EPO Plan

Benefit Booklet
Delta Dental of Pennsylvania
Group Number:  W0051416-M0009747
Effective Date:  January 1, 2016

blue of california
Claims Administered by Blue Shield of California
PLEASE NOTE

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

Participant Bill of Rights

As an EPO Plan Participant, you have the right to:

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

Participant Responsibilities

As an EPO Plan Participant, you have the responsibility to:

1. Carefully read all Claims Administrator EPO Plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Claims Administrator EPO Plan as explained in this booklet.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your Physician, and/or the Plan need to provide appropriate care for you.

4. Understand your health problems and take an active role in developing treatment goals with your medical provider, whenever possible.

5. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

7. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.

8. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.

9. Offer suggestions to improve the Claims Administrator EPO Plan.

10. Help the Claims Administrator to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

11. Notify the Claims Administrator as soon as possible if you are billed inappropriately or if you have any complaints.

12. Treat all Plan personnel respectfully and courteously as partners in good health care.

13. Pay your fees, Copayments and charges for non-covered services on time.

14. Follow the provisions of the Claims Administrator’s Benefits Management Program.
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This booklet constitutes only a summary of the health Plan. The health Plan document must be consulted to determine the exact terms and conditions of coverage.

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

This is an EPO. Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

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

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

IMPORTANT

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

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

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

Delta Dental of Pennsylvania and Delta Dental of New York are the Employers. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

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

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

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

## Summary of Benefits

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<th>Calendar Year Medical Deductible</th>
<th>Participant Deductible Responsibility</th>
</tr>
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<tbody>
<tr>
<td>Calendar Year Medical Deductible</td>
<td>$0 per Participant/ $0 per Family</td>
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</table>

<table>
<thead>
<tr>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>Participant Maximum Calendar Year Out-of-Pocket Amount</th>
</tr>
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<tbody>
<tr>
<td>Calendar Year Out-of-Pocket Maximum</td>
<td>$2,000 per Participant/ $4,000 per Family</td>
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</table>

<table>
<thead>
<tr>
<th>Maximum Lifetime Benefits</th>
<th>Maximum Claims Administrator Payment</th>
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<tr>
<td>Lifetime Benefit Maximum</td>
<td>No maximum</td>
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<td>Benefit</td>
<td>Participant Copayment</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td><strong>Acupuncture Benefits</strong></td>
<td></td>
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<tr>
<td>Acupuncture services</td>
<td>Not covered</td>
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<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy serum purchased separately for treatment</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Office visits (includes visits for allergy serum injections)</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Ambulance Benefits</strong></td>
<td></td>
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<tr>
<td>Emergency or authorized transport</td>
<td>$100 per trip</td>
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<td><strong>Ambulatory Surgery Center Benefits</strong></td>
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<tr>
<td>Note: Participating Ambulatory Surgery Centers may not be available in</td>
<td></td>
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<tr>
<td>all areas. Outpatient ambulatory surgery services may also be obtained</td>
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<tr>
<td>from a Hospital or an Ambulatory Surgery Center that is affiliated with</td>
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<tr>
<td>a Hospital, and will be paid according to the Hospital Benefits (Facility</td>
<td></td>
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<tr>
<td>Services) section of this Summary of Benefits.</td>
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<td>Ambulatory Surgery Center outpatient surgery facility services</td>
<td>$100 per visit</td>
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<tr>
<td>Ambulatory Surgery Center outpatient surgery Physician services</td>
<td>You pay nothing</td>
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<td><strong>Chiropractic Benefits</strong> (12 visits per Participant per Calendar Year</td>
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<td>maximum¹)</td>
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<tr>
<td>Chiropractic services – office location</td>
<td>$20 per visit</td>
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<td><strong>Clinical Trial for Treatment of Cancer or Life-Threatening Conditions</strong></td>
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<tr>
<td>Clinical Trial for Treatment of Cancer or Life Threatening Conditions</td>
<td>You pay nothing</td>
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<td>Covered Services for Participants who have been accepted into an ap-</td>
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<td>proved clinical trial when prior authorized by the Claims Administrator.</td>
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<td>Note: Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.</td>
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<td>Benefit</td>
<td>Participant Copayment 4</td>
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<td><strong>Diabetes Care Benefits</strong></td>
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<td>Devices, equipment and supplies 5</td>
<td>You pay nothing</td>
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<td>Diabetes self-management training – office location 1</td>
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<td><strong>Dialysis Center Benefits</strong></td>
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<td>Dialysis services</td>
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<td>Note: Dialysis services may also be obtained from a Hospital. Dialysis services obtained from a Hospital will be paid at the Participating or Non-Participating level as specified under Hospital Benefits (Facility Services) in this Summary of Benefits.</td>
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<td><strong>Durable Medical Equipment Benefits</strong></td>
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<td>Breast pump 1</td>
<td>You pay nothing</td>
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<td>Other Durable Medical Equipment</td>
<td>You pay nothing</td>
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<td>Emergency Room Physician services</td>
<td>You pay nothing</td>
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<td>Note: After services have been provided, the Claims Administrator may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Participating or Non-Participating Provider levels as specified under Professional (Physician) Benefits, “Outpatient Physician services, other than an office setting” in this Summary of Benefits.</td>
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<tr>
<td>Emergency Room services not resulting in admission</td>
<td>$150 per visit</td>
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<td>Note: After services have been provided, the Claims Administrator may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits will be paid at the applicable Participating or Non-Participating Provider levels as specified under Hospital Benefits (Facility Services), “Outpatient Services for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies” in this Summary of Benefits.</td>
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<td>Emergency Room services resulting in admission (billed as part of inpatient Hospital services)</td>
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<td>Note: Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc), the facility Copayment listed under the applicable facility benefit in the Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), an intrauterine device (IUD), and tubal ligation.</td>
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<td>Counseling and consulting ¹</td>
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<tr>
<td>Diaphragm fitting procedure ¹</td>
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<td>Intrauterine device (IUD) ¹</td>
<td>You pay nothing</td>
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<td>Tubal ligation ¹</td>
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<td>Vasectomy</td>
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<td>(Including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist or occupational therapist)</td>
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<td>Up to a maximum of 100 visits per Participant, per Calendar Year, by home health care agency providers.</td>
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<td>If your benefit plan has a Calendar Year Medical Deductible, the number of visits starts counting toward the maximum when services are first provided even if the Calendar Year Medical Deductible has not been met.</td>
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<td>Medical supplies</td>
<td>You pay nothing</td>
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<td>Services provided by a hemophilia infusion provider and prior authorized by the Claims Administrator. Includes blood factor product.</td>
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<tr>
<td>Home infusion injectable therapy provided by a Home Infusion Agency (Home infusion agency visits are not subject to the visit limitation under Home Health Care Benefits.)</td>
<td>You pay nothing</td>
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<td>Note: Non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit which is provided through your prescription drug carrier, Caremark.</td>
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<td>Home visits by an infusion nurse</td>
<td>$20 per visit</td>
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<td>Hemophilia home infusion nursing visits are not subject to the Home Health Care and Home Infusion/Home Injectable Therapy Benefits Calendar Year visit limitation.</td>
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<td>Participant Copayment</td>
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<td>approved Hospice Program</td>
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<td>The Hospice Program Benefit must be prior authorized by the Claims</td>
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<td>Administrator and must be received from a Participating Hospice Agency.</td>
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<td>24-hour continuous home care</td>
<td>$75 per day</td>
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<td>Short term inpatient care for pain and symptom management</td>
<td>$75 per day</td>
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<tr>
<td>Inpatient respite care</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Pre-hospice consultation</td>
<td>You pay nothing</td>
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<td>Routine home care</td>
<td>You pay nothing</td>
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<td><strong>Hospital Benefits (Facility Services)</strong></td>
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<tr>
<td>Inpatient Facility Services</td>
<td>$250 per admission</td>
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<tr>
<td>Semi-private room and board, services and supplies, including Subacute</td>
<td></td>
</tr>
<tr>
<td>Care</td>
<td></td>
</tr>
<tr>
<td>Inpatient skilled nursing services, including Subacute Care</td>
<td>$50 per day</td>
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<tr>
<td>Up to a maximum of 60 days per Participant, per calendar year combined</td>
<td></td>
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<tr>
<td>with Freestanding Skilled Nursing Facility Unit, except when received</td>
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<tr>
<td>through a Hospice Program provided by a Participating Hospice Agency.</td>
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<tr>
<td>This day maximum is a combined Benefit maximum for all skilled nursing</td>
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<tr>
<td>services whether rendered in a Hospital or a free-standing Skilled</td>
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<td>Nursing Facility.</td>
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<td>If your benefit plan has a Calendar Year Medical Deductible, the number</td>
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<td>of days counts towards the day maximum even if the Calendar Year Medical</td>
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<tr>
<td>Deductible has not been met.</td>
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<td>Inpatient services to treat acute medical complications of detoxification</td>
<td>$250 per admission</td>
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<td>Outpatient diagnostic testing: X-Ray, diagnostic examination and clinical</td>
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<tr>
<td>laboratory services</td>
<td>You pay nothing</td>
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<td>Outpatient dialysis services</td>
<td>$100 per visit</td>
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<tr>
<td>Outpatient Facility services</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Outpatient services for treatment of illness or injury, radiation</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>therapy, chemotherapy, and supplies</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td></td>
</tr>
<tr>
<td>Treatment of gum tumors, damaged natural teeth resulting from Accidental</td>
<td></td>
</tr>
<tr>
<td>Injury, TMJ as specifically stated, and orthognathic surgery for skeletal</td>
<td></td>
</tr>
<tr>
<td>deformity.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center outpatient surgery facility services</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital services</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Office location for Services performed by Doctors of Medicine who are</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>doctors of internal medicine, family doctors, general practitioners,</td>
<td></td>
</tr>
<tr>
<td>gynecologists, obstetricians or pediatricians 1</td>
<td></td>
</tr>
<tr>
<td>Office location for Services performed by Doctors of Medicine who are</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>other than doctors of internal medicine, family doctors, general</td>
<td></td>
</tr>
<tr>
<td>practitioners, gynecologists, obstetricians or pediatricians 1</td>
<td></td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental Health and Substance Abuse Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital services</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Inpatient Professional (Physician) services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Residential care for Mental Health Condition</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Residential care for Substance Abuse Condition</td>
<td>$250 per admission</td>
</tr>
<tr>
<td><strong>Non-Routine Outpatient Mental Health and Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Treatment in home or other non-institutional setting</td>
<td>Not covered</td>
</tr>
<tr>
<td>Behavioral Health Treatment in an office-setting</td>
<td>Not covered</td>
</tr>
<tr>
<td>Electroconvulsive Therapy (ECT)</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Office-based opioid treatment: outpatient opioid detoxification and/or</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>maintenance therapy including methadone maintenance treatment</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization Program</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Psychological testing to determine mental health diagnosis</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Transcranial magnetic stimulation</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Routine Outpatient Mental Health and Substance Abuse Services</strong></td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) office visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Orthotics Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits by Doctors of Medicine who are doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians ¹</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Office visits by Doctors of Medicine who are other than doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Orthotic equipment and devices</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Outpatient Prescription Drug Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>A description of your Outpatient prescription drug Benefits is provided separately through your prescription drug carrier, Caremark.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient X-Ray, Pathology, Laboratory Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient diagnostic X-ray, pathology, diagnostic examination and clinical laboratory Services, including mammography and Papanicolaou test.</td>
<td></td>
</tr>
<tr>
<td>See Radiological and Nuclear Imaging Benefits for CT scans, MRIs, MRAs, PET scans, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Laboratory Center or Outpatient Radiology Center</strong></td>
<td></td>
</tr>
<tr>
<td>Note: Preferred Laboratory Centers and Preferred Radiology Centers may not be available in all areas.</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>PKU Related Formulas and Special Food Products Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Formulas and Special Food Products</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Podiatric Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Podiatric Services – office location</td>
<td>$40 per visit</td>
</tr>
<tr>
<td><strong>Pregnancy and Maternity Care Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Note: Routine newborn circumcision is only covered as described in the Covered Services section of the Benefit Booklet. Services will be covered as any other surgery and paid as noted in this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital services for normal delivery, Cesarean section, and complications of pregnancy</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Outpatient X-Ray, Pathology, Laboratory Benefits for prenatal genetic testing.</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient Facility Radiology and Ultrasound</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Prenatal and preconception Physician office visit: initial visit ¹</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Prenatal and preconception Physician office visit: subsequent visits,</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Postnatal Physician office visits</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Professional Laboratory and Genetic Testing</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Professional Radiology and Ultrasound</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Abortion Services</td>
<td>$100 per surgery</td>
</tr>
</tbody>
</table>

¹ Copayment shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (Hospital or Outpatient Facility), an additional facility copayment may apply.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Participant Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the Benefit Booklet, for more information.</td>
<td></td>
</tr>
<tr>
<td><strong>Professional (Physician) Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Outpatient Physician Services, other than an office setting</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Physician home visits</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Physician office visits by Doctors of Medicine who are doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Note: For other services with the office visit, you may incur an additional Copayment as listed for that service within this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Physician office visits by Doctors of Medicine who are other than doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Physician services in an Urgent Care Center by Doctors of Medicine who are doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Physician services in an Urgent Care Center who are other than doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$40 per visit</td>
</tr>
<tr>
<td><strong>Prosthetic Appliance Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits by Doctors of Medicine who are other than doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Office visits by Doctors of Medicine who are other than doctors of internal medicine, family doctors, general practitioners, gynecologists, obstetricians or pediatricians</td>
<td>$40 per visit</td>
</tr>
<tr>
<td>Prosthetic equipment and devices</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Reconstructive Surgery Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>For Physician services for these Benefits, see the “Professional (Physician) Benefits” section of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgery Center outpatient surgery facility services</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>Inpatient Hospital services</td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$100 per visit</td>
</tr>
<tr>
<td><strong>Radiological and Nuclear Imaging Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient non-emergency radiological and nuclear imaging procedures including CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine. Prior authorization required by the Plan.</td>
<td></td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Prior authorization required by the Plan.</td>
<td></td>
</tr>
<tr>
<td>Radiology Center</td>
<td>You pay nothing</td>
</tr>
<tr>
<td>Note: Preferred Radiology Centers may not be available in all areas. Prior authorization required by the Plan.</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Participant Copayment</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Rehabilitation and Habilitation Services Benefits (Physical, Occupational and Respiratory Therapy)</strong></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation and Habilitation Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility (SNF) Benefits</strong></td>
<td>$50 per day</td>
</tr>
<tr>
<td>Skilled nursing services by a free-standing Skilled Nursing Facility Up to a maximum of 60 days per Participant, per calendar year combined with Hospital Skilled Nursing Facility Unit, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing SNF. If your benefit plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Speech Therapy Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid at the Participating or Non-Participating level as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.</td>
<td></td>
</tr>
<tr>
<td>Office location</td>
<td>$20 per visit</td>
</tr>
<tr>
<td>Outpatient department of a Hospital</td>
<td>$20 per visit</td>
</tr>
<tr>
<td><strong>Transplant Benefits – Tissue and Kidney</strong></td>
<td>$250 per admission</td>
</tr>
<tr>
<td>Organ Transplant Benefits for transplant of tissue or kidney.</td>
<td></td>
</tr>
<tr>
<td>Hospital services</td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) services</td>
<td>You pay nothing</td>
</tr>
<tr>
<td><strong>Transplant Benefits – Special</strong></td>
<td>$250 per admission</td>
</tr>
<tr>
<td>The Claims Administrator requires prior authorization for all Special Transplant Services, and all services must be provided at a Special Transplant Facility designated by the Claims Administrator. See the Transplant Benefits – Special Transplants section of the Principal Benefits (Covered Services) section in the Benefit Booklet for important information on this Benefit.</td>
<td></td>
</tr>
<tr>
<td>Facility services in a Special Transplant Facility</td>
<td></td>
</tr>
<tr>
<td>Professional (Physician) services</td>
<td>You pay nothing</td>
</tr>
</tbody>
</table>
Summary of Benefits

Footnotes:

1. All Benefits must be provided by Preferred Providers in Pennsylvania, except in an emergency.

2. There is no Calendar Year deductible for covered Services received from Preferred Providers.

3. Copayments or Coinsurance for Covered Services accrue to the Calendar Year Out-of-Pocket Maximum, except for the following:
   - Charges in excess of specified benefit maximums
   - Any optional Infertility Benefits;
   - Any optional Hearing Aid Benefits.

   Copayments or Coinsurance for Emergency Services received from Non-Participating Providers accrue to the Calendar Year Out-of-Pocket Maximum established for Services by Participating Providers.

   Note: Copayments, Coinsurance and charges for services not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Participant's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

4. Coinsurance is calculated based on the Allowable Amount unless otherwise specified.

5. Professional (Physician) office visit copayment/coinsurance may also apply.


7. For Non-Routine Outpatient Mental Health and Substance Abuse Services - Partial Hospitalization Program services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.

8. The Participant’s Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.

9. Preventive Health Services are only covered when provided by Participating or Preferred Providers.
INTRODUCTION

The Claims Administrator EPO Plan is specifically designed for you to use Preferred Providers. Preferred Providers include Physicians, Hospitals and many other health care professionals.

IMPORTANT

All covered services, except for emergency services, must be provided by Preferred Providers. No benefits are provided when you receive services from a Non-Preferred Provider, except for Medically Necessary Covered Services received for emergency services. If a Preferred Provider refers you to a Non-Preferred Provider, you are responsible for the total amount billed by the Non-Preferred Provider (billed charges).

To determine whether a provider is a Preferred Provider, you may access the Blue Cross Blue Shield Association’s Internet site located at http://provider.bcbs.com or by calling Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider’s status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider.

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

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

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

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

In order to receive Benefits, you should assure that your provider is a Preferred Provider (see the “Preferred Providers” section).

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

1. You or your Physician must obtain the Claims Administrator approval at least 5 working days before Hospital or Skilled Nursing Facility admissions for all non-Emergency Inpatient Hospital or Skilled Nursing Facility Services. (See the “Preferred Providers” section for information.)

2. You or your Physician must notify the Claims Administrator within 24 hours or by the end of the first business day following emergency admissions, or as soon as it is reasonably possible to do so.

3. You or your Physician must obtain prior authorization in order to determine if contemplated services are covered. See “Prior Authorization” in the “Benefits Management Program” section for a listing of Services requiring prior authorization.

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

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

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

PREFERRED PROVIDERS

All Preferred Providers are located within the state of Pennsylvania. There are no Preferred Providers outside of the state of Pennsylvania.

The Claims Administrator EPO Plan is specifically designed for you to use Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other Providers. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers.

To determine whether a provider is a Preferred Provider, you may verify this information by accessing the Blue Cross Blue Shield Association’s Internet site located at http://provider.bcbs.com, or by calling Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider’s status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider.

Note: Services are covered only if rendered by a Preferred Provider within Pennsylvania. Using a Non-Preferred Provider will result in no payment by the Claims Administrator for services except for Medically Necessary Emergency Services.

Preferred Providers agree to accept the Claims Administrator’s payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums, as payment in full for covered Services,
You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, except as provided under the Exception for Other Coverage provision.

If you go to a Non-Preferred Provider, you are responsible for the amount billed by the Non-Preferred Provider except for Medically Necessary Emergency Services. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

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

**CONTINUITY OF CARE BY A TERMINATED PROVIDER**

Participants who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is no longer a Preferred Provider. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

**FINANCIAL RESPONSIBILITY FOR CONTINUITY OF CARE SERVICES**

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

**ELIGIBILITY**

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

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

When you decline coverage for yourself or your Dependants during the initial enrollment period and later request enrollment, you and your Dependants will be considered to be Late Enrollees. When Late Enrollees decline enrollment during the initial enrollment period, they will be eligible the earlier of 12 months from the date of the request for enrollment or at the Employer’s next Open Enrollment Period. The Claims Administrator will not consider applications for earlier effective dates.

You and your Dependants will not be considered to be Late Enrollees if either you or your Dependants lose coverage under another employer’s health plan and you apply for coverage under this Plan within 31 days of the date of loss of coverage. You will be required to furnish the Claims Administrator written proof of the loss of coverage.

Newborn infants of the Participant, spouse, or his or her Domestic Partner will be eligible immediately after birth for the first 31 days. A child placed for adoption will be eligible immediately upon the date the Participant, spouse or Domestic Partner has the right to control the child’s health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Participant’s, spouse’s or Domestic Partner’s right to control the child’s health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to and received by the Claims Administrator within 31 days from the date of birth or placement for adoption of such Dependent.

A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship, if an application is submitted within 31 days of becoming eligible.

You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 days from the date of acquisition of the Dependent:

a. to continue coverage of a newborn or child placed for adoption;

b. to add a spouse after marriage, or add a Domestic Partner after establishing a domestic partnership;

c. to add yourself and spouse or Domestic Partner following the birth of a newborn or placement of a child for adoption;

d. to add yourself and spouse after marriage; or add a Domestic Partner after establishing a domestic partnership;

e. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.
A completed health statement may be required with the application. Coverage is never automatic; an application is always required.

If both partners in a marriage or domestic partnership are both eligible to be Participants, children may be eligible and may be enrolled as a Dependent of either parent, but not both.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the Employee for support and maintenance, and (2) the Employee must submit a Physician’s written certification of such disabling condition. The Claims Administrator or the Employer will notify you at least 90 days prior to the date the Dependent child would otherwise lose eligibility. You must submit the Physician’s written certification within 60 days of the request for such information by the Employer or by the Claims Administrator. Proof of continuing disability and dependency must be submitted by the Employee as requested by the Claims Administrator but not more frequently than 2 years after the initial certification and then annually thereafter.

The Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group Plan. See your Employer for further information.

If a Participant fails or refuses to provide Blue Shield access to documents and other information necessary to determine eligibility or to administer Benefits under the plan, he or she will immediately lose eligibility to continue enrollment.

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

**Effective Date of Coverage**

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

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

If you or your Dependent is a Late Enrollee, your coverage will become effective the earlier of 12 months from the date you made a written request for coverage or at the Employer’s next Open Enrollment Period. The Claims Administrator will not consider applications for earlier effective dates.

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

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

1. For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment;
2. For birth, the effective date will be the date of birth;
3. For a child placed for adoption, the effective date will be the date the Participant, spouse, or Domestic Partner has the right to control the child’s health care.

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

Any individual who becomes eligible at a time other than during the annual Open Enrollment Period (e.g., newborn, child placed for adoption, child acquired by legal guardianship, new spouse or Domestic Partner, newly hired or newly transferred Employees) must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for a child placed for adoption will become effective on the date the Participant, spouse or Domestic Partner has the right to control the child’s health care, following submission of evidence of such control (a health facility minor release report, a medical authorization form or a relinquishment form). In order to have coverage continue beyond the first 31 days without lapse, a written application must be submitted to and received by the Claims Administrator within 31 days. An application may also be submitted electronically, if available. A Dependent spouse becomes eligible on the date of marriage. A Domestic Partner becomes eligible on the date a domestic partnership is established as set forth in the Definitions section of this booklet. A child acquired by legal guardianship will be eligible on the date of the court ordered guardianship.

If a court has ordered that you provide coverage for your spouse, Domestic Partner or Dependent child under your health benefit Plan, their coverage will become effective
within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party.

If you or your Dependents voluntarily discontinued coverage under this Plan and later request reinstatement, you or your Dependents will be covered the earlier of 12 months from the date of request for reinstatement or at the Employer’s next Open Enrollment Period.

If this Plan provides Benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your Employer;

1. you and all your Dependents who were validly covered under the previous group health plan on the date of discontinuance, will be eligible under this Plan except that,

2. if you or your Dependents were enrolled in the previous group health plan for less than 6 months and were Totally Disabled on the date of discontinuance of the previous group health plan and were entitled to an extension of benefits, you or your Dependents will not be entitled to any benefits under this Plan for services or expenses directly related to any condition which caused such Total Disability for a period not to exceed 6 months.

**RENEWAL OF PLAN**

The Claims Administrator will offer to renew the Plan except in the following instances:

1. non-payment of fees (see “Termination of Benefits”);
2. fraud, or intentional misrepresentation of a material fact;
3. failure to comply with the Claims Administrator's applicable eligibility, participation or contribution rules;
4. termination of plan type by the Claims Administrator;
5. association membership ceases.

All groups will renew subject to the above.

**SERVICES FOR EMERGENCY CARE**

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

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

Note: To ensure services are covered, covered non-Emergency Services or emergency room follow-up Services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician’s office.

**UTILIZATION REVIEW**

Applicable law requires that health plans disclose to Participants and health plan providers the process used to authorize or deny health care Services under the Plan. The document describing Blue Shield’s Utilization Management Program is available online at www.blueshieldca.com or Participants may call the Customer Service Department at the number provided on the back page of this Benefit Booklet to request a copy.

**SECOND MEDICAL OPINION POLICY**

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

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

State law requires that health plans disclose to Participants, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call Customer Service Department at the number provided on the back page of this booklet.

**HEALTH EDUCATION AND HEALTH PROMOTION SERVICES**

Health education and health promotion Services provided by the Claims Administrator’s Center for Health and Wellness offer a variety of wellness resources including, but not limited to: a Participant newsletter and a prenatal health education program.

**RETAIL-BASED HEALTH CLINICS**

Retail-based health clinics are Outpatient facilities, usually attached or adjacent to retail stores, pharmacies, etc., which provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners under the direction of a Physician and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Online Physician Directory located at http://provider.bcbcs.com. See the Preferred Providers section for information on the advantages of choosing a Preferred Provider.

**NURSEHELP 24/7 SM**

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

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

If your Physician’s office is closed, just call NurseHelp 24/7 at 1-877-304-0504. (If you are hearing impaired dial 711 for the relay service in California.) The telephone number is listed on your Participant identification card.

The NurseHelp 24/7 program provides Participants with no charge, confidential telephone support for information, consultations, and referrals for health issues. Participants may obtain these services by calling a 24-hour, toll-free telephone number. There is no charge for these services.

Participants may call a registered nurse toll free via 1-877-304-0504, 24 hours a day, to receive confidential support and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics.

THE CLAIMS ADMINISTRATOR ONLINE

The Claims Administrator’s Internet site is located at http://www.blueshieldca.com/deltadental. Participants with Internet access and a Web browser may view and download healthcare information.

BENEFITS MANAGEMENT PROGRAM

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

The Benefits Management Program includes prior authorization requirements for Inpatient admissions, selected Inpatient and Outpatient Services, office-administered injectable drugs, and home infusion-administered drugs, as well as emergency admission notification, and Inpatient utilization management. The program also includes Participant services such as, discharge planning, case management and palliative care Services.

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

PRIOR AUTHORIZATION

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

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

If prior authorization was not obtained, and services provided to the Participant are determined not to be a Benefit of the Plan, or were not Medically Necessary, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Participant or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed on an Outpatient, nonemergency basis:

1) CT (Computerized Tomography) scan
2) MRI (Magnetic Resonance Imaging)
3) MRA (Magnetic Resonance Angiography)
4) PET (Positron Emission Tomography) scan
5) Diagnostic cardiac procedures utilizing nuclear medicine

If prior authorization was not obtained and the radiological or nuclear imaging services provided to the Participant are determined not to be a Benefit of the Plan, or were not Medically Necessary, coverage will be denied.

Prior Authorization for Medical Services Included on the Prior Authorization List

The “Prior Authorization List” is a list of designated medical and surgical Services and Drugs that require prior authorization. Participants are encouraged to work with their providers to obtain prior authorization. Participants and providers may call Customer Service at the number provided on the back page of this Benefit Booklet to inquire about the need for prior authorization. Providers may also access the Prior Authorization List on the provider website.

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

For certain medical services and Drugs, Benefits are limited to Services rendered by a Participating Provider. If prior authorization was not obtained and the medical services or Drugs provided to the Participant are determined not to be a Benefit of the Plan, were not Medically Necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all nonemergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care and Special Transplant. The Participant or provider should call Customer Service at least five business days prior to the admission. For Special Transplant Services, failure to obtain prior authorization will result in a denial of coverage.

If prior authorization was not obtained for an inpatient Hospital admission and the services provided to the Participant are determined not to be a Benefit of the Plan, or were not Medically Necessary, coverage will be denied.

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

Prior Authorization for Mental Health or Substance Abuse Hospital Admissions and Non-Routine Outpatient Services

Prior authorization is required for all nonemergency mental health or substance abuse Hospital admissions including acute Inpatient care and Residential Care. The provider should call Customer Service at the telephone number listed on the back page of this Benefit Booklet at least five business days prior to the admission. Non-Routine Outpatient Mental Health and Substance Abuse Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the Claims Administrator.

If prior authorization was not obtained for an inpatient mental health or substance abuse Hospital admission or for any Non-Routine Outpatient Mental Health services and the services provided to the Participant are determined not to be a Benefit of the Plan, or were not Medically Necessary, coverage will be denied.

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

Emergency Admission Notification

When a Participant is admitted to the Hospital for Emergency Services, the Claims Administrator should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most Inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an Inpatient Hospital stay may be extended or reduced as warranted by the Participant’s condition. When a determination is made that the Participant no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Participant. If discharge does not occur within 24 hours of notification, the Participant is responsible for all Inpatient charges accrued beyond the 24 hour timeframe.

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

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

Discharge Planning

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

Case Management

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

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

Palliative Care Services

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

**Deductible**

For Zero Deductible Plans, there is no Calendar Year Deductible for covered Services received from Preferred Providers.

**Calendar Year Deductible (Medical Plan Deductible)**

The Calendar Year per Participant and per Family Deductible amounts are shown on the Summary of Benefits. After the Calendar Year Deductible is satisfied for those Services to which it applies, Benefits will be provided for covered Services. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductible. The Deductible must be satisfied once during each Calendar Year by or on behalf of each Participant separately, except that the Deductible shall be deemed satisfied with respect to the Participant and all of his covered Dependents collectively after the Family Deductible amount has been satisfied.

Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan.

**No Lifetime Benefit Maximum**

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

**No Annual Dollar Limits on Essential Benefits**

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

**Payment**

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

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

**Limited Out-of-Area Benefits**

Benefits will be provided for Covered Services received outside of Pennsylvania, but within the United States, Puerto Rico, and U.S. Virgin Islands for Emergency Services only. The Claims Administrator calculates the Participant’s Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. When Covered Services are received from a provider affiliated with a Blue Cross and/or Blue Shield plan, the Participant’s Copayment will be based on the local Blue Cross and/or Blue Shield plan’s arrangement with its providers. See the BlueCard Program section in this booklet.

If you do not see a provider affiliated with a Blue Cross and/or Blue Shield plan, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Claims Administrator for payment. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim. You will be responsible for paying the entire difference between the amount paid by the Claims Administrator and the amount billed.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.

**Care for Covered Urgent Care and Emergency Services Outside the United States**

Benefits will also be provided for covered urgent and emergency services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center either at the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, 7 days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call the Claims Administrator at the customer service number noted on the back of your identification card. For Inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

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

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

**BlueCard Program**

The Claims Administrator has relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred as the BlueCard Program. Whenever you obtain Covered Services from Preferred Providers, the claims for these services will be processed through the BlueCard® Program.
When you access Covered Services from Preferred Providers you are obtaining care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with a Blue Cross and/or Blue Shield Licensee (a “Host Plan”).

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

The BlueCard Program enables you to obtain Covered Services, as defined, from a healthcare provider participating with a Host Plan. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment and Deductible amounts, if any, as stated in this booklet.

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

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transactions noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

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

Claims for Covered Services are paid based on the Allowable Amount as defined in this booklet.

**Participant’s Maximum Calendar Year Out-of-Pocket Responsibility**

The per Participant and per Family maximum Out-of-Pocket responsibility each Calendar Year for covered Services is shown on the Summary of Benefits.

Once a Participant’s maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for that Participant’s covered Services for the remainder of that Calendar Year, except as described below. Once the Family maximum responsibility has been met*, the Plan will pay 100% of the Allowable Amount for the Participant’s and all covered Dependents’ covered Services for the remainder of that Calendar Year, except as described below.

Charges for Services which are not covered, charges above the Allowable Amount, charges in excess of the amount covered by the Plan, and reduced payments Incurred under the Benefits Management Program are the Participant’s responsibility and are not included in the maximum Calendar Year Out-of-Pocket responsibility.

*Note: Certain Services and amounts are not included in the calculation of the maximum Calendar Year Out-of-Pocket. These items are shown on the Summary of Benefits.

Charges for these items may cause a Participant’s payment responsibility to exceed the maximums.

Copayments and charges for Services not accruing to the Participant’s maximum Calendar Year Out-of-Pocket responsibility continue to be the Participant’s responsibility after the Calendar Year Out-of-Pocket maximum is reached.

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

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

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

Except as specifically provided herein, Services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.
ACUPUNCTURE BENEFITS
This benefit is not covered under this plan.

ALLERGY TESTING AND TREATMENT BENEFITS
Benefits are provided for allergy testing and treatment.

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

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

Outpatient routine newborn circumcisions are covered when performed in an ambulatory surgery center. For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures are covered when performed in an ambulatory surgery center because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant’s health is compromised and for whom general anesthesia is medically necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

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

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

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

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

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

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

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

CLINICAL TRIAL FOR TREATMENT OF CANCER OR LIFE THREATENING CONDITIONS BENEFITS
Benefits are provided for routine patient care for a Participant who have been accepted into an approved clinical trial for treatment of cancer or a life threatening condition when prior authorized by the Claims Administrator, and:

1. the clinical trial has a therapeutic intent and a Participating Provider determines that the Participant’s participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary; and

2. the Hospital and/or Physician conducting the clinical trial is a Participating Provider, unless the protocol for the trial is not available through a Participating Provider.

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

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

1. The investigational item, device, or service, itself;
2. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
3. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses;
4. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
5. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

6. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

7. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

1. Federally funded and approved by one or more of the following:
   a) one of the National Institutes of Health;
   b) the Centers for Disease Control and Prevention;
   c) the Agency for Health Care Research and Quality;
   d) the Centers for Medicare & Medicaid Services;
   e) a cooperative group or center of any of the entities in a to d, above; or the federal Departments of Defense or Veterans Administration;
   f) qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

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

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

**DIABETES CARE BENEFITS**

**Diabetes Equipment**

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

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

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug Benefit which is provided separately through your prescription drug carrier, Caremark.

**Diabetes Outpatient Self-Management Training**

Benefits are provided for diabetes Outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Participant to properly use the devices, equipment and supplies, and any additional Outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Participant’s Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Services will be covered when provided by Physicians, registered dieticians or registered nurses who are certified diabetes educators.

**DIALYSIS CENTERS BENEFITS**

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

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

**DURABLE MEDICAL EQUIPMENT BENEFITS**

Medically necessary Durable Medical Equipment for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Other covered items include peak flow monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by the Claims Administrator. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance.
Medically necessary Durable Medical Equipment for Activities of Daily Living, including repairs, is covered as described in this section, except as noted below:

1. No benefits are provided for rental charges in excess of the purchase cost;

2. Replacement of Durable Medical Equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item*

   *This does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (Note: For benefits for asthma inhalers and inhaler spacers, see the Outpatient Prescription Drug Benefit which is provided separately through your prescription drug carrier, Caremark.);

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

No benefits are provided for environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature. No benefits are provided for backup or alternate items.

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

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

**EMERGENCY ROOM BENEFITS**

Benefits are provided for Medically Necessary Services provided in the Emergency Room of a Hospital. For the lowest out-of-pocket expenses you should obtain Services that are not emergencies such as Emergency Room follow-up Services (e.g., suture removal, wound check, etc.) in a Participating Physician’s office.

Emergency Services are Services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Participant’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When a Participant is admitted to the Hospital for Emergency Services, the Claims Administrator should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition.

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

For Emergency Room Services directly resulting in an admission to a different Hospital, the Participant is responsible for the Emergency Room Participant Copayment plus the appropriate Admitting Hospital Services Participant Copayment as shown on the Summary of Benefits.

**FAMILY PLANNING BENEFITS**

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

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

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

1. Family planning counseling and consultation Services, including Physician office visits for diaphragm fitting or injectable contraceptives;

2. Intrauterine devices (IUDs), including insertion and/or removal;

3. Implantable contraceptives;

4. Injectable contraceptives when administered by a Physician;

5. Voluntary sterilization (tubal ligation and vasectomy) and abortion services;

6. Diaphragm fitting procedure.

**HOME HEALTH CARE BENEFITS**

Benefits are provided for home health care Services when the Services are Medically Necessary, ordered by the attending Physician, and included in a written treatment plan. Covered Services are subject to any applicable Deductibles and Copayments. Visits by home health care agency providers will be payable up to a combined per Person per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled Services are covered up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:
1. Registered nurse;
2. Licensed vocational nurse;
3. Physical therapist, occupational therapist, or speech therapist;
4. Certified home health aide in conjunction with the Services of 1., 2. or 3. above;
5. Medical social worker.

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

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

This Benefit does not include medications, drugs or injectables covered under the Home Infusion/Home Injectable Therapy Benefits or under the supplemental Benefit for Outpatient Prescription Drugs which are provided separately through your prescription drug carrier, Caremark.

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

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

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

**HOME INFUSION/HOME INJECTABLE THERAPY BENEFITS**

Benefits are provided for home infusion and intravenous (IV) injectable therapy, except for Services related to hemophilia which are described below. Services include home infusion agency skilled nursing visits, parenteral nutrition Services, enteral nutrition Services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory Services, and for Medically Necessary FDA approved injectable medications when prescribed by a Doctor of Medicine and provided by a home infusion agency.

This Benefit does not include medications, drugs, Insulin, Insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefits which are provided separately through your prescription drug carrier, Caremark, and Services related to hemophilia which are described below.

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

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

**Hemophilia home infusion products and Services**

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All Services must be prior authorized by the Claims Administrator (see the Benefits Management Program section for specific prior authorization requirements), and must be provided by a Preferred Hemophilia Infusion Provider. (Note: Most Participating Home Health Care and Home Infusion Agencies are not Preferred Hemophilia Infusion Providers.) To find a Preferred Hemophilia Infusion Provider, consult the Preferred Provider Directory. You may also verify this information by calling Customer Service at the telephone number shown on the last page of this booklet.

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

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

Included in this Benefit is the blood factor product for in-home infusion use by the Participant, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for Services in infusion suites managed by a Preferred Hemophilia Infusion Provider, and Medically Necessary Services to treat complications of hemophilia replacement therapy are not covered under this Benefit but may be covered under other medical benefits described elsewhere in this Principal Benefits and Coverages (Covered Services) section.

This Benefit does not include:
1. physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2. services from a hemophilia treatment center or any Non-Preferred Hemophilia Infusion Provider; or,
3. self-infusion training programs, other than nursing visits to assist in administration of the product.

*Services may be covered under the Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy), Outpatient Prescription Drug Benefits if selected as an optional Benefit through your prescription drug carrier, Caremark, or as described elsewhere in this Principal Benefits and Coverages (Covered Services) section.
HOSPICE PROGRAM BENEFITS

Benefits are provided for the following Services through a Participating Hospice Agency when an eligible Participant requests admission to and is formally admitted to an approved Hospice Program. The Participant must have a Terminal Illness as determined by their Physician’s certification and the admission must receive prior approval from the Claims Administrator. (Note: Participants with a Terminal Illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.) Covered Services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Participants can continue to receive covered Services that are not related to the palliation and management of the Terminal Illness from the appropriate provider.

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

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

Participants are allowed to change their Participating Hospice Agency only once during each Period of Care. Participants may receive hospice care for two 90-day periods followed by unlimited 60-day periods of care, depending on their diagnosis. The extension of care continues through another Period of Care if the Personal Physician recertifies that the Participant is Terminally ill.

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

DEFINITIONS

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

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

Home Health Aide Services - services providing for the personal care of the Terminally Ill Participant and the performance of related tasks in the Participant’s home in accordance with the Plan of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by appropriate state authorities.

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

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

1. Considers the Participant and the Participant’s family in addition to the Participant, as the unit of care.

2. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Participant and their family.

3. Requires the interdisciplinary team to develop an overall Plan of Care and to provide coordinated care which emphasizes supportive Services, including, but not limited to, home care, pain control, and short-term Inpatient Services. Short-term Inpatient Services are intended to ensure both continuity of care and appropriateness of services for those Participants who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

4. Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

5. Provides for Bereavement Services following the Participant’s death to assist the family to cope with social and emotional needs associated with the death.


7. Provides Services in the Participant’s home or primary place of residence to the extent appropriate based on the medical needs of the Participant.

8. Is provided through a Participating Hospice.

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

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

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

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

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

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

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

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

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

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

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

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital’s established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.

2. Use of operating room and specialized treatment rooms.

3. In conjunction with a covered delivery, routine nursery.
care for a newborn of the Participant, covered spouse or Domestic Partner.

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

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

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

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

5. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.

6. Rehabilitation when furnished by the Hospital and approved in advance by the Claims Administrator under its Benefits Management Program.

7. Drugs and oxygen.

8. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.

9. X-ray examination and laboratory tests.

10. Dialysis and radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.

11. Use of medical appliances and equipment.

12. Subacute Care.

13. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant’s health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

14. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Participant is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the Plan.

Outpatient Services for Treatment of Illness or Injury

1. Medically Necessary Services provided in the Outpatient Facility of a Hospital.

2. Outpatient care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which Inpatient admission was made.

3. Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.

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

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

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

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

5. Outpatient Services including general anesthesia and associated facility charges in connection with dental procedures when performed in the Outpatient Facility of a
Hospital because of an underlying medical condition or clinical status and the Participant is under the age of seven or developmentally disabled regardless of age or when the Participant’s health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

6. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth.

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

**MEDICAL TREATMENT OF THE TEETH, GUMS, JAW JOINTS OR JAW BONES BENEFITS**

Benefits are provided for Hospital and professional Services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

1. the treatment of tumors of the gums;
2. the treatment of damage to natural teeth caused solely by an Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Participant as determined by the Plan;
   Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This Benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.
3. Medically Necessary non-surgical treatment (e.g., splint and Physical Therapy) of Temporomandibular Joint Syndrome (TMJ);
4. surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
5. Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones);
6. orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct a skeletal deformity; or
7. dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate repair.

No benefits are provided for:

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

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

**MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS**

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

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

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

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

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

1. Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure; used in the treatment of severe mental health conditions.
2. Intensive Outpatient Program - an Outpatient mental health or substance abuse treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
3. Office-Based Opioid Treatment – outpatient opioid detoxification and/or maintenance therapy, including methadone maintenance treatment

4. Partial Hospitalization Program – an Outpatient treatment program that may be freestanding or Hospital-based and provides services at least five hours per day, four days per week. Participants may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

5. Psychological Testing - testing to diagnose a Mental Health Condition when referred by a Participating Provider.


**Inpatient Services**

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

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

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

**Orthotics Benefits**

Benefits are provided for orthotic appliances, including:

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

Benefits are provided for orthotic devices for maintaining normal Activities of Daily Living only. No benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet. No benefits are provided for backup or alternate items.

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

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

Benefits are provided for X-ray services, diagnostic testing, clinical pathology, and laboratory services when provided to diagnose illness or injury.

Benefits are provided for genetic testing for at-risk Participants according to Blue Shield medical policy and for prenatal genetic screening and diagnostic services as follows:

1) prenatal genetic screening to identify women who are at increased risk for carrying a fetus with a specific genetic disorder;
2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy.

See the section on Radiological and Nuclear Imaging Benefits for additional diagnostic procedures which require prior authorization by the Claims Administrator.

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

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

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. All Benefits must be prescribed and/or ordered by the appropriate health care professional.

**Podiatric Benefits**

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

**Pregnancy and Maternity Care Benefits**

Benefits are provided for maternity services, including the following:
1) prenatal care;
2) outpatient maternity services;
3) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);
4) inpatient hospital maternity care including labor, delivery and post-delivery care;
5) abortion services; and
6) outpatient routine newborn circumcisions performed within 18 months of birth.

See the Outpatient X-ray, Pathology and Laboratory Benefits section for information on prenatal genetic screening and diagnosis of genetic disorders of the fetus for high risk pregnancy.

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

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

PREVENTIVE HEALTH BENEFITS

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

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

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at www.blueshieldca.com/preventive or by calling Customer Service.

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

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

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

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

Covered lab and X-ray Services provided in conjunction with these Professional Services listed below, are described under the Outpatient X-ray, Pathology and Laboratory Benefits section.

Note: A Preferred Physician may offer extended hour and urgent care Services on a walk-in basis in a non-hospital setting such as the Physician’s office or an urgent care center. Services received from a Preferred Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found in the Preferred Provider Directory or the Online Physician Directory located at http://www.blueshieldca.com.

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

1. Visits to the office, beginning with the first visit;
2. Services of consultants, including those for second medical opinion consultations;
3. Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
4. Asthma self-management training and education to enable a Participant to properly use asthma-related medi-
cation and equipment such as inhalers, spacers, nebulizers and peak flow monitors.

5. Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room;

6. Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay;

7. Surgical procedures. When multiple surgical procedures are performed during the same operation, benefits for the secondary procedure(s) will be determined based on the Claims Administrator Medical Policy. No benefits are provided for secondary procedures which are incidental to, or an integral part of, the primary procedure;

8. Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women’s Health & Cancer Rights Act, Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

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

• Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;

• Surgery to reform or reshape skin or bone;

• Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;

• Hair transplantation; and

• Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

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

9. Chemotherapy for cancer, including catheterization, and associated drugs and supplies;

10. Extra time spent when a Physician is detained to treat a Participant in critical condition;

11. Necessary preoperative treatment;

12. Treatment of burns;

13. Outpatient routine newborn circumcisions.*

*For the purposes of this Benefit, routine newborn circumcisions are circumcisions performed within 18 months of birth;


PROSTHETIC APPLIANCES BENEFITS

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

1) Tracheoesophageal voice prosthesis (e.g. Blom-Singer device, artificial larynx or other prosthetic device) for speech following laryngectomy, artificial limbs and eyes;

2) Internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;

3) Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia following cataract surgery when no intraocular lens has been implanted. These contact lenses will not be covered under this plan if the Participant has coverage for contact lenses through a Claims Administrator vision plan;

4) Supplies necessary for the operation of prostheses;

5) Initial fitting and replacement after the expected life of the item; and

6) Repairs, except for loss or misuse.

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

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

RADIOLOGICAL AND NUCLEAR IMAGING BENEFITS

The following radiological and nuclear imaging procedures, when performed on an Outpatient, non-emergency basis, require prior authorization under the Benefits Management Program.

See the Benefits Management Program section for complete information.

1. CT (Computerized Tomography) scans;

2. MRIs (Magnetic Resonance Imaging);
3. MRAs (Magnetic Resonance Angiography);
4. PET (Positron Emission Tomography) scans; and
5. Cardiac diagnostic procedures utilizing nuclear medicine.

**Rehabilitation and Habilitation Benefits (Physical, Occupational and Respiratory Therapy)**

Benefits are provided for Outpatient Physical, Occupational, and/or Respiratory Therapy pursuant to a written treatment plan and when rendered in the provider’s office or Outpatient department of a Hospital.

Benefits for Speech Therapy are described in the section on Speech Therapy Benefits. The Claims Administrator reserves the right to periodically review the provider’s treatment plan and records for Medical Necessity. If the Claims Administrator determines that continued treatment is not Medically Necessary and not provided with the expectation that the patient has restorative potential pursuant to the treatment plan, the Claims Administrator will notify the Participant of this determination and benefits will not be provided for services rendered after the date of the written notification.

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

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

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

**Skilled Nursing Facility Benefits**

(Other than Hospice Program Benefits which are described elsewhere under Covered Services.)

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

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

**Speech Therapy Benefits**

Benefits are provided for Medically Necessary outpatient Speech Therapy services when ordered by a Physician and provided by a licensed speech therapist/pathologist, or other appropriately licensed or certified Health Care Provider pursuant to a written treatment plan to correct or improve (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development.

Continued Outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider’s treatment plan and records may be reviewed periodically for Medical Necessity. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist/pathologist, the Member will be notified of this determination and benefits will not be provided for services rendered after the date of the written notification.

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

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

**Transplant Benefits**

**Tissue and Kidney Transplants**

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

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

**Special Transplants**

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility located in Pennsylvania and contracted with a Host Plan to provide the procedure, (2) prior authorization is obtained, in writing, from the Host Plan’s Medical Director and (3) the recipient of the transplant is a Participant or Dependent. Benefits include services incident to obtaining the human transplant material from a living donor or an organ transplant bank.

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

The following procedures are eligible for coverage under this provision:

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

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

**General Exclusions and Limitations**

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

1. for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency and except as Medically Necessary;
2. for Rehabilitation Services, except as specifically provided in the Inpatient Services for Treatment of Illness or Injury, Home Health Care Benefits, Rehabilitation Benefits (Physical, Occupational, and Respiratory Therapy) and Hospice Program Benefits sections;
3. for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, Domiciliary Care, or Residential Care except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
4. performed in a Hospital by house officers, residents, interns and others in training;
5. performed by a Close Relative or by a person who ordinarily resides in the covered Participant's home;
6. for any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition;
7. for hearing aids, unless your Employer has purchased hearing aids coverage as an optional Benefit, in which case an accompanying supplement provides the Benefit description;
8. for or incident to Services by Non-Preferred Providers, except as may be provided for Medically Necessary Emergency Services;
9. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;
10. for any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
11. for routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, or insurance unless the examination is substituted for the Annual Health Appraisal Exam;
12. for or incident to acupuncture, except may be provided under Acupuncture Benefits;
13. for or incident to Speech Therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under Home Health Care Benefits, Speech Therapy Benefits and Hospice Program Benefits;
14. for drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA);
15. for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; or nutritional counseling except as specifically provided for under Diabetes Care Benefits;
16. for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
17. for or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications;
18. for callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports; or any type of massage procedure on the foot;
19. which are Experimental or Investigational in nature, except for Services for Participants who have been accepted into an approved clinical trial for cancer as provided under Clinical Trial for Cancer Benefits;
20. for testing for intelligence or learning disabilities, or behavioral problems or social skills training/therapy;
21. hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;
22. for dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under Medical Treatment of
23. for or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

24. incident to organ transplant, except as explicitly listed under Transplant Benefits;

25. for Cosmetic Surgery or any resulting complications, except that Benefits are provided for Medically Necessary Services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the Claims Administrator consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
   - Lower eyelid blepharoplasty;
   - Spider veins;
   - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures);
   - Hair removal by electrolysis or other means; and
   - Reimplantation of breast implants originally provided for cosmetic augmentation; and
   - Voice modification surgery.

26. for Reconstructive Surgery and procedures where there is another more appropriate covered surgical procedure, or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:
   - Surgery to excise, enlarge, reduce, or change the appearance of any part of the body.
   - Surgery to reform or reshape skin or bone.
   - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body.
   - Hair transplantation.

   - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

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

27. for patient convenience items such as telephone, television, guest trays, and personal hygiene items;

28. for which the Participant is not legally obligated to pay, or for services for which no charge is made;

29. incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers’ compensation law, occupational disease law or similar legislation. However, if the Claims Administrator provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the Claims Administrator for the treatment of such injury or disease;

30. in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;

31. for prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, and PKU Related Formulas and Special Food Products Benefit and except as provided through a Participating Hospice Agency;

32. for home testing devices and monitoring equipment except as specifically provided under Durable Medical Equipment Benefits;

33. for genetic testing except as described under Outpatient X-ray, Pathology and Laboratory Benefits and Pregnancy and Maternity Care Benefits;

34. for non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

35. incident to bariatric surgery Services;

36. for any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not
eligible for covered Pregnancy Benefits under the
Claims Administrator health plan;

37. for services provided by an individual or entity that is not
appropriately licensed or certified by the state to provide
health care services, or is not operating within the scope
of such license or certification, except as specifically
stated herein;

38. massage therapy that is not Physical Therapy or a com-
ponent of a multimodality rehabilitation treatment plan;

39. for prescribed drugs and medicines for Outpatient care
except as provided through a Participating Hospice
Agency when the Participant is receiving Hospice Ser-
vices and except as may be provided through your pre-
scription drug carrier, Caremark or Home Infu-
sion/Home Injectable Therapy Benefits in the Covered
Services section;

40. for services received outside of Pennsylvania

41. not specifically listed as a Benefit.

MEDICAL NECESSITY EXCLUSION

The Benefits of this Plan are intended only for Services that
are Medically Necessary. Because a Physician or other
provider may prescribe, order, recommend, or approve a ser-
vices or supply does not, in itself, make it Medically Necess-
ary even though it is not specifically listed as an exclusion
or limitation. The Claims Administrator reserves the right to
review all claims to determine if any exclusions or other limitations ap-
ply. The Claims Administrator may use the services of
Doctor of Medicine consultants, peer review com-
mittees of professional societies or Hospitals and other con-
sultants to evaluate claims. The Claims Administrator may
limit or exclude benefits for services which are not necessary.

LIMITATIONS FOR DUPLICATE COVERAGE

When you are eligible for Medicare

1. Your Claims Administrator group plan will provide ben-
efits before Medicare in the following situations:

a. When the Employee or his/her spouse or Domestic
Partner are eligible for Medicare due to age, if the
Employee is actively working for a group that em-
loys 20 or more employees (as defined by Medi-
care Secondary Payer laws).

b. When the Participant is eligible for Medicare due to
disability, if the Employee is covered by a group that
employs 100 or more employees (as defined by
Medicare Secondary Payer laws).

c. When a Participant is eligible for Medicare solely
due to end-stage renal disease during the first 30
months that you are eligible to receive benefits for
end-stage renal disease from Medicare.

2. Your Claims Administrator group plan will provide ben-
efits after Medicare in the following situations:

a. When the Employee or his/her spouse or Domestic
Partner is eligible for Medicare due to age, if the
Employee is actively working for a group that em-
loys less than 20 employees (as defined by Medi-
care Secondary Payer laws).

b. When the Participant is eligible for Medicare due to
disability, if the Employee is covered by a group that
employs less than 100 employees (as defined by
Medicare Secondary Payer laws).

c. When the Participant is eligible for Medicare solely
due to end-stage renal disease after the first 30
months that you are eligible to receive benefits for
end-stage renal disease from Medicare.

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

When you are a qualified veteran

If you are a qualified veteran your Claims Administrator
group plan will pay the reasonable value or the Claims Ad-
ministrator’s Allowable Amount for covered Services pro-
vided to you at a Veterans Administration facility for a con-
dition that is not related to military service. If you are a quali-
fied veteran who is not on active duty, your Claims Admin-
istrator group plan will pay the reasonable value or the
Claims Administrator’s Allowable Amount for covered Ser-
vices provided to you at a Department of Defense facility,
even if provided for conditions related to military service.

When you are covered by another government agency

If you are also entitled to benefits under any other federal or
state governmental agency, or by any municipality, county or
other political subdivision, the combined benefits from that
coverage and your Claims Administrator group plan will
be equal, but not exceed, what the Claims Administrator would
have paid if you were not eligible to receive benefits under
that coverage (based on the reasonable value or the Claims
Administrator’s Allowable Amount).

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

EXCEPTION FOR OTHER COVERAGE

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

CLAIMS REVIEW

The Claims Administrator reserves the right to review all
claims to determine if any exclusions or other limitations ap-
ply. The Claims Administrator may use the services of
Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

**REDUCTIONS – THIRD PARTY LIABILITY**

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

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

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

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

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

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

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (“ERISA”); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If the Participant receives Services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from the Participant the difference between the amount paid by the Plan and the Hospital’s reasonable and necessary charges for such Services when payment or reimbursement is received by the Participant for medical expenses.

**COORDINATION OF BENEFITS**

Coordination of Benefits is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive payments.

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

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

If the covered Participant is also entitled to benefits under any of the conditions as outlined under the “Limitations for Duplicate Coverage” provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.
The following rules determine the order of benefit payments:

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

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

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent.

3. If the above rules do not apply, the plan which has covered the Participant for the longer period of time will determine its benefits first, provided that:
   a. a plan covering a Participant as a laid-off or retired Employee, or as a Dependent of that Participant will determine its benefits after any other plan covering that Participant as an Employee, other than a laid-off or retired Employee, or such Dependent; and
   b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then paragraph (a.) above will not apply.

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

If this Plan is the secondary carrier in the order of payments, and the Claims Administrator is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Participant (1) assigns to the Claims Administrator the right to receive benefits from the other plan to the extent of the difference between the benefits which the Claims Administrator actually pays and the amount that the Claims Administrator would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

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

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

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

**Termination of Benefits**

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive benefits for services provided following termination of this health Plan.

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

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

If your Employer is subject to the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), your payment of fees will keep your coverage in force for such period of time as specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of family leaves.

The Claims Administrator may terminate your and your Dependent’s coverage for cause immediately upon written notice to you and your Employer for the following:

1. Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or the Claims Administrator; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;

2. Permitting use of your Participant identification card by someone other than yourself or your Dependents to obtain Services; or

3. Obtaining or attempting to obtain Services under the Plan Document by means of false, materially misleading, or fraudulent information, acts or omissions.

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

EXTENSION OF BENEFITS

If a Participant becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Plan terminates, the Claims Administrator will extend the Benefits of this Plan, subject to all limitations and restrictions, for covered Services and supplies directly related to the condition, illness, or injury causing such Total Disability for the duration specified in such Act(s). Your Employer is solely responsible for notifying you of the availability and duration of such reasonable intervals as determined by the Claims Administrator.

GROUP CONTINUATION COVERAGE

CONTINUATION OF GROUP COVERAGE

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

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

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

Under COBRA, a Participant is entitled to benefits if at the time of the qualifying event such Participant is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to an Employee:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.

2. With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Participant or Domestic Partner during a COBRA continuation period may be immediately added as Dependents, provided the Employer is properly notified of the birth or placement for adoption, and such children are enrolled within 31 days of the birth or placement for adoption):
   a. the death of an Employee; or
   b. the termination of the Participant’s employment (other than by reason of such Participant’s gross misconduct); or
   c. the reduction of the Participant’s hours of employment to less than the number of hours required for eligibility; or
the divorce or legal separation of the Participant from the Dependent spouse or termination of the domestic partnership; or

e. the Participant’s entitlement to benefits under Title XVIII of the Social Security Act (“Medicare”); or

f. a Dependent child’s loss of Dependent status under this Plan.

3. With respect to a Participant who is covered as a retiree, that retiree’s Dependent spouse and Dependent children, the Employer’s filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA.

Notification of a Qualifying Event

The Employee is responsible for notifying the Employer of divorce, legal separation, or a child’s loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

The Employee is responsible for notifying its COBRA administrator (or Plan administrator if the Employer does not have a COBRA administrator) of the Participant’s death, termination, or reduction of hours of employment, the Participant’s Medicare entitlement or the Employer’s filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Participant by first class mail of the Participant’s right to continue group coverage under this Plan. The Participant must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Participant’s right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

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

Duration and Extension of Continuation of Group Coverage

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

Payment of Dues

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

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

Effective Date of the Continuation of Coverage

The continuation of coverage will begin on the date the Participant’s coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

Termination of Continuation of Group Coverage

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this group health plan (if the Employer continues to provide any group benefit plan for employees, the Participant may be able to continue coverage with another plan);

2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer or to the Claims Administrator as applicable. Coverage will end as of the end of the period for which dues were paid;

3. the Participant becomes covered under another group health plan;

4. the Participant becomes entitled to Medicare;

5. the Participant commits fraud or deception in the use of the Services of this Plan.

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

Continuation of Group Coverage for Participants on Military Leave

Continuation of group coverage is available for Participants on military leave if the Participant’s Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Employees who are planning to enter the Armed Forces should contact their Employer for information about their rights under the USERRA. Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence.

General Provisions

Liability of Participants in the Event of Non-Payment by the Claims Administrator

In accordance with the Claims Administrator’s established policies, and by statute, every contract between the Claims Administrator and its Participating Providers and Preferred Providers stipulates that the Participant shall not be responsi-
ble to the Participating Provider or Preferred Provider for compensation for any Services to the extent that they are provided in the Participant’s Plan. Participating Providers and Preferred Providers have agreed to accept the Plan’s payment as payment-in-full for covered Services, except for the Deductibles, Copayments, amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If Services are provided by a Non-Preferred Provider, the Participant is responsible for all amounts, except for Medically Necessary Services for Emergency Services.

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

INDEPENDENT CONTRACTORS

Providers are neither agents nor employees of the Plan or the Claims Administrator but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person receiving or providing Services, including any Physician, Hospital, or other provider or their employees.

NON-ASSIGNABILITY

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

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

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

PLAN INTERPRETATION

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

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

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

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

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

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

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

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

Email Address:
blueshieldca_privacy@blueshieldca.com

ACCESS TO INFORMATION

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

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

CUSTOMER SERVICE

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

The hearing impaired may contact the Customer Service Department through the Claims Administrator’s toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: The Claims Administrator has established a procedure for our Participants and Dependents to request an expedited decision. A Participant, Physician, or representative of a Participant may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Participant, or when the Participant is experiencing severe pain. The Claims Administrator shall make a decision and notify the Participant and Physician as soon as possible to accommodate the Participant’s condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other healthcare Services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department at the number provided on the last page of this booklet.

SETTLEMENT OF DISPUTES

INTERNAL APPEALS

Initial Internal Appeal

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

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

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

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

Final Internal Appeal

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

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

Expedited Appeal (Initial and Final)

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

EXTERNAL REVIEW

Standard External Review

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

**Expedited External Review**

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

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

**Other Resources to Help You**

For questions about your appeal rights, or for assistance, you
may contact the Employee Benefits Security Administration
at 1-866-444-EBSA (3272).

**DEFINITIONS**

**PLAN PROVIDER DEFINITIONS**

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

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

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

- **Health Care Provider** — An appropriately licensed or certi-
  fied independent practitioner including: licensed vocational
  nurse; registered nurse; nurse practitioner; physician assist-
  ant; psychiatric/mental health registered nurse; registered di-
  etician; certified nurse midwife; licensed midwife; occupa-
  tional therapist; acupuncturist; registered respiratory ther-
  apist; speech therapist or pathologist; physical therapist; phar-
  macist; naturopath; podiatrist; chiropractor; optometrist;
  nurse anesthetist (CRNA); clinical nurse specialist; optician;
  audiologist; hearing aid supplier; licensed clinical social
  worker; psychologist; marriage and family therapist; board
certified behavior analyst (BCBA), licensed professional
  clinical counselor (LPCC); massage therapist.

- **Hospice or Hospice Agency** — an entity which provides Hos-
  pice services to Terminally Ill persons and holds an appro-
  riate state license or certification.

- **Hospital**

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

  2. a psychiatric Hospital accredited by the Joint Commiss-
     on on Accreditation of Healthcare Organizations; or

  3. a psychiatric healthcare facility.

- **Non-Participating Home Health Care and Home Infusion
  Agency** — an agency which is not located in Pennsylvania
  or has not contracted with a Host Plan.

- **Non-Participating/Non-Preferred Providers** — any
  provider who is not located in Pennsylvania or is not con-
  tracted with a Host Plan to accept the Host Plan's payment,
  plus any applicable Deductible, Copayment or amounts in ex-
  cess of specified Benefit maximums, as payment-in-full for
  covered Services. Services of this Plan are not covered if the
  service is provided by a Non-Participating/Non-Preferred
  Provider.

- **Non-Preferred Hemophilia Infusion Provider** — a
  provider that is not located in Pennsylvania or has not con-
  tracted with a Host Plan to furnish blood factor replacement
  products and services for in-home treatment of blood disor-
  ders such as hemophilia and accept reimbursement at negoti-
  ated rates, and that has not been designated as a contracted
  hemophilia infusion product provider by a Host Plan. Note:
  Non-Preferred Hemophilia Infusion Providers may include
  Participating Home Health Care and Home Infusion Agency
  Providers if that provider does not also have an agreement
  with a Host Plan to furnish blood factor replacement products
  and services.

- **Other Providers**

  1. Independent Practitioners — licensed vocational nurses;
     licensed practical nurses; registered nurses; licensed psy-
     chiatric nurses; registered dieticians; certified nurse mid-
     wifes; licensed occupational therapists; licensed
     acupuncturists; certified respiratory therapists; enteros-
     tomal therapists; licensed speech therapists or patholo-
     gists; dental technicians; and lab technicians.

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

- **Outpatient Facility** — a licensed facility, not a Physician's of-
  fice or Hospital, that provides medical and/or surgical services
  on an Outpatient basis.
**Participating Ambulatory Surgery Center** — an Outpatient surgery facility which:

1. is either licensed by the state of Pennsylvania as an ambulatory surgery center or is a licensed facility accredited by an ambulatory surgery center accrediting body; and,

2. provides services as a free-standing ambulatory surgery center which is licensed separately and bills separately from a Hospital and is not otherwise affiliated with a Hospital; and,

3. is located in the state of Pennsylvania and has contracted with a Host Plan to provide Services on an Outpatient basis.

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

**Participating Hospice or Participating Hospice Agency** — an entity which: 1) provides Hospice services to Terminally Ill Participants and holds a license, currently in effect, as a Hospice under state law, or a home health agency licensed under state law which has Medicare certification and 2) is located in Pennsylvania and has contracted with a Host Plan.

**Participating Physician** — a selected Physician or a Physician Member that is located in Pennsylvania and has contracted with a Host Plan to provide Services on an Outpatient basis and accept reimbursement at negotiated rates, and which has been designated as a contracted Hospice Provider by the Host Plan.

**Participating Provider** — a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that is located in Pennsylvania and has contracted with a Host Plan to furnish Services and to accept a Host Plan's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

**Preferred Dialysis Center** — a dialysis services facility which is located in Pennsylvania and has contracted with a Host Plan to provide dialysis Services on an Outpatient basis and accept reimbursement at negotiated rates.

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

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

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

**Preferred Hospital** — a Hospital that is located in Pennsylvania, has contracted with a Host Plan to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Host Plan.

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

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

**ALL OTHER DEFINITIONS**

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

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

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

**Acute Care** — care rendered in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.
Allowable Amount – unless otherwise stated in this booklet, the lower of either the Claims Administrator’s Agreed Amount, or the Claims Administrator’s Reasonable Amount.

Benefits (Services) — those Services which a Participant is entitled to receive pursuant to the Benefit Booklet.

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

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

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

Claims Administrator’s Agreed Amount — the amount agreed upon by the Claims Administrator and the provider or, if there is no agreement, the provider’s billed charges.

Claims Administrator’s Reasonable Amount — the amount determined by the Claims Administrator to be the fair value of the Services. In its discretion, the Claims Administrator may determine fair value based upon a variety of data or methods that the Claims Administrator determines to be appropriate based on the type of Service and the particular circumstances. The Claims Administrator’s determination of fair value typically may include use of one or more of the following factors: (1) the amounts paid by the Claims Administrator to providers who have agreements with the Claims Administrator; (2) studies, surveys or third-party compilations of amounts charged by providers for the Services; or (3) amounts paid by governmental or private payors for the Services. In addition, if the Services were rendered outside of Pennsylvania, the Claims Administrator may determine fair value based upon the amounts paid by the local Blue Cross and/or Blue Shield plan for the Services. If the Claims Administrator has not made a determination of the fair value of the Services, then the Claims Administrator’s Reasonable Amount will be the provider’s billed charges.

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

Copayment — the amount that a Participant is required to pay for specific Covered Services after meeting any applicable Deductible.

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

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

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

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

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

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

Dependent1 —

1. an Employee’s legally married spouse who is:
   a. not covered for Benefits as an Employee; and
   b. not legally separated from the Employee; or,

2. an Employee’s Domestic Partner who is not covered for Benefits as a Participant; or,

3. a child of, adopted by, or in legal guardianship of the Employee, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Participant, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as a Participant who is less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court ordered non-temporary legal guardianship) and who has been enrolled and accepted by the Claims Administrator as a Dependent and has maintained participation in accordance with the Claims Administrator Plan.

1If required by the applicable jurisdiction, coverage will be provided for an unmarried Dependent child up to the age of 29.

Note: Children of Dependent children (i.e., grandchildren of the Participant, spouse, or Domestic Partner) are not Dependents unless the Participant, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:
   a. the child must be chiefly dependent upon the Em-
ployee, spouse, or Domestic Partner for support and maintenance;

b. the Employee, spouse, or Domestic Partner submits to the Claims Administrator a Physician's written certification of disability within 60 days from the date of the Employer's or the Claims Administrator's request; and
c. thereafter, certification of continuing disability and dependency from a Physician is submitted to the Claims Administrator on the following schedule:

(1) within 24 months after the month when the Dependent would otherwise have been terminated; and

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

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

1) Both partners are (a) 18 years of age or older and (b) of the same or different sex;

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

3) The partners are (a) not currently married, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

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

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

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

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

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

Employer — is Delta Dental of Pennsylvania and Delta Dental of New York. Delta Dental of Pennsylvania is also the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for benefits under the Plan.

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

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

Family — the Employee and all enrolled Dependents.

Habilitation Services — 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.

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

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

1. the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
2. for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3. for women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
1. The eligible Employee or Dependent meets all of the following requirements of (a.), (b.), (c.) and (d.):
   a. The Employee or Dependent was covered under another employer health benefit plan at the time he or she was offered enrollment under this Plan; and
   b. The Employee or Dependent certified, at the time of the initial enrollment, that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if he or she was covered under another employer health plan, he or she was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee; and
   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his or her employment or of the individual through whom he or she was covered as a Dependent, change in his or her employment status or of the individual through whom he or she was covered as a Dependent, termination of the other plan’s coverage, exhaustion of COBRA continuation coverage, cessation of an employer’s contribution toward his or her coverage, death of the individual through whom he or she was covered as a Dependent, or legal separation, divorce or termination of a domestic partnership; and
   d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or
2. The Employer offers multiple health benefit plans and the eligible Employee elects this Plan during an open enrollment period; or
3. A court has ordered that coverage be provided for a spouse or Domestic Partner or minor child under a covered Employee’s health benefit Plan. The health Plan shall enroll a Dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code; or
4. For eligible Employees or Dependents who fail to elect coverage in this Plan during their initial enrollment period, the Plan cannot produce a written statement from the Employer stating that prior to declining coverage, the Employee or Dependent, or the individual through whom he or she was eligible to be covered as a Dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage form specifying that failure to elect coverage during the initial enrollment period permits the Plan to impose, at the time of his or her later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or
5. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, establishment of domestic partnership, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, establishment of domestic partnership, birth, or placement for adoption.

Medical Necessity (Medically Necessary) —

The Benefits of this Plan are provided only for Services which are Medically Necessary.

1. Services which are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the Claims Administrator, are:
   a. consistent with the Claims Administrator medical policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, the Claims Administrator will provide benefits based on the most cost-effective service.
3. Hospital Inpatient Services which are Medically Necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician's office, the Outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services not Medically Necessary include hospitalization:
   a. for diagnostic studies that could have been provided on an Outpatient basis;
nesses and Serious Emotional Disturbances of a Child. of Mental Disorders” (DSM), including Severe Mental Ill-
titudes used to support, align, prevent or correct deformities, or
Dependents may transfer from another health benefit plan
by the Employer during which eligible employees and their

Mental Health Condition — mental disorders listed in the
most current edition of the “Diagnostic & Statistical Manual
of Mental Disorders” (DSM), including Severe Mental Ill-

Mental Health Services — Services provided to treat a Men-
tal Health Condition.

Non-Routine Outpatient Mental Health Services — Outpa-
tient Facility and professional services for the diagnosis and
treatment of Mental Health Conditions, including but not lim-
ited, to the following:
1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
5) Transcranial Magnetic Stimulation
6) Behavioral Health Treatment
7) Psychological Testing
These services may also be provided in the office, home, or
other non-institutional setting.

Occupational Therapy — treatment under the direction of a
Doctor of Medicine and provided by a certified occupational
therapist, or other appropriately licensed Health Care Provider, utilizing arts, crafts, or specific training in daily liv-
ing skills, to improve and maintain a patient’s ability to func-
tion.

Open Enrollment Period — that period of time established
by the Employer during which eligible employees and their
Dependents may transfer from another health benefit plan
sponsored by the employer to the EPO Plan.

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

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

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

Participant — either an Employee or Dependent.

Physical Therapy — treatment provided by a registered
physical therapist, certified occupational therapist or other
appropriately licensed Health Care Provider. Treatment uti-
lizes physical agents and therapeutic procedures, such as ul-
trasound, heat, range of motion testing, and massage, to im-
prove a patient’s musculoskeletal, neuromuscular and respi-
atory systems.

Plan — the EPO Benefit Plan for eligible Employees of the
Employer.

Plan Administrator — is Delta Dental of Pennsylvania.

Plan Document — the document issued by the Plan that es-
tablishes the services that Participants and Dependents are
entitled to receive from the Plan.

Plan Sponsor — is Delta Dental of Pennsylvania.

Preventive Health Services — mean those primary preven-
tive medical Covered Services, including related laboratory
services, for early detection of disease as specifically listed
below:
1. Evidence-based items or services that have in effect a
rating of “A” or “B” in the current recommendations of
the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation
from either the Advisory Committee on Immunization
Practices of the Centers for Disease Control and Prevent-
tion, or the most current version of the Recommended
Childhood Immunization Schedule/United States,
jointly adopted by the American Academy of Pediatrics,
the Advisory Committee on Immunization Practices, and
the American Academy of Family Physicians;
3. With respect to infants, children, and adolescents, evi-
dence-informed preventive care and screenings provided
for in the comprehensive guidelines supported by the
Health Resources and Services Administration;
4. With respect to women, such additional preventive care
and screenings not described in paragraph 1. as provided
for in comprehensive guidelines supported by the Health
Resources and Services Administration.

Preventive Health Services include, but are not limited to,
cancer screening (including, but not limited to, colorectal
cancer screening, cervical cancer and HPV screening, breast
cancer screening and prostate cancer screening), osteopo-
sis screening, screening for blood lead levels in children at
risk for lead poisoning, and health education. More informa-
tion regarding covered Preventive Health Services is avail-
able at http://www.blueshieldca.com/preventive or by calling
Customer Service.

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

Note: Diagnostic audiometry examinations are covered un-
der the Professional (Physician) Benefits.
Prosthesis (Prosthetics) — an artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible; dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

Rehabilitation — Inpatient or Outpatient care furnished primarily to restore an individual’s ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy and are provided with the expectation that the patient has restorative potential. Benefits for Speech Therapy are described in the section on Speech Therapy Benefits.

Residential Care — Mental Health Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Participants who do not require acute Inpatient care.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a certified respiratory therapist, or other appropriately licensed or certified Health Care Provider to preserve or improve a patient’s pulmonary function.

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

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

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

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

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

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

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

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

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

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

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

Speech Therapy — treatment, under the direction of a Physician and provided by a licensed speech pathologist, speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient’s vocal or swallowing skills which have been impaired by diagnosed illness or injury.

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

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

Total Disability (or Totally Disabled) —

1. in the case of a Participant otherwise eligible for coverage as an Employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity;

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

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

Participants may call Customer Service toll free:
1-855-256-9404

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

Benefits Management Program Telephone Numbers
For Prior Authorization: Please call the Customer Service telephone number indicated on
the back of the Participant’s identification card
For prior authorization of Benefits Management Program Radiological Services: 1-888-642-2583
Please refer to the Benefits Management Program section of
this booklet for information.