration of oxygen in the home are covered under the Home Health Care benefit.

Copayment

See the member's *Evidence of Coverage* (EOC) and Summary of Benefits and Coverage for member copayments for:

Other Services

Durable Medical Equipment (DME)
Home Health Care (HHC) - Agency Visit

The cost of oxygen is not subject to an annual benefit maximum.

Oxygen

Benefit Limitations

See *Benefit Limitations* segments in the *HMO Benefit Guidelines* for *Durable Medical Equipment* and *Home Health Care*.

Examples of Covered Services

- Oxygen
- Professional services for the administration of the oxygen
- Supplies and equipment in conjunction with the Home Health treatment

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Durable Medical Equipment

Home Health Care

Original Date: 08/01/1995
Revision Date: 01/01/2019
Effective Date: 01/01/2019

Parenteral/Enteral Nutrition

Benefit Coverage

Parenteral and Enteral Nutritional Therapies are covered for home use when medically necessary and appropriately authorized.

Parenteral Nutritional (sometimes referred to as Total Parenteral Nutrition-TPN) is the intravenous (IV) feeding of the patient with a solution rich in nutrients.

Enteral Nutritional is the feeding of the patient through specialized tubes that empty directly into the esophagus, stomach, or intestines. This method is used when a functioning lower gastrointestinal tract is present, allowing for adequate digestion and absorption.

Parenteral/Enteral Nutritional Therapies, associated supplies and solutions are covered as a Home Health Care/Home Infusion Therapy benefit and require an authorized home treatment plan.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care

Parenteral/Enteral Nutrition

Examples of Covered Services

- Total Parenteral Nutritional Therapy
- Enteral Nutritional Therapy

Examples of Non-Covered Services

Services not authorized by the Primary Care Physician and Blue Shield HMO.

References

Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefits Guidelines for*:*

Home Health Care Services

Blue Shield HMO IPA/Medical Group Procedures Manual

Physician Services

Benefit Coverage

Outpatient

Professional office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury including specialist office visits, consultations, diabetic counseling, asthma self-management training, office surgery, outpatient chemotherapy, and radiation therapy are covered. This benefit includes services delivered via telehealth.

Medically necessary home visits by a physician are covered.

Inpatient

Physician services in a hospital or skilled nursing facility for examination, diagnosis, treatment, and consultation including the services of a specialist, surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist are covered when the inpatient stay has been authorized by the Blue Shield HMO. Physician services must either be provided by, or referred by, the member's Primary Care Physician (PCP), including services for members who are admitted for detoxification.

Access+ Specialist Services

The member may arrange an Access+ *Specialist* office visit with a plan specialist in the same IPA/medical group as the Primary Care Physician's without a referral when the IPA/medical group participates as an Access+ Provider. Each visit is subject to a copayment, including follow-up visits that are not referred or authorized by the Primary Care Physician. The Access+ *Specialist* visit includes:

- An office visit examination or consultation provided by a specialist in the same IPA/medical group as the Primary Care Physician.
- Conventional X-rays, but does not include diagnostic imaging such as CT, MRI, or bone density measurement.
- Routine laboratory services.
- Diagnostic or treatment procedures which a plan specialist would routinely provide under a referral from the Primary Care Physician. Only minor office based surgical procedures will be included as part of the Access+ *Specialist* visit (e.g., minor dermatology procedures, casting of minor fractures, removal of foreign body of the eye, etc.). If the Access+ *Specialist* believes that additional surgical or other treatment is necessary, authorization should be requested through the Primary Care Physician.

Physician Services

Benefit Coverage *(cont'd.)*

Access+ Specialist Visit for Mental Health and Substance Abuse Services

The member may arrange an Access+ *Specialist* office visit for mental health and substance abuse services without a referral (except for psychological testing) from the Mental Health Services Administrator (MHSA) as long as the provider is a MHSA participating provider. Each visit is subject to a copayment, including follow-up visits that are not referred or authorized by the MHSA.

OB/GYN Physician Services

Female members may arrange for obstetrical and gynecological physician services directly from an OB/GYN or family practice physician, designated as providing gynecological services, in the same IPA/medical group as her Primary Care Physician without obtaining a referral from the Primary Care Physician. Obstetrical and gynecological services are defined as:

- Physician services related to preconception, prenatal, perinatal, and postnatal (pregnancy) care
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia
- Physician services for treatment of disorders of the breast
- Routine annual gynecological examinations/annual well-woman examinations

Mental Health and Substance Abuse Services

Members may arrange for mental health and substance abuse services by calling the MHSA directly at (877) 263-9952. Members may also ask their Primary Care Physician to call MHSA and make the arrangements for them.

Physician Services

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for members copayment for:

Infertility Services

Physician (Professional) Services

Pregnancy and Maternity Care

Preventive Health Services

Mental Health and Substance Abuse Services

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Physician Services

Benefit Exclusion

Any physician service which:

- is not a covered benefit of the Blue Shield HMO Plan
- has not been provided or authorized by the member's Primary Care Physician except when it is a covered:
    - Access+ *Specialist* visit or
    - Maternity and gynecological physician service.

An Access+ *Specialist* visit does not include:

- Services which are not covered, not medically necessary, or provided by any provider other than the plan specialist providing the Access+ *Specialist* visit (such as podiatry and physical therapy), except for routine x-ray and laboratory services
- Allergy testing, endoscopic procedures, infertility, emergency, or urgent services
- Any diagnostic imaging, except routine X-rays
- Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics
- Inpatient services, or any services which result in a facility charge, except for routine x-ray and laboratory services
- Women's preventive health, maternity, and gynecological physician services, or services for which the IPA/medical group routinely allows the member to self-refer without authorization from the Primary Care Physician

Physician Services

Examples of Covered Services

- Office visits with the Primary Care Physician
- Office visits/consultations with specialists when referred by the Primary Care Physician
- Office visits for asthma self-management training and education to enable a member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow meters
- Access+ *Specialist* office visits/consultations
- Nutritional counseling provided by the treating physician as part of an office visit, and nutritional counseling for the treatment of diabetes

Examples of Non-Covered Services

- Office visits/consultations with specialists that are not referred by the Primary Care Physician, or the MHSA, except an Access+ *Specialist* visit and visits for maternity and gynecological physician services
- Professional services that are a exclusion of the plan
- Physician services performed by a close relative of the member, by a person who ordinarily resides in the member's home or by hospital officers, residents, interns, and others in training.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code, Section 1367.695

HMO Benefit Guidelines for:

Mental Health

Preventive Health Services

Substance Abuse

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PKU Formulas & Special Foods

Benefit Coverage

Enteral formulas, related medical supplies, and Special Food Products for the dietary treatment of phenylketonuria (PKU) are covered. All formulas and Special Food Products must be prescribed and ordered through the appropriate health care professional.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care Services and PKU

Benefit Exclusions

- Grocery store foods that are part of a standard diet and used by the general population.
- Food that is naturally low in protein unless specially formulated to have less than one gram of protein per serving.

Benefit Limitations

Enteral formulas and special food products are covered for the treatment of PKU when:

1. They are consistent with the recommendations and best practices of appropriately licensed or certified health care professionals that are recognized experts in the treatment of PKU; and
2. They are used in place of standard food products, such as grocery food products used by the general population.

Although coverage does not include a food naturally low in protein, a food product that is specially formulated to have less than one gram of protein per serving may be covered.

PKU Formulas & Special Foods

Examples of Covered Services

- PKU food products specially formulated to have less than one gram of protein per serving, such as baking mixes, cookies, rice starch bread, and low protein flour, and that are not a standard food used by the general population.

Examples of Non-Covered Services

- Grocery store items used by the general population, such as fruit, cereals, jams and jellies, and ketchup.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield HMO IPA/Medical Group Procedures Manual

Preventive Health Services – Grandfathered Plans

Benefit Coverage

Preventive care services are those provided for the early detection of disease when no symptoms are present.

Note: The Patient Protection and Affordable Care Act (PPACA) provisions of the Health Care Reform legislation, adopting United States (US) Preventive Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents and women is not applicable to some “Grandfathered” health plans. This benefit description is only for those plans. The Preventive Health Services – Non-Grandfathered Plans guideline provides a description of benefits applicable under PPACA for non-grandfathered plans.

Effective 01/01/2012, Small Group no longer offers grandfathered plans upon renewal.

Routine physical examinations are covered. The schedule for routine physicals for preventive care is as follows:

- Well baby care provided through 2 years.
- Examinations every year, for those 3-19 years.
- Examinations every 5 years, for those 20-40 years.
- Examinations every 2 years, for those 41-50 years.
- Examinations every year, for those over 50 years.
- Breast and pelvic exams and pap tests or other FDA approved cervical cancer screening tests, including a human papilloma virus (HPV) screening testing, every year for women.
- Cervical cancer, chlamydia, gonorrhea, and syphilis screening for all sexually active women under age 25 and over 25 at risk of infection.
- Osteoporosis screening for women age 65 and older or age 60 and older if at increased risk.
- Colorectal cancer screening for age 50 through 70 years including an annual Fecal Occult Blood Test (FOBT) and either a flexible sigmoidoscopy every five years, or a double contrast barium enema every five to ten years, or a colonoscopy every ten years.
- Pediatric and adult immunizations and the immunizing agent.

Preventive Health Services – Grandfathered Plans

Benefit Coverage *(cont'd.)*

- Vision and hearing screening by the primary care physician (PCP) for members under age 18.
- Newborn hearing and retinal screening.
- HIV screening tests as recommended by the US Preventive Services Task Force for all adolescents and adults at increased risk for HIV infection (including pregnant women).

A female member may arrange for a routine annual gynecological exam without referral from her PCP by making an appointment with an OB/GYN in the same medical group as her PCP. Benefits for a routine annual gynecological exam are in addition to the benefit for routine physical examinations, according to schedule, when performed by two different physicians. See the *HMO Benefit Guideline* for *Gynecological Examinations* for a description of obstetrical and gynecological services.

Medically necessary mammography for screening purposes, when referred by the PCP and prior authorized by the IPA/medical group, is covered.

Screening for prostate cancer, including prostate-specific antigen testing and digital rectal examinations, when provided or referred by the PCP, is covered.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Physical examinations required for licensure, employment, insurance, etc. are not covered, unless the examination corresponds to the schedule of routine physicals.

Preventive Health Services – Grandfathered Plans

Benefit Limitations

The nature of the annual gynecological exam may vary based on the member's age, family and personal history, but is limited to a routine breast and pelvic exam and pap test or other FDA approved cervical cancer screening tests.

Exceptions

Not applicable.

Examples of Covered Services

- Breast and pelvic exams and pap tests or other FDA approved cervical cancer screening tests for women once a year.
- Well baby care through age 2 years.
- Sigmoidoscopy when done as a health screening test beginning at age 50, and then only once every 5 years.
- Colonoscopy when performed as a health-screening test (e.g. patients age 50 and older with significant family history or other risk factors) every 10 years.
- Screening for blood lead levels in children at risk for lead poisoning, as determined by the primary care physician.

Examples of Non-Covered Services

Physical examinations solely for employment, licensure, school, DMV, etc. purposes, unless it corresponds to the schedule of routine physicals.

Preventive Health Services – Grandfathered Plans

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Gynecological Examinations

Immunizations and Vaccinations

Preventive Health Services – Non-Grandfathered Plans

Vision Screening

Health & Safety Code, Section 1367.64

Preventive Health Services – Non-Grandfathered Plans

Benefit Coverage

Preventive care services are those provided for the early detection of disease when no symptoms are present.

To view the most updated listing of preventive health care services for non-grandfathered plans, log on to Provider Connection at www.blueshieldca.com/provider and click on the *Eligibility & Benefits,* then *Preventive Health Guidelines.* The following Preventive Benefit Policies are listed on that page:

- 1A Women's Preventive Health Services [Pre-USPSTF]
- 1B Preventive Health Services [Post USPSTF (Including Women's Preventive)]

Copayment

There is no copayment for scheduled routine physical exams as outlined in the Preventive Health Services Policy.

Benefit Exclusions

Physical examinations required for licensure, employment, insurance, etc. are not covered, unless the examination corresponds to the schedule of routine physicals.

Benefit Limitations

The nature of the annual gynecological exam will vary based on the member's age, family and personal history, but may include a routine breast and pelvic exam, pap test or other FDA approved cervical cancer screening test, and counseling and screening services including screening for sexually-transmitted infections and Human Papillomavirus. Please see the 1B Preventive Health Services [Post USPSTF (Including Women's Preventive)] policy for screening criteria.

Exceptions

Not applicable.

Preventive Health Services – Non-Grandfathered Plans

Examples of Non-Covered Services

Physical examinations solely for employment, licensure, school, DMV, etc. purposes, unless it corresponds to the schedule of routine physicals.

References

Blue Shield Medical Policy

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Immunizations and Vaccinations

Preventive Health Services – Grandfathered Plans

Vision Screening

Health & Safety Code, Section 1367.64

Prostheses

Benefit Coverage

Medically necessary prostheses for maintaining normal Activities of Daily Living, defined as “Mobility skills required for independence and normal everyday living. Recreational, leisure, or sports activities are not included.” Covered services include the initial fitting, replacement after expected life of the item, and repairs (regardless if due to damage). Supplies necessary for the operation and functioning of the prostheses are covered. Benefits are provided at the most effective level of care that is consistent with professionally recognized standards of practice.

Copayment

See the member’s *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Surgically Implanted Devices

Orthotics, Prosthetics (external)

Durable Medical Equipment

Benefit Exclusions

- Dental implants
- Routine maintenance
- Backup or alternate items

Benefit Limitations

- Payment authorization will be provided for the least costly item that will meet the patient's medical needs.
- Surgically implanted accommodative lenses (e.g., Crystalens) that correct the post cataractomy eye and allow ciliary muscles to accommodate the optic lens for presbyopia are not covered. Such accommodative lenses are not medically necessary as the standard intraocular lens restores the eye to a functional state.

Prostheses

Examples of Covered Services

- Artificial eye
- Artificial hand
- Artificial leg
- Additional replacement devices to allow for growth and development
- Breast prosthesis after mastectomy; mastectomy bra (paid at surgical level of benefits and not subject to plan copayment for prostheses)
- Blom-Singer and artificial larynx prostheses following a laryngectomy

Examples of Covered Surgically Implanted Prosthetic Devices

- Breast implant after mastectomy
- Cochlear implants
- Hip prosthesis (pins, screws, rods)
- Pacemaker
- Prosthetic eye
- Blom-Singer and artificial larynx proxtheses

Examples of Non-Covered Services

- Dental implants
- Accommodative intraocular implants (e.g., Crystalens)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Rehabilitation and Habilitation Services

Benefit Coverage

Rehabilitation/habilitation therapies are defined as:

Rehabilitation Therapies – Inpatient or outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services include physical therapy, occupational therapy, and/or respiratory therapy. Rehabilitation services will be authorized for an initial treatment period and for any additional medically necessary subsequent treatment periods.

Habilitation Therapies – Medically Necessary services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health care condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Respite care, day care, recreational care, residential care, social services, custodial care, or education services of any kind are not considered Habilitative Services.

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

Physical Therapy – Treatment provided by a physician or when provided by a licensed physical therapist for services diagnosed by a physician or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to develop or improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Respiratory Therapy – Treatment under the direction of a physician and provided by a certified respiratory therapist to develop, preserve or improve a patient's pulmonary function.

Rehabilitation and Habilitation Services

Benefit Coverage *(cont'd.)*

Inpatient benefits are provided for medically necessary inpatient days of care in an acute hospital rehabilitation unit or skilled nursing facility rehabilitation unit.

Outpatient rehabilitation/habilitation therapy is covered for as long as continued treatment is medically necessary. Care must be rendered in the provider's office or outpatient department of a hospital.

Rehabilitation/habilitation therapy provided in the home by a home health agency will apply against the home health care visit limitations.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Inpatient Days

Office Visits

Outpatient Visits

Rehabilitation Therapy

Benefit Exclusions

- Services for spinal manipulation or adjustment.
- Massage therapy provided by a massage therapist.
- Services for or incident to services rendered in the home or hospital or during confinement in a health facility which are primarily for custodial, maintenance or domiciliary care, or rest.
- Services for or incident to reading, vocational, educational, recreational, art, dance or music therapy. This exclusion does not apply to medically necessary services that Blue Shield is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- Services for learning disabilities, behavioral problems, or social skills training/therapy. This exclusion does not apply to medically necessary services that Blue Shield is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.

Rehabilitation and Habilitation Services

Benefit Limitations

None

Exceptions

None

Examples of Covered Services

- Physical therapy following knee or hip surgery
- Physical therapy for an acute exacerbation of a chronic problem
- Occupational therapy for skill development or following injury or illness
- Occupational therapy to train or retrain following an illness or injury, in Activities of Daily Living (ADL)

Examples of Non-Covered Services

- Sensory integration (SI) therapy (CPT 97533) treatment for developmental disorders in patients with established dysfunction of sensory processing. Therapy usually involves activities that provide vestibular, proprioceptive, and tactile stimuli, which are selected to match specific sensory processing deficits of the child. *(Reference: Blue Shield of California Medical Policy)*
- Low-level laser therapy (LLLT) (HCPCS S8948), also called cold laser or photobiomodulation refers to the use of red-beam or near-infrared lasers with a wavelength between 600 and 1,000 nanometer and power from five to 500 milliwatt. Low-level laser therapy has been used to treat pain associated with a variety of conditions including, but not limited to, soft tissue injuries, tendinopathies, osteoarthritis, and carpal tunnel syndrome. *(Reference: Blue Shield of California Medical Policy)*

Rehabilitation and Habilitation Services

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield Medical Policy

Sensory Integration Therapy

Low-Level Laser Therapy

Original Date: 08/01/1995
Revision Date: 01/01/2019
Effective Date: 01/01/2019

Renal Dialysis

Benefit Coverage

Inpatient and outpatient renal dialysis is covered until Medicare assumes primary coverage. When Medicare assumes primary coverage, Blue Shield HMO pays as secondary.

For group members entitled to Medicare solely on the basis of renal disease there is a 30 to 33 month coordination period. During this time Medicare is the secondary payor. For IFP members, Medicare is primary after the initial three month waiting period, when applied.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Outpatient Hospital Services

Renal Dialysis

Inpatient Hospital Services

Benefit Exclusion

Not applicable.

Benefit Limitations

For members who qualify for renal dialysis benefits under the Medicare program, Medicare is the primary payor and Blue Shield HMO is the secondary payor.

Exceptions

Not applicable.

Renal Dialysis

Examples of Covered Services

- Outpatient renal dialysis as authorized by the member's Primary Care Physician
- Inpatient renal dialysis as authorized by the member's Primary Care Physician and Blue Shield HMO
- Renal dialysis outside a member's service area when temporarily traveling **only** when authorized by the Primary Care Physician or Blue Shield HMO *(reference HMO Benefit Guideline for Out-of-Area Services)*.

Examples of Non-Covered Services

Not applicable.

References

IFP Evidence of Coverage and Disclosure Form

Evidence of Coverage

Blue Shield HMO IPA/Medical Group Procedures Manual

HMO Benefit Guidelines for*:*

Blue Card

Out-of-Area Services

Second Opinion Consultation

Benefit Coverage

A second opinion consultation that is initiated at the request of an HMO member, Primary Care Physician (PCP), plan specialist, or other plan licensed health care provider is covered, subject to plan benefit limitations and exclusions.

A second opinion consultation is provided by an appropriately qualified health care professional who is a PCP or specialist acting within his or her scope of practice and who possesses a clinical background including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for second opinion.

A second opinion consultation is considered to be a covered service including, but not limited to, the following conditions:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

  Note: When the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion shall be authorized or denied as soon as possible to accommodate the patient's condition not to exceed 72 hours from receipt of the request.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the member requests a second opinion.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate length of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

Second Opinion Consultation

Benefit Coverage *(cont'd.)*

Second Opinions - Primary Care Physician

If the member is requesting a second opinion about care from their Primary Care Physician, the second opinion shall be provided by an appropriately qualified health care professional of the member's choice within the same IPA/medical group as their PCP as arranged by the IPA/medical group (IPA/MG).

The IPA/MG is responsible for obtaining a second opinion outside of the IPA/MG network if an appropriately qualified licensed health care professional is not available in the IPA/MG.

Second Opinions - Specialist

If the member is requesting a second opinion about care from a specialist or other licensed health care provider outside of their assigned IPA/MG, Blue Shield will authorize a second opinion by an appropriately qualified health care professional of the member's choice within the Blue Shield HMO network.

If there is no participating plan provider within the HMO network who meets the standards specified, then Blue Shield must authorize a second opinion by an appropriately qualified health professional outside of the Blue Shield HMO provider network.

Second Opinion Consultation

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician Outpatient/Consultation

Physician Inpatient/Consultation

Benefit Exclusions

Second opinion consultations regarding infertility are not a benefit for IFP members.

Benefit Limitations

Second opinion consultations for requests regarding care from the assigned PCP must be referred by the member's PCP and approved through the contracted IPA/medical group authorization process. Generally, members will be provided one second opinion consultation if requested. This is in addition to any consultations that the PCP or attending physician may determine are medically necessary.

Second Opinion Consultation

Exceptions

Members may arrange an Access+ *Specialist* visit with a plan specialist in the same IPA/medical group as the PCP without a referral when the IPA/medical group participates as an Access+ Provider.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Consultations

Infertility Services

Mental Health

Preventive Health Services

Substance Abuse-Optional Benefits

Blue Shield HMO IPA/Medical Group Procedures Manual

Skilled Nursing Facility (SNF)

Benefit Coverage

Two types of services are covered under the Skilled Nursing Facility (SNF) Services benefit:

- Medically necessary skilled nursing services are covered when authorized and provided in a skilled nursing facility.
- Medically necessary hospice services are covered when authorized and provided in a facility for Individual and Family Plan (IFP) members in the latter stages of a terminal illness as determined by a plan physician. See the *HMO Benefit Guideline* for *Hospice Care.*

A total of 100 days per calendar year is covered for these services. (Note: For Blue Shield HMO group members, hospice services provided by a participating hospice agency do not count toward the 100 days per calendar year maximum for Skilled Nursing Facility services. See the *HMO Benefit Guideline* for *Hospice Care.*

A skilled nursing facility (SNF) is defined as a facility licensed by the California State Department of Health as a “Skilled Nursing Facility” or similar institution licensed under the laws of any other state territory, or foreign country.

Copayment

See the member’s *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Skilled Nursing Facility (SNF)

Benefit Exclusions

- Services for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance or domiciliary care, rest, or to control or change a person's environment.
- Convenience items such as telephones, TVs, guest trays, and personal comfort items.
- Services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain.
- Services in connection with private duty nursing, except as medically necessary and authorized.
- Services for psychiatric hospitalization, psychiatric professional services delivered in conjunction with hospitalization, inpatient psychotherapy or psychological testing.
- SNF coverage for custodial and domiciliary care, homemaker services, personal and comfort items, and private duty nursing.
- Confinement in a SNF that does not require daily skilled nursing observation or treatment.
- Confinement in a SNF for social services reasons.

Benefit Limitations

Inpatient skilled nursing facility services are covered up to 100 days per calendar year. Skilled nursing facility services and hospice services (for IFP members only) rendered in a facility both apply toward the 100 day per calendar year benefit.

Exceptions

Rehabilitation services rendered in a SNF apply toward the Rehabilitation benefit.

Examples of Covered Services

- Intense and complex care needs that require skilled nursing facility care.
- Wound management that requires dressing changes with prescription medication such as for decubitus ulcers (Stage III and IV) requiring aseptic techniques twice daily or more often.

Examples of Non-Covered Services

- SNF care primarily for administration of routine oral medications, eye drops, and ointments.
- SNF care primarily for general maintenance care of colostomy or ileostomy.
- SNF care primarily for assistance in dressing, eating, and going to the toilet and other activities of daily living.

Skilled Nursing Facility (SNF)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Hospice

Rehabilitation and Habilitation Services

Substance Abuse-Optional Benefits

Blue Shield HMO IPA/Medical Group Procedures Manual

Original Date: 08/01/1995
Revision Date: 01/01/2019
Effective Date: 01/01/2019

Spinal Manipulation

Benefit Coverage

Spinal manipulation is not a benefit of the basic plan.

Optional Benefits

See Chiropractic Services.

Copayment

Not applicable.

Exclusions

To exclude services for a spinal manipulation or adjustment and adjunctive therapy rendered by any provider.

Benefit Limitations

None

Exceptions

Optional Benefit rider through American Specialty Health Plans. See Chiropractic Services section.

Examples of Covered Services

None

Examples of Non-Covered Services

None

Spinal Manipulation

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guideline for:

Chiropractic Services - Optional Benefits

Sterilizations

Benefit Coverage

To provide for voluntary female sterilization (tubal ligation/hysteroscopic tubal sterilization) and voluntary male sterilization (vasectomy).

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Family Planning
Tubal ligation
Vasectomy

Vasectomy

The professional copayment applies when a vasectomy is performed in the office or an outpatient hospital facility, to be collected by the physician. A hospital outpatient copayment may also apply when performed in an outpatient facility, to be collected by the facility.

If the member is admitted, the hospital copayment applies in addition to the sterilization copayment.

Tubal Ligation

Under the Affordable Care Act - Women's Preventive Health Services, there is no copayment for female sterilization (tubal ligation) when a member presents to an outpatient clinic or ambulatory surgery center for the exclusive service of the tubal ligation. When the tubal ligation is performed during a maternity stay at a hospital in conjunction with a vaginal or cesarean section delivery, the maternity copayment/ share of cost would apply based on the maternity benefits.

Benefit Exclusion

Services for or incident to reversal of voluntary surgical sterilization.

Benefit Limitations

Not applicable.

Sterilizations

Exceptions

Not applicable.

Examples of Covered Services

- Tubal Ligations
- Vasectomy

Examples of Non-Covered Services

- Tuboplasty (Salpingoplasty) for reversal of tubal ligation
- Vasovasostomy for reversal of vasectomy

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

Substance Abuse – Basic Plan – Small Business and IFP

Benefit Coverage

Outpatient

Outpatient visits or sessions for diagnosis and treatment of substance abuse are covered by Blue Shield's mental health service administrator (MHSA). The MHSA will provide substance abuse consultations requested by the IPA or medical group. The IPA or medical group will authorize and provide medical consultations requested by the MHSA.

The IPA or medical group will authorize and provide ancillary outpatient radiology and laboratory services and inpatient acute medical detoxification.

Members should call the MHSA directly at (877) 263-9952 to arrange for substance abuse services. Members may also ask their Primary Care Physicians to contact the MHSA for them at (877) 263-9870.

Acute Medical Detoxification

Acute medical detoxification is defined as medically focused interventions such as IV fluids, medications, ventilation assistance, and cardiac monitoring.

The Hospital Inpatient Care benefit covers medically necessary inpatient substance abuse detoxification services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal when a covered member is admitted through the emergency room or when medically necessary inpatient substance abuse detoxification is pre-authorized by the plan.

The IPA or medical group will authorize and provide inpatient acute medical detoxification.

Inpatient services to treat acute medical complications of detoxification is a medical benefit. It is not administered by the MHSA. It is accessed through Blue Shield using Blue Shield's Preferred Providers.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Mental Health/Substance Abuse

Outpatient Visits

Inpatient Hospital Service (detox only)

Substance Abuse – Basic Plan – Small Business and IFP

Benefit Exclusions

- Maintenance drugs dispensed during covered outpatient visits

Examples of Covered Services

Outpatient

- Outpatient visits or sessions for diagnosis and treatment of substance abuse
- Substance abuse counseling

Inpatient

Medically necessary inpatient substance abuse detoxification services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal when a covered member is admitted through the emergency room or when medically necessary inpatient substance abuse detoxification is pre-authorized by the plan.

Examples of Non-Covered Services

Outpatient

- Non-medical services provided by a vocational or rehabilitation therapist, or an employment counselor
- Maintenance drugs dispensed during covered visits

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Mental Health – Small Business and IFP

Preventive Health Services

Blue Shield HMO IPA/Medical Group Procedures Manual

Substance Abuse – Core Accounts (Optional Benefit)

Benefit Coverage

Outpatient

Outpatient visits or sessions for diagnosis and treatment of substance abuse conditions by Blue Shield's mental health service administrator (MHSA) and provided by a network of MHSA participating providers.

The MHSA will provide substance abuse consultations requested by the IPA or medical group. The IPA or medical group will authorize and provide medical consultations requested by the MHSA.

The IPA or medical group will authorize and provide ancillary outpatient radiology and laboratory services and inpatient acute medical detoxification.

Members should call the MHSA directly to arrange for substance abuse services at (877) 263-9952. Members may also ask their Primary Care Physician to contact the MHSA for them at (877) 263-9870.

Inpatient

Inpatient hospital facility services and professional (physician) services for substance abuse conditions are covered when authorized by the MHSA and provided by MHSA participating providers. Partial hospitalization is also covered.

> Note: Partial hospitalization/day treatment program is a treatment program that may be free-standing or hospital-based and provides services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute inpatient care following acute stabilization.

The IPA or medical group will authorize and provide inpatient acute medical detoxification.

Substance Abuse – Core Accounts (Optional Benefit)

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Mental Health/Substance Abuse

Outpatient Visits

Inpatient hospital service (detox only)

Benefit Exclusions

Maintenance drugs dispensed during covered outpatient visits are not covered.

Benefit Limitations

Outpatient

Benefits for Intensive Outpatient Care for substance abuse services require prior authorization.

Inpatient

Inpatient Services to treat acute medical complications of detoxification is a medical benefit. It is not administered by the MHSA. It is accessed through Blue Shield using Blue Shield's Preferred Providers.

Exceptions

Not applicable.

Substance Abuse – Core Accounts (Optional Benefit)

Examples of Covered Services

Outpatient

- Outpatient visits or sessions for diagnosis and treatment of substance abuse
- Substance abuse counseling

Inpatient

- Inpatient visits or sessions for diagnosis and treatment of substance abuse

Examples of Non-Covered Services

Outpatient

- Non-medical services provided by a vocational or rehabilitation therapist, or an employment counselor
- Maintenance drugs dispensed during covered visits

References

Substance Abuse Supplement to the Combined Evidence of Coverage and Disclosure Form

HMO Benefit Guideline for:

Mental Health

Blue Shield HMO IPA/Medical Group Procedures Manual

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Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage

Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues are a benefit only to the extent that these services are provided for or include in the Plan:

- Treatment of pre-malignant or malignant tumors (neoplasms) of the gingiva (gums), teeth, or soft and hard tissues of the oral cavity and associated structures.

  NOTE: Surgical removal of lesions in the soft and hard tissues of the mouth as a direct or indirect result of dental caries, teeth, or pulpal necrosis (e.g., "periapical lesions," cysts, abscesses) are not a benefit under this Plan. Pathology reports from "dental pathologists" for non-malignant or non pre-malignant lesions are not a benefit of this medical plan as these are covered under a member's dental plan.

  NOTE: A "neoplasm" is defined as an "abnormal mass of tissue characterized by excessive growth that is uncoordinated with that of the surrounding tissue and persists in the same excessive manner after cessation of the stimuli that initiated the change; also called a tumor" (Melloni's Illustrated Medical Dictionary, 4th Edition)

  Emergency palliative treatment or damage to the natural teeth and adjacent structures caused solely by an accidental injury.

  NOTE: The goal and definition of "emergency palliative" is the immediate treatment to dentally or medically stabilize the teeth or oral structures and/or to manage or treat acute, intractable (severe) oral pain; it is not necessarily to definitively restore teeth or oral structures. This benefit does not include services for damage to the natural teeth that are/is not accidental (for example resulting from chewing or biting). Covered services are limited to the immediate, medically necessary services for the initial, palliative **medical stabilization** ("first aid") of the member teeth and associated oral structures. Submission of pre- and post-accident radiographs of the site will be required when requesting services. For additional information, see the *HMO Benefit Guideline* for *Accidental Injury to Natural Teeth-Basic Plan*.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- Medically necessary, non-surgical, treatment of Temporomandibular Joint Syndrome (TMJ or TMD) dysfunction (for example splint and physical therapy). The treatment is a benefit when clinical evidence is provided showing there is pathology/disease to the TMJ articulating disk and not just **secondary** pain or discomfort ("soreness" or "tenderness") to the joint or the myo-facial tissues surrounding the joint from bruxism or clenching of the teeth (the mere presence of "clicking," or "soreness-tenderness" to area of the joints is, in-of-itself, not sufficient clinical documentation to arrive at a diagnosis of "TMJ" pathology or disease) . The Provider must provide clinical documentation distinguishing actual pathology/disease to the joint articulating disk versus pain/discomfort secondary to parafunctional oral habits.

- NOTE: Treatment of bruxism, obstructive sleep apnea related bruxism and nocturnal clenching of the teeth, or any parafunctional oral habits as the primary etiology of pain or discomfort to the muscles of mastication or inflammation to the jaw joints, are not covered in this Plan as these are considered by Blue Shield of California to be DENTAL issues.

- NOTE: Oral appliances sometimes referred to as "morning aligners" to prevent a TMJ issue from developing when using an oral appliance to manage obstructive sleep apnea are generally not a benefit since there is no reliable-consistent medical evidence that such appliances are medically necessary because the patient must be certified by the Provider to be "TMJ disease free" before an oral appliance for obstructive sleep apnea is provided as a benefit.

- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment of the TMJ failed (the Provider must provide documentation that conservative treatments, to include the use of medications and any oral appliances were attempted and WHY the treatments failed).

- Medically necessary treatment of maxilla and mandible (jaw joints and jaw bones) caused solely by an accident.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- Trigger point injections of various types of pain and anti-inflammatory medications for the relief of pain, inflammation, "soreness," and "tenderness" to the muscles of mastication (muscles used to operate the jaws) and temporo-mandibular joints are a benefit under the medical policy. Treatment request for the administration of "trigger point" injections to the muscles of mastication, "cluster" headaches, and the jaw joint capsule must meet the criteria outlined in the Blue Shield of California Medical Policy on the *Trigger Point and Tender Point Injections.* Only a physician (MD or DO) may administer the medications to the "trigger point" per Blue Shield of California Medical Policy.

- Oral appliances are a benefit under the medical policy for the management of obstructive sleep apnea when the submitted documentation meets all the criteria in Blue Shield of California's Medical Policy on the *Diagnosis and Management of Obstructive Sleep Apnea* for oral appliances. In general, a physician must order and evaluate the sleep study. If a diagnosis of obstructive apnea is made and member elects not to use a positive air pressure device to manage their sleep apnea, then a prescription must be provided by the referring medical doctor to a dentist to construct an oral appliance to manage the obstructive sleep apnea. The attending dentist must submit the following documentation for review to Blue Shield of California for an oral appliance:

    - A prescription for an oral appliance from the **sleep specialist** MEDICAL DOCTOR.
    - A current sleep study meeting the criteria for sleep studies per pertinent Blue Shield of California Medical Policy.
    - A report on the periodontal condition of the member.
    - A report on the temporomandibular joint of the member.
    - A current sleep survey (e.g., Epworth Sleep Scale).
    - A letter of medical necessity.
    - An affidavit of positive air pressure intolerance
    - A letter clearly indicating the oral appliance is **custom constructed** by a dentist.
    - A letter clearly indicating the member is not involved with any manner of orthodontic treatment.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- Orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is medically necessary to correct skeletal deformity. Refer to the Blue Shield Medical Policy on *Orthognathic Surgery* on necessary documentation when requesting services.

- NOTE: To expedite claims and pre-certifications or claims for orthognathic surgery, Blue Shield of California request providers submit **CURRENT** radiographs, cephalometric radiographs, cephalometric analysis, intra-oral photographs, full facial photographs and photographs of the jaw showing the jaw issue including POST orthodontic treatment radiographs and photographs of the teeth and jaws. In addition, a letter of medical necessity should accompany the treatment request. Blue Shield of California uses exclusively the **Steiner Cephalometric Analysis Protocol** to evaluate orthognathic treatment requests. Providers are requested to submit **ONLY** the values for **SNA, SNB, ANB, SN-GoGn, horizontal overjet, overbite and the fossa-cusp relationship of the first upper and lower permanent molars (to evaluate transverse discrepancies)**. Submission of any cephalometric analysis other than the Steiner Analysis will cause delays in processing the treatment request or have the treatment request returned to the provider requesting a Steiner Analysis and the specified angles outlined in this paragraph. Treatment request with missing documentation will delay processing of a treatment request or have the treatment request returned to the provider.

- Orthognathic surgery, to include all manner of soft/hard tissue surgery to the oral cavity, to manage obstructive sleep apnea must be accompanied with necessary radiographs (when requested), intra-oral photographs (when requested), jaw and facial photographs (when requested), documentation of positive air pressure treatment failure, a member signed affidavit of positive air pressure intolerance, a current sleep study, documentation of oral appliance use and subsequent treatment failure, letter of medical necessity, current cephalometric radiographs and cephalometric analysis (when requested). Refer to the Blue Shield of California Medical Policy on the *Surgical Management of Obstructive Sleep Apnea* for further information.

- Medically necessary dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures. Orthodontic services not associated with cleft palate/lip procedures are not a benefit under this Plan.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- General anesthesia administered in a hospital or surgery center for dental care. The general anesthesia must be required due to clinical status, medical necessity, developmental issues, or underlying medical condition of patient and consistent with the Blue Shield of California Medical Policy for "Dental Anesthesia" and all State of California Regulations pertaining to the appropriate use of this treatment modality. Not a benefit are services of "mobile dental anesthesia teams" that provide general anesthesia and sedation services in dental offices because they generally do not meet the minimum State of California Regulations for the administration of a general anesthetic in an outpatient treatment facility.

- Documentation, when requesting treatment for any dental, oral structures, and jaw shall always include necessary current **radiographs** (not just a radiographic report), and medical pathology reports when applicable. When necessary include pre-accident radiographs, intra and extraoral photographs must be provided for review.

Treatment of the teeth, jaws, and jawbones covered under the Basic Plan must be reviewed and pre-authorized (except after an accident to the teeth or jaws).

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Inpatient Hospital Services

Outpatient Hospital Services

Teeth, Jaws and Jawbones – Basic Plan

Benefit Exclusions *(cont'd.)*

- Routine dental care, including fluoride treatments (except when used with radiation therapy to the oral cavity).
- Visits to hospital emergency departments or urgent care clinics for the alleviation or treatment of dental pain associated with dental caries (cavities), soft tissue (gum) inflammation, chipped or fractured teeth due to chewing, clenching, bruxism, biting, neglect, or poor oral hygiene.
- Services performed on the teeth, gums associated oral structures, periodontal structures, alveolar bone, any treatment(s) to prepare the mouth for dentures/dental implants, dental orthotics, dental orthosis and prosthesis, requests for biopsies of oral tissues (hard and soft), and dental-oral related abscesses, and cysts, including related hospitalization.
- Routine care of teeth and gums, diagnostic services, preventive, dental prophylaxis, or periodontal treatments to include fluoride treatments.
- Anesthesia (general anesthesia, intravenous sedation, oral conscious sedation or nitrous oxide gas) administered in the dental office.
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except medically necessary dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures), including treatment to alleviate TMJ.
- Any procedure (for example, vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures.
- Dental implants and any dental procedures associated with or a prelude to the future placement of a dental implant (endosteal, subperiosteal, or transosteal).
- Alveolar ridge surgery of the jaws if performed primarily to treat natural bone recession associated with loss of teeth and/or the normal aging process, diseases related to the teeth, gums or periodontal structures or from natural or from prosthetic teeth.
- Bone or soft tissue grafts placed into or around the tooth or bone sockets of the jaws after extractions of teeth.
- Treatment for damage to the natural teeth that is not accidental, e.g., resulting from chewing, bruxism, clenching, neglect, caries (cavities), poor oral hygiene, tooth mobility or biting.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Coverage *(cont.)*

- Replacement of existing partial removable or full denture(s) in case of accident, damage, or loss to include losses due to a hospital or clinic visit. Any dental services provided after the initial, palliative medical stabilization of the member.

- Swellings (inflammatory edema), infections, pain, hypertrophy (over-growth) to the gingiva due to poor oral hygiene, food impaction, medication use, chronic gingivitis or periodontitis are not a benefit of this Plan. When and where appropriate radiographs and photographs will be required to submit a claim or request pre-certification for treatment.

- Oral appliances used to hold medications in or against structures of the mouth, jaws, tongue, face, and soft tissues of the oral cavity (sometimes referred to as “medication stents or splints”).

- Oral appliances used for weigh loss treatment.

Teeth, Jaws and Jawbones – Basic Plan

Benefit Limitations

Coverage for dental anesthesia (and associated facility charges) required by member's clinical status or underlying medical condition is limited to members who:

- Are less than seven years of age, or
- Developmentally disabled, regardless of age, or
- Whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

NOTE: The use of itinerate (mobile) dental anesthesia teams in an out-patient treatment facility to perform dentistry or oral surgery, not previously licensed to provide general anesthesia by the California State Dental Board, do not meet the California State Dental Board regulations for a physical facility anesthesia permit from the Dental Board to administer a general anesthetic, intravenous sedation, oral sedation, and etc. .

Benefit Exclusions

Routine restorative dentistry, routine removal of teeth to include 3rd molars, endodontic (root canal) treatment, periodontal (gum) treatments, prosthodontic (dentures, crowns, implants, fixed bridges, removable dental bridges, etc.) services, oral medicine, oral pathology services, preventive dentistry services, dental radiographs to include 3-dimensional radiographs, orthodontics, routine oral surgery, photographs of the mouth/face/jaws, any pediatric dentistry, any and all treatments that are usually provided by a dentist.

Exceptions

Maxillofacial prosthesis replacing all or part of a jaw to restore FUNCTION and when it is not primarily a cosmetic procedure.

Teeth, Jaws and Jawbones – Basic Plan

Examples of Covered Services

- Medically necessary splint therapy of the temporomandibular joint (TMJ) when there is documentation of DISEASE-PATHOLOGY to the articulating joint disk.
- Surgical and arthroscopic treatment of TMJ if conservative medical treatment has failed (thorough documentation must be provided to include current joint radiographs).
- Orthognathic surgery to correct skeletal deformity (surgery to reposition the upper and/or lower jaw). Not a benefit is orthognathic surgery that does not significantly improve the FUNCTIONAL of the jaws and/or associated structures or is primarily provided to improve the esthetics of the jaw and/or face of the member.
- Dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures.
- Treatment of malignant and pre-malignant **tumors** (neoplasms) of the soft tissues of the mouth (gums) and malignant or pre-malignant **tumors** (neoplasms) of dental origin of the jaws.
- General anesthesia administered for dental care and associated facility charges (when the member **MEETS** specified clinical criteria).
- Orthognathic and soft tissue surgery to manage obstructive sleep apnea (refer to the Blue Shield of California *Medical Policy on the Surgical Management of Obstructive Sleep Apnea*).

Teeth, Jaws and Jawbones – Basic Plan

Examples of Non-Covered Services

- Endodontics
- Orthodontia
- Routine dental extractions of non-restorable or diseased teeth
- Extraction of teeth for orthodontic reasons.
- Extractions of impacted 3rd molars
- Surgical services to drain soft or hard tissue cysts and abscesses
- Treatment of periodontal disease or periodontal surgery for inflammatory conditions such as gingivitis or acute necrotizing ulcerative gingivitis.
- Preventive dental care
- Treatment of pain of dental origin or structures associated with the teeth due to dental caries (cavities), chipped or fractured teeth due to biting or chewing, and poor oral hygiene
- Routine dental care (even if related anesthesia and associated facility charges are covered)
- Replacement of existing partial removable or full denture(s) in case of accident, damage or loss from or due to hospital or clinic visit
- Dental x-rays used for the detection of caries (“cavities”), impacted 3rd molars, and the ectopic eruption of teeth

Teeth, Jaws and Jawbones – Basic Plan

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code Section 1367.71

HMO Benefit Guideline for:

Accidental Injury to Natural Teeth-Basic Plan

Teeth, Jaws and Jawbones – Basic Plan

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Transplant Services

Benefit Coverage

Hospital and professional services are covered in connection with the following human organ, bone marrow/stem cell transplants when: 1) the recipient is a member; 2) the procedure is medically necessary and not experimental or investigational for specific diagnosis or condition; 3) is pre-authorized by Blue Shield Medical Care Solutions Transplant Team and; 4) is performed at a Blue Shield approved Major Organ/Bone Marrow Transplant Facility:

- Bone Marrow
- Stem Cell
- Cord Blood
- Kidney and Pancreas (for kidney only see below)
- Heart
- Heart/Lung
- Lung
- Liver
- Small Bowel
- Multi Organ Transplants

The IPA/medical group is responsible for medical necessity review of and authorization for the following transplants:

- Cornea
- Kidney
- Skin

No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

Services to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Transplant Services

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Physician-Inpatient

Inpatient Hospital Services

Outpatient Hospital Services

Benefit Exclusions

All transplants of organs other than the human organs listed above are excluded. All transplants that are not medically necessary or are considered experimental/investigational are excluded. Donor costs for a member when the recipient is a non-member are excluded.

Benefit Limitations

Organ transplant services and organ procurement services are only covered when the recipient is a Blue Shield HMO Member.

Major organ/bone marrow transplant services must be performed at Blue Shield Major Organ/Bone Marrow Transplant Facility.

Hematopoietic Cell Transplantation, including Autologous Stem Cell Transplantation, Allogeneic Stem Cell Transplantation, or Cord Blood Transplantation used to support high-dose chemotherapy, are covered when such treatment is medically necessary and is not experimental or investigational.

Exceptions

None

Transplant Services

Examples of Covered Services

Human organ transplant services for:

- Bone Marrow
- Stem Cell
- Cord Blood
- Kidney and Pancreas (for kidney only see below)
- Heart
- Heart/Lung
- Small Bowel
- Liver
- Multi Organ Transplants
- Cornea
- Kidney
- Skin Organ Transplant

Examples of Non-Covered Services

- Transplants determined not to be medically necessary or considered to be experimental/investigational for a specific diagnosis

Transplant Services

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield Medical Policy

Blue Shield HMO IPA/Medical Group Procedures Manual

Urgent Care

Benefit Coverage

Blue Shield defines urgent care as treatment provided within the Primary Care Physician's (PCP) service area to prevent serious deterioration of a member's health due to unforeseen illness, injury or complications of an existing medical condition. In an urgent situation, treatment cannot reasonably be delayed.

Urgent Services are defined as those covered services rendered outside of the PCP's service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment can not reasonably be delayed until the member returns to the PCP's service area.

Out-of-area follow-up care is defined as non-emergent medically necessary out-of-area services to evaluate the member's progress after an initial emergency or urgent service.

Urgent care within the PCP's service area is a covered benefit when:

- The member first contacts their PCP and care is rendered or referred by the PCP. This includes services rendered in an urgent care clinic when instructed by the PCP or assigned IPA/medical group, or
- The assigned IPA/medical group has provided the member with advance instructions for obtaining care from an urgent care clinic within the PCP's service area.

Urgent Services outside of the PCP's service area are a covered benefit when:

- Within California - Services are provided by a Blue Shield participating provider or a non-participating provider. If possible, the member should call Blue Shield Member Services for assistance in receiving urgent care services through a Blue Shield of California Plan Provider.
- Outside California but within the USA - Services are provided through a BlueCard participating provider or a non-participating provider.
- Outside California and outside of the USA - Services are provided through a BlueCard Worldwide Network participating provider or a non-participating provider.

Urgent Care

Benefit Coverage *(cont'd.)*

For assistance locating Urgent Services providers outside of California and within the United States, the member can call toll-free (800) 810-BLUE (2583) 24 hours a day, 7 days a week. For assistance locating Urgent Services providers outside of the United States, the member can call collect (804) 673-1177 24 hours a day.

Out-of-area follow-up care is defined as medically necessary services following an initial emergency or urgent service to stabilize the patient's condition. Out-of-area follow-up care is covered through a Blue Shield or BlueCard participating provider or a non- participating provider. However, authorization by the Blue Shield HMO is required for more than two out-of-area follow-up outpatient visits (except for non-marketed IFP plan members) or for care that involves a surgical or other procedure or inpatient stay. The Blue Shield HMO may direct the patient to receive extended follow-up care from their PCP.

If urgent services or out of area follow-up care are not available through a Blue Shield or BlueCard participating provider, any member who received services from a non-Blue Shield or non-BlueCard provider must submit a claim to Blue Shield. The services will be reviewed retrospectively by the plan to determine whether the services were for medically necessary urgent treatment.

Urgent Care

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverag*e for member copayments for:

Physician - Outpatient

Office Visits/Consultations/Surgery

BlueCard Worldwide

Benefit Exclusion

- Urgent care that is not provided or authorized by the Primary Care Physician when the member is located within the member's service area.
- More than two unauthorized follow-up urgent care visits when the member is located outside of the member's service area.
- Unauthorized outpatient care that involves a surgical or other procedure or inpatient stay.

Benefit Limitations

Not applicable.

Urgent Care

Examples of Covered Services

Evaluation of:

- high or persistent fever
- symptoms of infection
- traumatic injury

Examples of Non-Covered Services

- Ongoing treatment, such as chemotherapy
- Routine services
- Out-of-area follow-up care that is not medically necessary following an emergency or urgent care visit
- Out-of-area follow-up care in excess of two outpatient visits that was not authorized by Blue Shield HMO
- Out-of-area follow-up care that involves any surgical procedure or inpatient stay unless prior authorized by Blue Shield HMO

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

BlueCard

Emergency Services

Out-of-Area Services

Vision Care (VPA Optional Benefit)

Benefit Coverage

Blue Shield HMO offers an optional vision plan through Blue Shield's Vision Plan Administrator (VPA) to group members. The plan provides payments based on prevailing fees not to exceed amounts calculated under the VPA's Schedule of Allowances for the following services:

- One comprehensive eye examination in a 12 consecutive month period
- One pair of standard lenses in a 24 consecutive month period, or at a 12-month interval if the examination indicates a change in prescriptions. A significant prescription change is defined as:
    - A total change of 0.50 diopter or more in one or both eyes, or
    - A shift in axis of astigmatism of 15%, or
    - A difference in vertical prism greater than 1 prism diopter.
- One standard frame in a 24-month period. A standard frame is any frame supplied by one of the VPA's participating dispensers that retails up to the amount specified in the *Schedule of Allowances*.
- One pair of contact lenses in any 24 consecutive months, or at a 12-month interval if the prescription changes are significant. A significant prescription change is defined as:
    - A total change of 0.50 diopter or more in one or both eyes, or
    - A shift in axis of astigmatism of 15%, or
    - A difference in vertical prism greater than 1 prism diopter.
- Medically necessary contact lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for certain conditions of Keratoconus or Anisometropia; or for certain conditions of Myopia, Hyperopia or Astigmatism. A report from the provider and prior authorization from Blue Shield's VPA is required. If contact lenses are for convenience purpose, the plan will pay the amount specified in the *Schedule of Allowances* towards their cost. The balance, if any, is the member's responsibility. This allowance is in addition to the examination benefit.
- Any cost for services beyond the allowance or cost of non-covered services is assumed by the member.

Note: Contact lenses are in lieu of other eyewear benefit.

Vision Care (VPA Optional Benefit)

Copayment

See *VPA Optional Care Schedule of Allowances*

Benefit Exclusions

- Services and supplies in connection with special procedures such as vision training and subnormal vision aids (for example, magnifying glass).
- Non-prescription eyewear.
- Medical or surgical treatment of the eyes.
- Eye examinations required by an employer as a condition of employment except when benefits are otherwise available.

Benefit Limitations

- Lenses or frames which were furnished under this plan and which have been lost, stolen or broken will not be replaced, except when benefits are otherwise available.
- No-line (blended type) bifocal lenses, coated lenses, or oversized lenses exceeding the allowance for covered lenses.
- Contact lenses and tints will be limited to the Schedule of Allowances.

Call Blue Shield's VPA at (877) 601-9083 for eligibility verification, benefit determination, or pricing issues.

Vision Care (VPA Optional Benefit)

Exceptions

- Orthoptic therapy is covered if a medical diagnosis has been confirmed. The therapy is generally done by an optometrist or ophthalmologist and is a capitated service covered under the Basic Plan.
- Contact lenses deemed medically necessary to treat keratoconmus and keratitis sicca, and for treatment following cataract surgery are covered under the Basic Plan.

Examples of Covered Services

- Bifocal Lenses
- Comprehensive Opthalmologic examination
- Contact Lenses
- Frames

Examples of Non-Covered Services

- Radial Keratotomy

References

Blue Shield HMO Evidence of Coverage and Disclosure Form Vision Plan Benefits Supplement

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Vision Screening – Basic Plan

Benefit Coverage

Vision screening by the Primary Care Physician (PCP) for group plan members through the age of 18 to determine the need for an eye examination for refractive error is covered.

For IFP members, vision screening by the PCP through the age of 16 to determine the need for an eye examination for refractive error is covered.

Diagnostic tests and treatment for medical conditions associated with the eye are covered under medical/surgical benefits, subject to contract terms and conditions.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

Excluded eye services include but not limited to:

- Eye examinations for refractive error
- Vision screening performed by someone other than the PCP
- Lenses and frames for eye glasses and contact lenses
- Surgery to correct refractive error (such as, but not limited to, radial keratotomy and refractive keratoplasty)

Benefit Limitations

Covered benefits are limited to vision screening for group plan members through the age of 18 and IFP members under the age of 18; eye exams to for refractive error are not covered. Only vision screening conducted by the PCP is covered.

Vision Screening – Basic Plan

Exceptions

Contact lenses are covered when medically necessary to treat eye conditions such as keratoconus and keratitis sicca.

Examples of Covered Services

Vision screening by the PCP is covered for group plan members through the age of 18 and IFP members under the age of 18.

Examples of Non-Covered Services

- Vision screening not provided by the PCP
- Eye refractions
- Lenses and frames for glasses

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Vision Care - VPA Optional Benefit

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