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Período de cobertura: del 1/1/2021 en adelante

Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental INF

Cobertura para: Persona + Familia | Tipo de plan: HMO

El Resumen de Beneficios y Cobertura (SBC, por sus siglas en inglés) lo ayudará a escoger un plan de salud. El SBC le muestra cómo usted y el plan compartirían el costo de los servicios de atención de la salud cubiertos. NOTA: Se entregará por separado información sobre el costo de este plan (llamado "prima"). Este documento es solo un resumen. Para obtener más información sobre su cobertura o conseguir una copia de los términos de cobertura completos, visite bsca.com/policies/M0023528_EOC.pdf o llame al **1-855-258-3744**. Para ver una definición general de las palabras usadas con frecuencia, como cantidad permitida, facturación del saldo, coseguro, copago, deducible, proveedor u otras palabras subrayadas, consulte el Glosario. Puede ver el Glosario en healthcare.gov/sbc-glossary o llamar al **1-866-444-3272** para pedir una copia.

Preguntas importantes	Respuestas	Conceptos importantes:
¿Cuál es el deducible general?	**$0.**	Vea el cuadro de situaciones médicas comunes que está a continuación para conocer los costos de los servicios que cubre este plan.
¿Hay servicios que están cubiertos antes de que alcance su deducible?	Sí. La atención preventiva y los servicios que están incluidos en los términos de cobertura completos.	Este plan cubre algunos productos y servicios aunque todavía no haya alcanzado la cantidad del deducible. Sin embargo, es posible que tenga que pagar un copago o coseguro. Por ejemplo, este plan cubre ciertos servicios preventivos sin costo compartido y antes de que alcance su deducible. Vea la lista de servicios preventivos cubiertos en healthcare.gov/coverage/preventive-care-benefits.
¿Hay otros deducibles para servicios específicos?	No.	No tiene que alcanzar deducibles para servicios específicos.
¿Cuál es el límite de gastos de bolsillo para este plan?	**$4,500** por persona/**$9,000** por familia para proveedores participantes.	El límite de gastos de bolsillo es la cantidad máxima que podría pagar en un año por los servicios cubiertos. Si tiene otros familiares incluidos en este plan, tienen que alcanzar sus propios límites de gastos de bolsillo hasta que se haya alcanzado el límite de gastos de bolsillo familiar total.
¿Qué no se incluye en el límite de gastos de bolsillo?	Los copagos para ciertos servicios, las primas y la atención de la salud que no cubra este plan.	Aunque usted pague estos gastos, no cuentan para el límite de gastos de bolsillo.
¿Pagará menos si usa un proveedor de la red?	Sí. Para ver una lista de proveedores de la red, visite blueshieldca.com/fad o llame al **1-855-258-3744**.	Este plan usa una red de proveedores. Pagará menos si usa un proveedor de la red del plan. Sin embargo, pagará la cantidad máxima si usa un proveedor fuera de la red; además, un proveedor podría enviarle una factura por la diferencia entre lo que cobra el proveedor y lo que paga su plan (facturación del saldo). Tenga en cuenta que su proveedor de la red podría usar un proveedor fuera de la red para algunos servicios (como los análisis de laboratorio). Pregúntele a su proveedor antes de recibir los servicios.
¿Necesita una referencia para ver a un especialista?	Sí.	Este plan pagará una parte o la totalidad de los costos de los servicios cubiertos en la consulta con un especialista, pero solo si usted tiene una referencia antes de la consulta con el especialista.

Todos los costos de **copago** y **coseguro** que están en este cuadro son después de que haya alcanzado su **deducible** (si es que hay un **deducible)**.

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si visita el consultorio o la clínica de un proveedor de atención de la salud	Visita de atención primaria para tratar una lesión o enfermedad	$20/visita	Sin cobertura	----------Ninguna----------
	Visita a un especialista	*Especialista de Trio+ Specialist*: $30/visita *Otro especialista*: $30/visita	Sin cobertura	La autorreferencia está disponible para las visitas a especialistas de Trio+ Specialist.
	Atención preventiva/pruebas de detección/inmunizaciones	Sin cargo	Sin cobertura	Es posible que tenga que pagar por los servicios que no sean preventivos. Pregúntele a su proveedor si los servicios que necesita son preventivos. Después averigüe qué pagará su plan.
Si se hace una prueba	Prueba de diagnóstico (radiografías, análisis de sangre)	*Análisis de laboratorio y patología*: $20/visita *Radiografías y diagnóstico por imágenes:* $30/visita *Otros exámenes de diagnóstico:* $30/visita	*Análisis de laboratorio y patología*: Sin cobertura *Radiografías y diagnóstico por imágenes:* Sin cobertura *Otros exámenes de diagnóstico:* Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. Los servicios mencionados se brindan en un centro independiente.
	Diagnóstico por imágenes (tomografía computarizada, tomografía por emisión de positrones e imágenes por resonancia magnética)	*Centro de radiología para pacientes ambulatorios*: $100/visita *Hospital para pacientes ambulatorios*: $100/visita	*Centro de radiología para pacientes ambulatorios*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en** bsca.com/policies/M0023528_EOC.pdf**.**

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si necesita medicamentos para tratar su enfermedad o problema de salud Hay más información disponible sobre la cobertura de medicamentos recetados en blueshieldca.com/formulary	Nivel 1	*Al por menor*: Nivel A: $5/receta Nivel B: $7/receta *Servicio por correo*: $10/receta	*Al por menor*: Sin cobertura *Servicio por correo*: Sin cobertura	Se necesita autorización previa para ciertos medicamentos. Si no consigue una autorización previa, es posible que no se paguen los beneficios. *Al por menor*: Cubre un suministro de hasta 30 días. *Servicio por correo:* Cubre un suministro de hasta 90 días.
	Nivel 2	*Al por menor*: Nivel A: $20/receta Nivel B: $35/receta *Servicio por correo*: $40/receta	*Al por menor*: Sin cobertura *Servicio por correo*: Sin cobertura	
	Nivel 3	*Al por menor*: Nivel A: $30/receta Nivel B: $50/receta *Servicio por correo*: $60/receta	*Al por menor*: Sin cobertura *Servicio por correo*: Sin cobertura	
	Nivel 4	*Farmacias especializadas de la red y al por menor*: 10% de coseguro hasta un máximo de $250/receta *Servicio por correo:* 10% de coseguro hasta un máximo de $500/receta	*Al por menor*: Sin cobertura *Servicio por correo*: Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. *Farmacias especializadas de la red y al por menor*: Cubre un suministro de hasta 30 días. Los medicamentos especializados deben comprarse en una farmacia especializada de la red. *Servicio por correo*: Cubre un suministro de hasta 90 días.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en bsca.com/policies/M0023528_EOC.pdf.**

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si le tienen que hacer una cirugía ambulatoria	Tarifa del centro de atención (p. ej., centro quirúrgico ambulatorio)	*Centro quirúrgico ambulatorio*: $100/cirugía *Hospital para pacientes ambulatorios*: $100/cirugía	*Centro quirúrgico ambulatorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	----------Ninguna----------
	Tarifas del médico/cirujano	$25/visita	Sin cobertura	
Si necesita atención médica inmediata	Atención en la sala de emergencias	*Tarifa del centro de atención*: $150/visita *Tarifa del médico*: Sin cargo	*Tarifa del centro de atención*: $150/visita *Tarifa del médico*: Sin cargo	----------Ninguna----------
	Transporte médico de emergencia	$150/transporte	$150/transporte	Este pago es para transporte autorizado o de emergencia.
	Atención urgente	$20/visita	*Dentro del área de servicio del plan*: Sin cobertura *Fuera del área de servicio del plan*: $20/visita	----------Ninguna----------

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en** bsca.com/policies/M0023528_EOC.pdf**.**

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
En caso de hospitalización	Tarifa del centro de atención (p. ej., la habitación del hospital)	$250/día hasta un máximo de 5 días/admisión	Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
	Tarifas del médico/cirujano	Sin cargo	Sin cobertura	----------Ninguna----------
Si necesita servicios de salud mental, conductual o por abuso de sustancias adictivas	Servicios para pacientes ambulatorios	*Visita al consultorio*: $20/visita *Otros servicios para pacientes ambulatorios*: $20/visita *Hospitalización parcial*: $20/visita *Pruebas psicológicas*: $20/visita	*Visita al consultorio*: Sin cobertura *Otros servicios para pacientes ambulatorios:* Sin cobertura *Hospitalización parcial*: Sin cobertura *Pruebas psicológicas*: Sin cobertura	Se necesita autorización previa, menos para las visitas al consultorio. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
	Servicios para pacientes internados	*Servicios para pacientes internados brindados por un médico*: Sin cargo *Servicios hospitalarios*: $250/día hasta un máximo de 5 días/admisión *Atención en una residencia:* $250/día hasta un máximo de 5 días/admisión	*Servicios para pacientes internados brindados por un médico:* Sin cobertura *Servicios hospitalarios:* Sin cobertura *Atención en una residencia*: Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en bsca.com/policies/M0023528_EOC.pdf.**

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si está embarazada	Visitas al consultorio	Sin cargo	Sin cobertura	----------Ninguna----------
	Servicios profesionales para el nacimiento/parto	Sin cargo	Sin cobertura	
	Servicios de un centro de atención para el nacimiento/parto	$250/día hasta un máximo de 5 días/admisión	Sin cobertura	
Si necesita ayuda para su recuperación u otros cuidados de salud especiales	Atención de la salud en el hogar	$20/visita	Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. Cobertura limitada a 100 visitas por miembro por año calendario.
	Servicios de rehabilitación	*Visita al consultorio*: $20/visita *Hospital para pacientes ambulatorios*: $20/visita	*Visita al consultorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	----------Ninguna----------
	Servicios de habilitación	*Visita al consultorio*: $20/visita *Hospital para pacientes ambulatorios*: $20/visita	*Visita al consultorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	

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Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
	Atención de enfermería especializada	*Centro de enfermería especializada independiente*: $150/día hasta un máximo de 5 días/admisión *Centro de enfermería especializada en un hospital*: $150/día hasta un máximo de 5 días/admisión	*Centro de enfermería especializada independiente*: Sin cobertura *Centro de enfermería especializada en un hospital*: Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. Cobertura limitada a 100 días por miembro por período de beneficios.
	Equipo médico duradero	10% de coseguro	Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
	Cuidados para pacientes terminales	Sin cargo	Sin cobertura	Se necesita autorización previa, menos para la consulta previa a los cuidados para pacientes terminales. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
Si su hijo/a necesita atención dental o de la vista	Examen de la vista para niños	Sin cargo	Sin cobertura	Cobertura limitada a un examen por miembro por año calendario.
	Anteojos para niños	Sin cargo	Sin cobertura	Cobertura limitada a un marco y a cristales para anteojos o a lentes de contacto en lugar de anteojos, hasta el beneficio por año calendario. El costo corresponde a lentes de visión simple.
	Chequeo dental para niños	Sin cargo	Sin cobertura	Cobertura de servicios de profilaxis (limpieza) limitada a una por cada período de seis meses.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en** bsca.com/policies/M0023528_EOC.pdf**.**

Servicios excluidos y otros servicios cubiertos:

Servicios que su plan generalmente NO cubre (Revise los documentos de su póliza o plan para tener más información y ver una lista de otros servicios excluidos).

- Atención quiropráctica
- Cirugía estética
- Atención dental (adultos)
- Audífonos
- Atención a largo plazo
- Atención que no sea de emergencia cuando viaja fuera de los Estados Unidos
- Servicio de enfermería privado
- Atención de la vista de rutina (adultos)
- Atención de los pies de rutina
- Programas para la pérdida de peso

Otros servicios cubiertos (Es posible que se apliquen limitaciones a estos servicios. Esta no es una lista completa. Lea el documento de su plan).

- Acupuntura
- Cirugía bariátrica
- Tratamiento para la esterilidad
- Servicios relacionados con el aborto

Sus derechos a seguir con su cobertura: Hay agencias que pueden ayudarlo si quiere seguir con su cobertura después de que termina. La información de contacto de esas agencias es la siguiente: el teléfono del Center for Consumer Information and Insurance Oversight (Centro de Información para el Consumidor y Control de Seguros) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) es 1-877-267-2323 ext. 61565 y la página web es cciio.cms.gov. Es posible que también haya otras opciones de cobertura disponibles para usted, incluso la posibilidad de comprar cobertura de seguro individual por medio del mercado de seguros de salud. Para tener más información sobre el mercado, visite HealthCare.gov o llame al 1-800-318-2596.

Sus derechos a reclamos y apelaciones: Sus derechos a reclamos y apelaciones: Esta queja se llama "reclamo" o "apelación". Para tener más información sobre sus derechos, lea la explicación de beneficios que recibirá por esa reclamación médica. Los documentos de su plan también tienen información completa sobre cómo presentar ante su plan una reclamación, una apelación o un reclamo por cualquier razón. Si quiere recibir más información sobre sus derechos o esta notificación, o si necesita ayuda, llame a Servicio al Cliente de Blue Shield al 1-855-258-3744 o a la Employee Benefits Security Administration (Administración para la Seguridad de los Beneficios del Empleado) del Department of Labor (Departamento de Trabajo) al **1-866-444-EBSA (3272)**, o visite dol.gov/ebsa/healthreform. También puede comunicarse con el Centro de Ayuda del Department of Managed Health Care (DMHC, Departamento de Atención de la Salud Administrada) de California al 1-888-466-2219 o escribir a la dirección de correo electrónico helpline@dmhc.ca.gov, o bien visitar http://www.healthhelp.ca.gov.

¿Brinda este plan una cobertura esencial mínima? Sí.
La cobertura esencial mínima suele incluir planes, seguro de salud disponible por medio del mercado u otras pólizas del mercado individual, Medicare, Medicaid, CHIP, TRICARE y alguna otra cobertura. Si es elegible para ciertos tipos de cobertura esencial mínima, es posible que no sea elegible para el crédito de impuestos para primas.

¿Cumple este plan con el estándar de valor mínimo? Sí.
Si su plan no cumple con los estándares de valor mínimo, es posible que sea elegible para recibir crédito de impuestos para primas para ayudarlo a pagar un plan por medio del mercado.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en bsca.com/policies/M0023528_EOC.pdf.**

Servicios de acceso a idiomas:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل باتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

Para ver cómo este plan podría cubrir costos usando una situación médica de ejemplo, consulte la siguiente sección.

Declaración de divulgación de la PRA

De acuerdo con la Paperwork Reduction Act (PRA, Ley para la Reducción del Papeleo) de 1995, ninguna persona está obligada a responder a un pedido de recopilación de información, a menos que haya un número de control de la Office of Management and Budget (OMB, Oficina de Administración y Presupuesto) válido. El número de control de la OMB válido para esta recopilación de información es **0938-1146**. Se calcula que el tiempo promedio necesario para completar esta recopilación de información es de **0.08** horas por respuesta, incluido el tiempo para leer las instrucciones, buscar las fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la información recopilada. Si tiene algún comentario sobre la exactitud del tiempo calculado o alguna sugerencia para mejorar este formulario, escríbanos a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en bsca.com/policies/M0023528_EOC.pdf.**

Sobre estos ejemplos de cobertura:

Estos ejemplos no son estimadores de costos. Los tratamientos son solo ejemplos de cómo este plan cubriría la atención médica. Los costos que tenga que pagar serán diferentes según la atención real que reciba, los precios que cobren sus proveedores y muchos otros factores. Preste atención a los costos compartidos (deducibles, copagos y coseguro) y a los servicios excluidos del plan. Use esta información para comparar los costos que pagaría según los distintos planes de salud. Recuerde que estos ejemplos de cobertura son solo para cobertura individual.

Embarazo de Peg
(9 meses de atención prenatal participante y parto en un hospital)

- **Deducible general del plan** **$0**
- **Copago de especialista** **$30**
- **Copago de hospital (centro)** **$250**
- **Otro copago** **$20**

Este EJEMPLO incluye servicios como:
Visitas al consultorio de especialistas (*atención prenatal)*
Servicios profesionales para el nacimiento/parto
Servicios de un centro de atención para el nacimiento/parto
Pruebas de diagnóstico (*ecografías y análisis de sangre*)
Visita a un especialista *(anestesia)*

Costo total del ejemplo	**$12,700**

En este ejemplo, Peg pagaría:

Costo compartido	
Deducibles	$0
Copagos	$900
Coseguro	$0
Lo que no está cubierto	
Límites o exclusiones	$70
Total que pagaría Peg	**$970**

Control de la diabetes tipo 2 de Joe
(un año de atención de rutina participante para un problema de salud controlado)

- **Deducible general del plan** **$0**
- **Copago de especialista** **$30**
- **Copago de hospital (centro)** **$250**
- **Otro copago** **$20**

Este EJEMPLO incluye servicios como:
Visitas al consultorio del médico de atención primaria (*incluso educación sobre la enfermedad)*
Pruebas de diagnóstico *(análisis de sangre)*
Medicamentos recetados
Equipo médico duradero *(medidor de glucosa)*

Costo total del ejemplo	**$5,600**

En este ejemplo, Joe pagaría:

Costo compartido	
Deducibles	$0
Copagos	$300
Coseguro	$80
Lo que no está cubierto	
Límites o exclusiones	$3,500
Total que pagaría Joe	**$3,880**

Fractura simple de Mía
(visita a la sala de emergencias y atención de seguimiento participantes)

- **Deducible general del plan** **$0**
- **Copago de especialista** **$30**
- **Copago de hospital (centro)** **$250**
- **Otro copago** **$30**

Este EJEMPLO incluye servicios como:
Atención en la sala de emergencias *(incluso suministros médicos)*
Pruebas de diagnóstico (*radiografías*)
Equipo médico duradero (*muletas*)
Servicios de rehabilitación (*fisioterapia*)

Costo total del ejemplo	**$2,800**

En este ejemplo, Mía pagaría:

Costo compartido	
Deducibles	$0
Copagos	$500
Coseguro	$10
Lo que no está cubierto	
Límites o exclusiones	$10
Total que pagaría Mía	**$520**

El **plan** sería responsable de los otros costos relacionados con los servicios cubiertos de este EJEMPLO.

Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental

Evidence of Coverage

Group

blue of california

COVERED CALIFORNIA | FOR SMALL BUSINESS

Blue Shield of California

Evidence of Coverage

Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

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

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

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

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

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

For questions about this plan, please contact Shield Concierge at the address or telephone number provided on the back page of this Evidence of Coverage.

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

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

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

Notice About Reproductive Health Services: Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You

should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at the Shield Concierge telephone number provided on the back page of this Evidence of Coverage to ensure that you can obtain the health care services that you need.

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

The Trio HMO plan offers a limited selection of IPAs and Medical Groups from which Members must choose, and a limited network of Hospitals. Except for Emergency Services, Urgent Services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member's Primary Care Physician.

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

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

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

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

Blue Shield of California

Member Bill of Rights

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

1) Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2) Receive information about all health services available to you, including a clear explanation of how to obtain them.
3) Receive information about your rights and responsibilities.
4) Receive information about your health plan, the services we offer you, the Physicians and other practitioners available to care for you.
5) Select a Primary Care Physician and expect their team of health workers to provide or arrange for all the care that you need.
6) Have reasonable access to appropriate medical services.
7) 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.
8) A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
9) 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) Receive preventive health services.
11) Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
12) 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 Primary Care Physician.
13) Communicate with and receive information from Shield Concierge in a language you can understand.
14) Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
15) Obtain a referral from your Primary Care Physician for a second opinion.
16) Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17) Voice complaints about the health plan or the care provided to you.
18) Participate in establishing Public Policy of the Blue Shield health plan, as outlined in your Evidence of Coverage or Group Health Service Agreement.
19) Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

Blue Shield of California

Member Responsibilities

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

1) Carefully read all Blue Shield health 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 Blue Shield membership as explained in the Evidence of Coverage.
2) Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3) Provide, to the extent possible, information that your Physician, and/or 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 care provider, whenever possible.
5) Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6) Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7) Make and keep medical appointments and inform the Plan Physician ahead of time when you must cancel.
8) Communicate openly with the Primary Care Physician you choose so you can develop a strong partnership based on trust and cooperation.
9) Offer suggestions to improve the Blue Shield health plan.
10) Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, Family status and other health plan coverage.
11) Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
12) Select a Primary Care Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection.
13) Treat all Plan personnel respectfully and courteously as partners in good health care.
14) Pay your Premiums, Copayments, Coinsurance and charges for non-Covered Services on time.
15) For Mental Health Services and Substance Use Disorder Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA).

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blue of california

COVERED CALIFORNIA

Group Plan
HMO Plan

Summary of Benefits

Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Trio ACO HMO Network**

This Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Pharmacy Network: **Rx Spectrum**

Drug Formulary: **Standard Formulary**

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$4,500
Family coverage	$4,500: individual
	$9,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Trio+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$30/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an outpatient facility	$25/visit	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$20/visit	
Acupuncture services	$20/visit	
Chiropractic services	Not covered	
Teladoc consultation	$0	
Family planning • Counseling, consulting, and education	$0	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$25/surgery	
Podiatric services	$30/visit	
Pregnancy and maternity care		
Physician office visits: prenatal and initial postnatal	$0	
Physician services for pregnancy termination	$25/surgery	
Emergency services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$150/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment: When using a Participating Provider[3]	Your payment: CYD[2] applies
Urgent care center services	$20/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$150/transport	
Outpatient facility services		
Ambulatory Surgery Center	$100/surgery	
Outpatient Department of a Hospital: surgery	$100/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	
Inpatient facility services		
Hospital services and stay	$250/day up to 5 days/admission	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	$250/day up to 5 days/admission	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$20/visit	
• Outpatient Department of a Hospital	$20/visit	
X-ray and imaging services *Includes diagnostic mammography.*		
• Outpatient radiology center	$30/visit	
• Outpatient Department of a Hospital	$30/visit	
Other outpatient diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$30/visit	
• Outpatient Department of a Hospital	$30/visit	
Radiological and nuclear imaging services		
• Outpatient radiology center	$100/visit	
• Outpatient Department of a Hospital	$100/visit	

Benefits[5]	Your payment When using a Participating Provider[3]	CYD[2] applies
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.*		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	10%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$20/visit	
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs and medical supplies.*	$0	
Home visits by an infusion nurse	$20/visit	
Hemophilia home infusion services *Includes blood factor products.*	$0	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*		
Freestanding SNF	$150/day up to 5 days/admission	
Hospital-based SNF	$150/day up to 5 days/admission	
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	10%	
• Self-management training	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Dialysis services	10%	
PKU product formulas and Special Food Products	$0	
Allergy serum billed separately from an office visit	10%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc behavioral health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$20/visit	
Partial Hospitalization Program	$20/visit	
Psychological Testing	$20/visit	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$250/day up to 5 days/admission	
Residential Care	$250/day up to 5 days/admission	

Prescription Drug Benefits[7,8]	Your payment		
	When using a Participating Pharmacy[3]		CYD[2] applies
	Level A	Level B	
Retail pharmacy prescription Drugs			
Per prescription, up to a 30-day supply.			
Contraceptive Drugs and devices	$0	$0	
Tier 1 Drugs	$5/prescription	$7/prescription	
Tier 2 Drugs	$20/prescription	$35/prescription	
Tier 3 Drugs	$30/prescription	$50/prescription	
Tier 4 Drugs	10% up to $250/prescription	10% up to $250/prescription	

Prescription Drug Benefits[7,8]	Your payment	
	When using a Participating Pharmacy[3]	**CYD[2] applies**
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$10/prescription	
Tier 2 Drugs	$40/prescription	
Tier 3 Drugs	$60/prescription	
Tier 4 Drugs	10% up to $500/prescription	
Oral Anticancer Drugs *Per prescription, up to a 30-day supply.*	Applicable Tier 1, Tier 2, Tier 3, or Tier 4 Copayment up to $250/prescription	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**
Pediatric dental[9]		
Diagnostic and preventive services		
• Oral exam	$0	
• Preventive – cleaning	$0	
• Preventive – x-ray	$0	
• Sealants per tooth	$0	
• Topical fluoride application	$0	
• Space maintainers - fixed	$0	
Basic services		
• Restorative procedures • Periodontal maintenance	See Dental Copay Schedule in Evidence of Coverage	
Major services		
• Oral surgery • Endodontics • Periodontics (other than maintenance) • Crowns and casts • Prosthodontics	See Dental Copay Schedule in Evidence of Coverage	
Orthodontics (Medically Necessary)	$1,000	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**
Pediatric vision[10]		
Comprehensive eye examination *One exam per Calendar Year.*		
• Ophthalmologic visit	$0	
• Optometric visit	$0	
Eyewear/materials *One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.*		
• Contact lenses		
Non-elective (Medically Necessary) - hard or soft	$0	
Up to two pairs per eye per Calendar Year.		
Elective (cosmetic/convenience)		
Standard and non-standard, hard	$0	
Up to a 3 month supply for each eye per Calendar Year based on lenses selected.		
Standard and non-standard, soft	$0	
Up to a 6 month supply for each eye per Calendar Year based on lenses selected.		
• Eyeglass frames		
Collection frames	$0	
Non-collection frames	All charges above $150	
• Eyeglass lenses		
Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.		
Single vision	$0	
Lined bifocal	$0	
Lined trifocal	$0	
Lenticular	$0	
Optional eyeglass lenses and treatments		
• Ultraviolet protective coating (standard only)	$0	
• Polycarbonate lenses	$0	
• Standard progressive lenses	$0	
• Premium progressive lenses	$95	
• Anti-reflective lens coating (standard only)	$35	
• Photochromic - glass lenses	$25	
• Photochromic - plastic lenses	$0	
• High index lenses	$30	
• Polarized lenses	$45	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**
Low vision testing and equipment • Comprehensive low vision exam *Once every 5 Calendar Years.* • Low vision devices *One aid per Calendar Year.*	$0 $0	
Diabetes management referral	$0	

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

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

3 Using Participating Providers:

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

Participating Pharmacies. Blue Shield has two participation levels for retail pharmacies; Level A and Level B. You can go to any Level A or Level B pharmacy to obtain covered Drugs.

Teladoc. Teladoc mental health and substance use disorder (behavioral health) consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered, charges above the Allowed Charges, and charges for services above any Benefit maximum.

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

Notes

Calendar Year. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM.

5 Separate Member Payments When Multiple Covered Services are Received:

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

6 Preventive Health Services:

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

7 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

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

8 Outpatient Prescription Drug Coverage:

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

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

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

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

9 Pediatric Dental Coverage:

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

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

10 Pediatric Vision Coverage:

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

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

Notes

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

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

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

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

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

Introduction to the Blue Shield of California Health Plan

Trio HMO Plans offer a limited selection of IPAs and medical groups from which Members must choose, and a limited network of Hospitals. The IPAs and medical groups in Trio HMO participate in accountable care organization collaborations with Blue Shield.

It is important for Members to review the list of providers within the Trio HMO Physician and Hospital Directory before enrolling in this Plan. In many areas, there may only be one (1) IPA or Medical Group from which to select a Primary Care Physician or to receive Covered Services.

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

Please read this Evidence of Coverage and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about the role of the Primary Care Physician in the coordination and authorization of Covered Services and Member responsibilities such as payment of Copayments, Coinsurance and Deductibles.

Capitalized terms in this Evidence of Coverage have a special meaning. Please see the *Definitions* section for a clear understanding of these terms. Members may contact Shield Concierge with questions about their Benefits. Contact information can be found on the back page of this Evidence of Coverage.

This health Plan is offered through Covered California for Small Business (CCSB). For more information about Covered California for Small Business, please visit www.coveredca.com or call 1-888-975-1142.

How to Use This Health Plan

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

Selecting a Primary Care Physician

Each Member must select a general practitioner, family practitioner, internist, obstetrician/gynecologist, or pediatrician as their Primary Care Physician at the time of enrollment. Individual Family members must also designate a Primary Care Physician, but each may select a different provider as their Primary Care Physician. A list of Blue Shield Trio HMO Providers is available online at www.blueshieldca.com. Members may also call Shield Concierge at the telephone number provided on the back page of this Evidence of Coverage for assistance in selecting a Primary Care Physician.

The Member's Primary Care Physician must be located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If the Member does not select a Primary Care Physician at the time of enrollment, Blue Shield will designate a Primary Care Physician and the Member will be notified. This designation will remain in effect until the Member requests a change.

A Primary Care Physician must also be selected for a newborn or child placed for adoption within 31 days from the date of birth or placement for adoption. The selection may be made prior to the birth or placement for adoption and a pediatrician may be selected as the Primary Care Physician. For the month of birth, the Primary Care Physician must be in the same Medical Group or Independent Practice Association (IPA) as the mother's Primary Care Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Primary Care Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If a Primary Care Physician is not selected for the child, Blue Shield will designate a Primary Care Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred.

To change the Primary Care Physician for the child after the first month, see the section below on *Changing Primary Care Physicians or Designated Medical Group or IPA*.

The child must be enrolled with Blue Shield to continue coverage beyond the first 31 days from the date of birth or placement for adoption. See the *Eligibility and Enrollment* section for additional information.

Primary Care Physician Relationship

The Physician-patient relationship is an important element of an HMO Plan. The Member's Primary Care Physician will make every effort to ensure that all Medically Necessary and appropriate professional services are provided in a manner compatible with the Member's wishes. If the Member and Primary Care Physician fail to establish a satisfactory relationship or disagree on a recommended course of treatment, the Member may contact Shield Concierge at the number provided on the back page of this Evidence of Coverage for assistance in selecting a new Primary Care Physician.

If a Member is not able to establish a satisfactory relationship with his or her Primary Care Physician, Blue Shield will provide access to other available Primary Care Physicians.

Role of the Primary Care Physician

The Primary Care Physician chosen by the Member at the time of enrollment will coordinate all Covered Services including primary care, preventive services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological Physician services, Trio+ Specialist, and Mental Health, Behavioral Health, and Substance Use Disorder Services), Hospice admission through a Participating Hospice Agency, Emergency Services, Urgent Services and Hospital admission. The Primary Care Physician will also manage prior authorization when needed.

Because Physicians and other Health Care Providers set aside time for scheduled appointments, the Member should notify the provider's office within 24 hours if unable to keep an appointment. Some offices may charge a fee (not to exceed the Member's Copayment or Coinsurance) unless the missed appointment was due to an emergency situation or 24-hour advance notice is provided.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for obstetrical and/or gynecological (OB/GYN) Covered Services by an obstetrician/gynecologist or family practice Physician who is not her designated Primary Care Physician without a referral from the Primary Care Physician or Medical Group/IPA. However, the obstetrician/gynecologist or family practice Physician must be in the same Medical Group/IPA as the Member's Primary Care Physician.

Obstetrical and gynecological services are defined as Physician services related to:

1) prenatal, perinatal and postnatal (pregnancy) care,
2) diagnose and treatment of disorders of the female reproductive system and genitalia,
3) treatment of disorders of the breast,
4) routine annual gynecological/well-woman examinations.

Obstetrical/Gynecological Physician services are separate from the Trio+ Specialist feature described later in this section.

Referral to Specialty Services

Although self-referral to Plan Specialists is available through the Trio+ Specialist feature, Blue Shield encourages Members to receive specialty services through a referral from their Primary Care Physician.

When the Primary Care Physician determines that specialty services, including laboratory and X-ray, are Medically Necessary, he or she will initiate a referral to a designated Plan Provider and request necessary authorizations. The Primary Care Physician will generally refer the Member to a Specialist or other Health Care Provider within the same Medical Group/IPA. The Specialist or other Health Care Provider will send a report to the Primary

Care Physician after the consultation so that the Member's medical record is complete.

In the event no Plan Provider is available to perform the needed services, the Primary Care Physician will refer the Member to a non-Plan Provider after obtaining authorization. Specialty services are subject to all benefit and eligibility provisions, exclusions and limitations described in this Evidence of Coverage.

See the *Mental Health, Behavioral Health, and Substance Use Disorder Services* section for information regarding Mental Health Services, Behavioral Health Treatment and Substance Use Disorder Services.

Role of the Medical Group or IPA

Most Blue Shield HMO Primary Care Physicians contract with a Medical Group or IPA to share administrative and authorization responsibilities (some Primary Care Physicians contract directly with Blue Shield). The Primary Care Physician coordinates the Member's care within the Member's Medical Group/IPA and directs referrals to Medical Group/IPA Specialists or Hospitals, unless care for the Member's health condition is unavailable within the Medical Group/IPA.

The Member's Medical Group/IPA ensures that a full panel of Specialists is available and assists the Primary Care Physician with utilization management of Plan Benefits. Medical Groups/IPAs also have admitting arrangements with Blue Shield's contracted Hospitals within their service area. The Medical Group/IPA also works with the Primary Care Physician to authorize Covered Services and ensure that Covered Services are performed by Plan Providers.

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

The Member's Primary Care Physician and Medical Group/IPA are listed on the Member's identification (ID) card.

Changing Primary Care Physicians or Designated Medical Group or IPA

The Trio HMO Plan offers a limited selection of IPAs and Medical Groups from which Members must choose. Members may change their Primary Care Physician to another Primary Care Physician within their selected Medical Group/IPA by calling Shield Concierge at the number provided on the back of this Evidence of Coverage, on the back of the ID Card, or by submitting a request through the Blue Shield member portal.

It is important for Members to review the list of providers within the Trio HMO Physician and Hospital Directory before enrolling in this Plan. In many areas, there may only be one (1) IPA or Medical Group from which to select a Primary Care Physician or to receive Covered Services.

In scenarios where there is only one (1) IPA or Medical Group, Members may not change their Trio HMO Medical Group/IPA except by enrolling in a different health plan, either at open enrollment or as the result of a qualifying event.

In some circumstances, however, more than one Medical Group/IPA serves a particular area. In such situations, Members may change their selected Medical Group/IPA to another Medical Group/IPA the same way they change their Primary Care Physician. If the selected Medical Group/IPA does not have an affiliation with the Member's Primary Care Physician, a change in Medical Group/IPA may also require the Member to select a new Primary Care Physician.

Changes in Medical Group/IPA or Primary Care Physician are effective the first day of the month following notice of approval by Blue Shield. Once the change of Primary Care Physician is effective, all care must be provided or arranged by the new Primary Care Physician, except for OB/GYN services and Trio+ Specialist visits as noted in earlier sections.

Once the Medical Group/IPA change is effective, authorizations for Covered Services provided by the former Medical Group/IPA are no longer valid. Care must be transitioned to specialists within the new Medical Group/IPA, and except for Trio+

Specialist visits, new authorizations must be obtained. Members may call Shield Concierge for assistance with Primary Care Physician or Medical Group/IPA changes.

Voluntary Medical Group/IPA changes are not permitted while the Member is confined to a Hospital or during the third trimester of pregnancy. The effective date of the new Medical Group/IPA will be the first of the month following discharge from the Hospital, or when pregnant, following the completion of postpartum care.

Additionally, changes in Primary Care Physician or Medical Group/IPA during an on-going course of treatment may interrupt care. For this reason, the effective date of a Primary Care Physician or Medical Group/IPA change, when requested during an on-going course of treatment, will be the first of the month following the date it is medically appropriate to transfer the Member's care to a new Primary Care Physician or Medical Group/IPA, as determined by Blue Shield.

Exceptions must be approved by a Blue Shield Medical Director. For information about approval for an exception to the above provisions, please contact Shield Concierge at the number provided on the back page of this Evidence of Coverage.

If a Member's Primary Care Physician terminates participation in the Plan, Blue Shield will notify the Member in writing and designate a new Primary Care Physician who is immediately available to provide the Member's medical care. Members may also make their own selection of a new Primary Care Physician within 15 days of this notification. The Member's selection must be approved by Blue Shield prior to receiving any Covered Services under the Plan.

Trio+ Specialist

The Member may arrange an office visit with a Trio+ Plan Specialist within their Primary Care Physician's Medical Group/IPA without a referral from the Primary Care Physician. The Member is responsible for the Copayment or Coinsurance listed in the Summary of Benefits for each Trio+ Specialist visit including the initial visit and follow up care not referred through the Member's Primary Care Physician.

See the *Mental Health, Behavioral Health, and Substance Use Disorder Services* section for information regarding Trio+ Specialist visits for Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services.

A Trio+ Specialist visit includes an office visit for an examination or other consultation including diagnosis and treatment provided by a Medical Group or IPA Plan Specialist without a Primary Care Physician referral

A Trio+ Specialist visit does not include:

1) Services which are not otherwise covered;
2) Services provided by a non-Trio+ Provider (such as Podiatry and Physical Therapy);
3) Allergy testing;
4) Endoscopic procedures
5) Diagnostic and nuclear imaging including CT, MRI, or bone density measurement;
6) Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics;
7) Infertility services;
8) Emergency Services;
9) Urgent Services;
10) Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services;
11) Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Primary Care Physician;
12) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Primary Care Physician.

Trio+ Satisfaction

Members may provide Blue Shield with feedback regarding the service received from Plan Physicians. If a Member is dissatisfied with the service provided during an office visit with a Plan Physician, the Member may contact Shield Concierge at the number provided on the back page of the Evidence of Coverage.

Mental Health, Behavioral Health, and Substance Use Disorder Services

Blue Shield contracts with a Mental Health Service Administrator (MHSA) to underwrite and deliver all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a unique network of MHSA Participating Providers. All non-emergency Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Hospital admissions and Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services, except for Trio+ Specialist visits, must be arranged through and authorized by the MHSA. Members are not required to coordinate Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through their Primary Care Physician.

All Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services must be provided by an MHSA Participating Provider, apart from the exceptions noted in the next paragraph. Information regarding MHSA Participating Providers is available online at www.blueshieldca.com. Members, or their Primary Care Physician, may also contact the MHSA directly for information and to select an MHSA Participating Provider by calling 1-877-263-9952. Your Primary Care Physician may also contact the MHSA to obtain information regarding the MHSA Participating Providers.

Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services received from an MHSA Non-Participating Provider will not be covered except as an Emergency or Urgent Service or when no MHSA Participating Provider is available to perform the needed services and the MHSA refers the Member to an MHSA Non-Participating Provider and authorizes the services. Mental Health and Substance Use Disorder Services received from a health professional who is an MHSA Non-Participating Provider at a facility that is an MHSA Participating Provider will also be covered. Except for these stated exceptions, all charges for Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services not rendered by an MHSA Participating Provider will be the Member's responsibility. For complete information regarding Benefits for Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, see the *Mental Health, Behavioral Health, and Substance Use Disorder Benefits* section.

Prior Authorization for Mental Health, Behavioral Health, and Substance Use Disorder Services

The MHSA Participating Provider must obtain prior authorization from the MHSA for all non-emergency Mental Health Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Other Outpatient Mental Health Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), electroconvulsive therapy, Psychological Testing, and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA.

The MHSA will render a decision on all requests for prior authorization of services as follows:

1) for Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
2) for other services, within five 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 Member within two business days of the decision.

If prior authorization is not obtained for a mental health inpatient admission or for any Other Outpatient Mental Health Services and the services provided to the member are determined not to be a Benefit of the plan, coverage will be denied.

Prior authorization is not required for an emergency admission.

Continuity of Care

Continuity of care with a non-Plan Provider is available for the following Members: for Members who are currently seeing a provider who is no longer in the Blue Shield network; for newly-covered Members whose previous health plan was withdrawn from the market; or for newly-covered Members whose coverage choices do not include out-of-network Benefits.

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

To request continuity of care with a non-Plan Provider, visit www.blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will review the request. The non-Plan Provider must agree to accept Blue Shield's Allowed Charges as payment in full for ongoing care. When authorized, the Member may continue to see the non-Plan Provider for up to 12 months. For a maternal mental health condition, the Member may continue to see the non-Plan Provider for 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later.

Second Medical Opinion

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

If the second opinion involves care provided by the Member's Primary Care Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA. If the second opinion involves care received from a Specialist, the second opinion may be provided by any Blue Shield Specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the Medical Group/IPA.

Urgent Services

The Blue Shield Trio HMO Health Plan provides coverage for you and your family for your Urgent Services needs when you or your family are temporarily traveling outside of your Primary Care Physician Service Area.

Urgent Services are defined as those Covered Services rendered outside of the Primary Care Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Primary Care Physician Service Area.

Out-of-Area Follow-up Care is defined as non-emergent Medically Necessary out-of-area services to evaluate the Member's progress after an initial Emergency or Urgent Service.

(Urgent Care) While in your Primary Care Physician Service Area

If you require urgent, same-day care for a condition that could reasonably be treated in your Primary Care Physician's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), you must first call your Primary Care Physician. However, you may go directly to an urgent care clinic when your assigned Medical Group/IPA has provided you with instructions for obtaining care from an urgent care clinic in your Primary Care Physician Service Area.

Outside of California

The Blue Shield Trio HMO Health Plan provides coverage for you and your family for your Urgent

Service needs when you or your family are temporarily traveling outside of California. Urgent Services may be obtained from any provider; however, using the BlueCard® or Blue Shield Global Core programs can be more cost-effective and may eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. See the *Inter-Plan Arrangements* section of this EOC for more information on the BlueCard® and Blue Shield Global Core programs.

Out-of-Area Follow-up Care is also covered and services may be received through the BlueCard® or Blue Shield Global Core programs. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

Within California

If you are temporarily traveling within California, but are outside of your Primary Care Physician Service Area, if possible you should call Shield Concierge at the number provided on the back page of this booklet for assistance in receiving Urgent Services through a Blue Shield of California provider. You may also locate a provider by visiting our web site at www.blueshieldca.com. However, you are not required to use a Blue Shield of California provider to receive Urgent Services; you may use any California provider.

Out-of-Area Follow-up Care is also covered through a Blue Shield of California provider or from any California provider. Authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from their Primary Care Physician.

If services are not received from a Blue Shield of California provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield. Claims for Urgent Services obtained outside of your Primary Care Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Primary Care Physician Service Area within California, the amount you pay, if not subject to a flat dollar Copayment, is calculated based on Blue Shield's Allowed Charges.

Emergency Services

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. For information on Emergency Services received outside of California through the BlueCard and Blue Shield Global Core programs, see the section on *Inter-Plan Arrangements.*

For Emergency Services from any provider, the Member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowed Charges Blue Shield is obligated to pay.

Members who reasonably believe that they have an Emergency Medical Condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital.

Members should go to the closest Plan Hospital for Emergency Services whenever possible. The Member should notify their Primary Care Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization.

Claims for Emergency and Urgent Services

If Emergency or Urgent Services are not received from a Blue Shield of California provider, the Member may be required to pay the provider for the entire cost of the service and request reimbursement from Blue Shield. A completed claim form and medical records must be submitted to Blue Shield within one year of the service date. Claims for Emergency or Urgent Services will be reviewed retrospectively for coverage.

For information on claims for Emergency or Urgent Services received outside of California see the *Inter-Plan Arrangements* section of the EOC.

NurseHelp 24/7 SM

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

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

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

In the case of a medical emergency, call 911.

For personalized medical advice, Members should consult with their Primary Care Physician.

Blue Shield Online

Blue Shield's internet site is located at www.blueshieldca.com. Members with internet access may view and download healthcare information.

Health Education and Health Promotion Services

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

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Plan Providers:

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

Note: For availability of interpreter services at the time of the Member's appointment, consult the list of Blue Shield Trio+ Providers available at www.blueshieldca.com or by calling Shield Concierge at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the *Notice of the Availability of Language Assistance Services* section of this EOC.

Cost Sharing

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

Calendar Year Medical Deductible

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

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

ceived at a facility that is a Plan Provider will accrue to the Calendar Year Medical Deductible whether Services are provided by a health professional who is a Plan Provider or non-Plan Provider.

There are individual and Family Calendar Year Medical Deductible amounts. The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Medical Deductible within the Family Medical Deductible. This means Blue Shield will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met. Any amount you pay toward the individual Medical Deductible will be applied to both the individual Medical Deductible and the Family Medical Deductible.

Once the respective Deductible is reached, Covered Services are paid as Allowed Charges, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

Calendar Year Pharmacy Deductible

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

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

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. If a benefit plan has any Calendar Year Medical Deductible, it will accumulate toward the Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum. Covered Services received at a facility that is a Plan Provider will accrue to the Calendar Year Out-of-Pocket Maximum whether Services are provided by a health professional who is a Plan Provider or non-Plan Provider.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts. The individual Calendar Year Out-of-Pocket Maximum applies when an individual is covered by the plan. The Family Calendar Year Out-of-Pocket Maximum applies when a Family is covered by the plan. There is also an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means that any Family member who meets the individual Out-of-Pocket Maximum will receive 100% Benefits for Covered Services, before the Family Out-of-Pocket Maximum is met. Any amount you pay toward the individual Out-of-Pocket Maximum will be applied to both the individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum.

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

Charges for services that are not covered and charges in excess of Allowed Charges or the contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Liability of Subscriber or Member for Payment

As described in Role of the Primary Care Physician and adjacent sections above, in general all services must be prior authorized by the Primary Care Physician or Medical Group/IPA. In addition, as designated in Prior Authorization for Mental Health, Behavioral Health Treatment, and Sub-

stance Use Disorder Services above, all non-emergency inpatient services must be prior authorized by the MHSA and all Other Outpatient Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services must be prior authorized by the MHSA. However, a Member will not be responsible for payment of covered Mental Health and Substance Use Services requiring prior authorization solely because an MHSA Participating Provider fails to obtain prior authorization.

The following services do not require prior authorization by the Member's Primary Care Physician, Medical Group/IPA, or the MHSA:

1) Emergency Services;
2) Urgent Services;
3) Trio+ Specialist visits;
4) Hospice program services provided by a Participating Hospice Agency after the Member has been referred and accepted into the Hospice Program;
5) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the Primary Care Physician's Medical Group/IPA; and
6) Office Visits for Outpatient Mental Health and Substance Use Disorder Services by an MHSA Participating Provider.

In general, the Member is responsible for payment for:

1) Any services that are not Covered Services; and
2) Any Covered Services (except Emergency Services or Urgent Services) that are rendered by a non-Plan Provider, unless the Member has been referred to such services by their Primary Care Physician or the MHSA and the services are prior authorized by the Primary Care Physician or the MHSA. Prior authorization will not be granted and payment will not be made for services (other than Emergency Services or Urgent Services) that are rendered by a non-Plan Provider unless there is no Plan Provider available to render such services.

Limitation of Liability

Members shall not be responsible to Plan Providers or health professionals who are non-Plan Providers rendering services at a Plan Provider facility, for payment of services if they are a Benefit of the Plan. When Covered Services are rendered by a Plan Provider, or rendered by a health professional who is a non-Plan Provider at a Plan Provider facility, the Member is responsible only for the applicable Deductible, Copayment or Coinsurance, except as set forth in the Third Party Liability section. Members are responsible for the full charges for any non-Covered Services they obtain.

If a Plan Provider terminates his or her relationship with the Plan, affected Members will be notified. Blue Shield will make every reasonable and medically appropriate provision necessary to have another Plan Provider assume responsibility for the Member's care. The Member will not be responsible for payment (other than the applicable Deductible, Copayment or Coinsurance) to a former Plan Provider for any authorized services received. Once provisions have been made for the transfer of the Member's care, the services of the former Plan Provider are no longer covered.

Out-of-Area Services

Overview

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (Licensees). Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you obtain health care services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you access services outside of California you may obtain care from one of two kinds of providers. Most providers are participating providers and contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Some providers are non-participating providers because they don't contract with the Host Blue. Blue Shield's payment practices in both instances are described in this section.

The Blue Shield Trio HMO plan provides limited coverage for health care services received outside of California. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other services will not be covered when processed through an Inter-Plan Arrangement unless authorized by Blue Shield.

Inter-Plan Arrangements

Emergency Services

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

BlueCard Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Evidence of Coverage. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services outside of California, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance, and Deductible amounts, if any, as stated in the Summary of Benefits.

When you receive Out-of-Area Covered Health Care Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed charges for your Out-of-Area Covered Health Care Services; or
2) The negotiated price that the Host Blue makes available to Blue Shield.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care 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 health care 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 as noted above. However, such adjustments will not affect the price Blue Shield uses for your claim because these adjustments will not be applied retroactively to claims already paid.

Non-participating Providers Outside of California

Coverage for health care services provided outside of California and within the BlueCard Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment Blue Shield will make for Out-of-Area Covered Health Care Services as described in this paragraph.

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

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

Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (BlueCard Service Area), you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is not served by a Host Blue. As such, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

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

Submitting a Blue Shield Global Core Claim

When you pay directly for Out-of-Area Covered Health Care Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. The claim form is available from Blue Shield Customer Service, the service center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Utilization Management

State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing Blue Shield's Utilization Management Program is available online at www.blueshieldca.com or Members may call Shield Concierge at the number provided on the back page of this Evidence of Coverage to request a copy.

Principal Benefits and Coverages (Covered Services)

Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurance, charges in excess of Benefit maximums and Participating Provider provisions.

These services and supplies are covered only when Medically Necessary and authorized by the Member's Primary Care Physician, the Medical Group/IPA, the Mental Health Service Administrator (MHSA), or Blue Shield. Unless specifically authorized, Covered Services must be provided by the Member's Primary Care Physician, an Obstetrical/Gynecological Physician within the Member's Medical Group/IPA, a Trio+ Specialist, or an MHSA Participating Provider. All terms, conditions, Limitations, Exceptions, Exclusions and Reductions set forth in this Evidence of Coverage apply as well as conditions or limitations illustrated in the benefit descriptions below.

When appropriate, the Primary Care Physician will assist the Member in applying for admission into a Hospice program through a Participating Hospice Agency. Hospice services obtained through a Participating Hospice Agency after the Member has been admitted into the Hospice program, do not require authorization.

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

The determination of whether services are Medically Necessary, urgent or emergent will be made by the Medical Group/IPA or by Blue Shield. This determination will be based upon a review that is consistent with generally accepted medical stand-

ards, and will be subject to grievance in accordance with the procedures outlined in the *Grievance Process* section.

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

For all acupuncture services, Blue Shield has contracted with American Specialty Health Plans, Inc. (ASH Plans) to act as the Plan's acupuncture services administrator.

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

Contact ASH Plans with questions about acupuncture services, ASH Participating Providers, or acupuncture Benefits. Contact ASH Plans at:

1-800-678-9133
American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans can answer many questions over the telephone.

Allergy Testing and Immunotherapy Benefits

Benefits are provided for allergy testing and immunotherapy services.

Benefits include:

1) allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
2) preparation and provision of allergy serum; and
3) allergy serum injections.

This Benefit does not include:

1) blood testing for allergies.

Ambulance Benefits

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

For air ambulance services from any provider, the Member is only responsible for the applicable Deductible, Copayment or Coinsurance as shown in the Summary of Benefits.

Ambulatory Surgery Center Benefits

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

Bariatric Surgery Benefits

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

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

Services for Residents of Designated Counties

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric services*, Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

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

*See the list of designated counties below.

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

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

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

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

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

Bariatric Travel Expense Reimbursement for Residents of Designated Counties

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

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

1) Transportation to and from the facility up to a maximum of $130 per round trip:
    a. for the Member for a maximum of three trips:
        i. one trip for a pre-surgical visit,
        ii. one trip for the surgery, and
        iii. one trip for a follow-up visit.
    b. for one companion for a maximum of two trips:
        i. one trip for the surgery, and
        ii. one trip for a follow-up visit.
2) Hotel accommodations not to exceed $100 per day:
    a. for the Member and one companion for a maximum of two days per trip,
        i. one trip for a pre-surgical visit, and
        ii. one trip for a follow-up visit.
    b. for one companion for a maximum of four days for the duration of the surgery admission.
        i. Hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.
3) Related expenses judged reasonable by Blue Shield not to exceed $25 per day per Member up to a maximum of four days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

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

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

1) services are consistent with Blue Shield's medical policy; and,
2) prior authorization is obtained through the Member's Primary Care Physician.

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

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

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

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

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

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

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

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 diseases or conditions, 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 disease or 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, for the management and treatment of diabetes:

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

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

Diabetic Outpatient Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management, training, education and medical nutrition therapy when directed or prescribed by the Member's Primary Care Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetic educator.

Dialysis Benefits

Benefits are provided for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting, or in your home.

Benefits include:

1) renal dialysis;
2) hemodialysis;
3) peritoneal dialysis; and
4) self-mangement training for home dialysis.

Benefits do not include:

1) comfort, convenience, or luxury equipment; or
2) non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable Medical Equipment Benefits

Benefits are provided for durable medical equipment (DME) for Activities of Daily Living, supplies needed to operate DME, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function. Other covered items include peak flow monitor for self-management of asthma, glucose monitor for self-management of diabetes, apnea monitor for management of newborn apnea, required dialysis equipment and medical supplies, breast pump and home prothrombin monitor for specific conditions as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice.

No DME Benefits are provided for the following:

1) rental charges in excess of the purchase cost;
2) replacement of DME except when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the *Outpatient Prescription Drug Benefits* section

for benefits for asthma inhalers and inhaler spacers);

3) breast pump rental or purchase when obtained from a non-Plan Provider;
4) for repair or replacement due to loss or misuse;
5) 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; and
6) for backup or alternate items.

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

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

Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. Covered non-Emergency Services and emergency room follow-up services within the Primary Care Physician service area (e.g., suture removal, wound check, etc.) must be authorized by Blue Shield or obtained through the Member's Primary Care Physician.

Emergency Services are 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) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When a Member is admitted to the Hospital for Emergency Services, Blue Shield should receive emergency admission notification within 24 hours or as soon as it is reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition.

Services Provided at a Non-Plan Hospital Following Stabilization of an Emergency Medical Condition

When the Member's Emergency Medical Condition is stabilized, and the treating health care provider at the non-Plan Hospital believes additional Medically Necessary Hospital services are required, the non-Plan Hospital must contact Blue Shield to obtain timely authorization. Blue Shield may authorize continued Medically Necessary Hospital services by the non-Plan Hospital.

If Blue Shield determines the Member may be safely transferred to a Hospital that is contracted with the Plan and the Member refuses to consent to the transfer, the non-Plan Hospital must provide the Member with written notice that the Member will be financially responsible for 100% of the cost for services provided following stabilization of the Emergency Medical Condition. As a result, the Member may be billed by the non-Plan Hospital. Members should contact Shield Concierge at the number provided on the back page of the Evidence of Coverage for questions regarding improper billing for services received from a non-Plan Hospital.

For information on Emergency Services received outside of California, see the *Inter-Plan Arrangements* section of the EOC.

Family Planning and Infertility Benefits

Family Planning Benefits

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

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

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

Infertility Benefits

Benefits are provided for the diagnosis and treatment of the cause of Infertility, including professional, Hospital, Ambulatory Surgery Center, and ancillary services to diagnose and treat the cause of Infertility, with the exception of what is excluded in the *Principal Limitations, Exceptions, Exclusions and Reductions* section.

No Benefits are provided for family planning services from non-Plan Providers.

Home Health Care Benefits

Benefits are provided for home health care services when ordered and authorized through the Member's Primary Care Physician.

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

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

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

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

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

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

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

Skilled services provided by a home health agency are limited to a combined visit maximum as shown in the Summary of Benefits per Member per Calendar Year for all providers other than Plan Physicians.

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

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

Home Infusion and Home Injectable Therapy Benefits

Benefits are provided for home infusion and injectable medication therapy when ordered and authorized through the Member's Primary Care Physician.

Services include home infusion agency Skilled Nursing visits, infusion therapy provided in infusion suites associated with a home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit, medications injected or administered intravenously and related laboratory services when prescribed by the Primary Care Physician and prior authorized, and when provided by a home infusion agency. Services related to hemophilia are described separately.

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

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the non-participating home infusion agency and Blue Shield.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. Members may also verify this information by calling Shield Concierge at the telephone number provided on the back page of this Evidence of Coverage.

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

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

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

No Benefits are provided for:

1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications*;
2) services from a hemophilia treatment center or any provider not authorized by Blue Shield; or,
3) self-infusion training programs, other than nursing visits to assist in administration of the product.

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

Hospice Program Benefits

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

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver and the Family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Participating Hospice Agency.

1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.
2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:
    a. Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;
    b. Home Health Aide services to provide personal care (supervised by a registered nurse);

c. homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);

d. bereavement services for the immediate surviving Family members for a period of at least one year following the death of the Member;

e. medical social services including the utilization of appropriate community resources;

f. counseling/spiritual services for the Member and Family;

g. dietary counseling;

h. medical direction provided by a licensed Physician acting as a consultant to the interdisciplinary Hospice team and to the Member's Primary Care Physician with regard to pain and symptom management and as a liaison to community physicians;

i. physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;

j. respiratory therapy;

k. volunteer services.

3) Drugs, DME, and supplies.

4) Continuous home care when Medically Necessary to achieve palliation or management of acute medical symptoms including the following:

a. Eight to 24 hours per day of Continuous Nursing Services (eight-hour minimum);

b. homemaker or Home Health Aide services up to 24 hours per day to supplement skilled nursing care.

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

6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.

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

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

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

1) Semi-private room and board unless a private room is Medically Necessary.

2) General nursing care and special duty nursing.

3) Meals and special diets.

4) Intensive care services and units.

5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.

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

7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield.

8) Drugs and oxygen.

9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.

10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.

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

12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.

13) Subacute Care.

14) Medical social services and discharge planning.

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

16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder detoxification is authorized through the Member's Primary Care Physician.

Outpatient Services for Treatment of Illness or Injury

Benefits include the following outpatient Hospital services:

1) Dialysis services.

2) Care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which an inpatient admission is planned.

3) Surgery.

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

5) Routine newborn circumcision within 18 months of birth.

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

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

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

1) treatment of tumors of the gums;

2) treatment of damage to natural teeth caused solely by an Accidental Injury is limited to palliative services necessary for the initial medical stabilization of the Member as determined by Blue Shield;

3) non-surgical treatment (e.g. splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

4) surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;

5) treatment of maxilla and mandible (Jaw Joints and Jaw Bones);

6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;

7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair; or

8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck.

9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

No Benefits are provided for:

1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;
2) dental implants (endosteal, subperiosteal or transosteal);
3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and
5) fluoride treatments except when used with radiation therapy to the oral cavity.

Mental Health, Behavioral Health, and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services for Blue Shield Members within California. All non-emergency inpatient Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, including Residential Care must be prior authorized by the MHSA. Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services (except Teladoc behavioral health consultations) must be prior authorized by the MHSA.

Office Visits for Outpatient Mental Health and Substance Use Disorder Services

Benefits are provided for professional office visits for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions in the individual, Family or group setting. Telehealth services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers and are a Covered Service regardless of the Member's age.

Teladoc Mental Health and Substance Use Disorder (Behavioral Health) Consultations

Benefits are provided for Teladoc consultations for Mental Health and Substance Use Disorder Services. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA). Call 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc to schedule a call with a psychiatrist, psychologist, licensed clinical social worker, professional clinical counselor, certified drug and alcohol abuse counselor, or marriage and family therapist. Teladoc Mental Health and Substance Use Disorder services are not available for Members under age 18. Members under age 18 may obtain telehealth services for Mental Health and Substance Use Disorders from MHSA Participating Providers, see the section above on *Office Visits for Outpatient Mental Health and Substance Use Disorder Services*.

Before this service can be accessed, you must complete a medical history form and a short mental health intake form. These forms can be completed online on Teladoc's website or on the mobile app at no charge.

Teladoc consultation services are not intended to replace services from your mental health professional but are a supplemental service. You do not need to contact your Physician before using Teladoc consultation services.

Teladoc psychiatrists can prescribe from a limited list of medications. Other types of Teladoc Mental Health and Substance Use Disorder Services providers cannot prescribe medications. If the Teladoc psychiatrist determines that other medications may be appropriate, they will recommend an in-person office visit with your mental health professional. When medications are prescribed, the applicable Outpatient Prescription Drug Benefits Copayments and requirements will apply.

Mental Health and Behavioral Health – Other Outpatient Services

Benefits are provided for Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions. These services may

also be provided in the office, home or other non-institutional setting. Other Outpatient Mental Health Services and Behavioral Health Treatment include, but may not be limited to the following:

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

   BHT is covered when prescribed by a Plan Physician or licensed psychologist and provided under a treatment plan developed by an MHSA Participating Provider. BHT must be obtained from MHSA Participating Providers.

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

2) Electroconvulsive Therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.

3) Intensive Outpatient Program – an outpatient mental health or behavioral health treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

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

5) Psychological Testing – testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

6) Transcranial Magnetic Stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Outpatient Substance Use Disorder Services

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

1) Intensive Outpatient Program – an outpatient Substance Use Disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

2) Office-Based Opioid Detoxification and/or Maintenance Therapy, including Methadone maintenance treatment.

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

Inpatient Services

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

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

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

Orthotics Benefits

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

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

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

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

Outpatient Prescription Drug Benefits

This Plan provides benefits for outpatient prescription Drugs as specified in this section.

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

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

Outpatient Drug Formulary

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

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

The Formulary drug list is categorized into drug tiers as described in the chart below. The Member's Copayment or Coinsurance will vary based on the drug tier. Drug tiering is based on recommendations made by the Pharmacy and Therapeutics Committee.

Drug Tier	Description
Tier 1	Most Generic Drugs, and low-cost, Preferred Brand Drugs.
Tier 2	1. Non-preferred Generic Drugs; 2. Preferred Brand Name Drugs; and 3. Any other Drugs recommended by the plan's Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost.

Tier 3	1. Non-preferred Brand Name Drugs; 2. Drugs that are recommended by the P&T Committee based on drug safety, efficacy and cost; or 3. Generally, have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	1. Drugs that are biologics and Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; 2. Drugs that require the Member to have special training or clinical monitoring; or 3. Drugs that cost the health plan (net of rebates) more than $600 for a one-month supply.

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Pharmacy by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Shield Concierge at the number listed on the Identification Card. If the Member obtains Drugs at a Non-Participating Pharmacy, Blue Shield will deny the claim, unless it is for Emergency Services.

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

Blue Shield has two participation levels for retail Participating Pharmacies: Level A and Level B. If you select a pharmacy that participates at Level A, cost share for covered Drugs will be lower than your cost share would be at a Level B Participating Pharmacy. Specific Copayment and Coinsurance amounts are provided in the Summary of Benefits. You may go to either Level A or Level B Participating Pharmacies to obtain covered Drugs.

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

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

If the Member, their Physician or Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, the Member pays the difference in cost, plus the Tier 1 Copayment or Coinsurance. This is calculated by taking the difference between the Participating Pharmacy's

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

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

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

Blue Shield created a Patient Review and Coordination (PRC) program to help reduce harmful prescription drug misuse and the potential for abuse. Examples of harmful misuse include obtaining an excessive number of prescription medications or obtaining very high doses of prescription opioids from multiple providers or pharmacies within a 90-day period. If Blue Shield determines a Member is using prescription drugs in a potentially harmful, abusive manner, Blue Shield may, subject to certain exemptions and upon 90 days' advance notice, restrict a Member to obtaining all non-emergent outpatient prescriptions drugs at a single pharmacy home. This restriction applies for a 12-month period and may be renewed. The pharmacy home, a single Participating Pharmacy, will be assigned by Blue Shield or a Member may request to select a pharmacy home. Blue Shield may also require prior authorization for all opioid medications if sufficient medical justification for their use has not been provided. Members that disagree with their enrollment in the PRC program can file an appeal or submit a grievance to Blue Shield as described in the *Grievance Process* section. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Customer Service at the number listed on their Identification Card.

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

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

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

  Blue Shield of California
  P.O. Box 52136
  Phoenix, AZ 85072-2136

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

Claim forms may be obtained by calling Shield Concierge or visiting www.blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

The Member has an option to use Blue Shield's Mail Service Prescription Drug Program when he or she takes maintenance Drugs for an ongoing condition. This allows the Member to receive up to a 90-day supply of their Drug and may help the Member to save money. The Member may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. The Member's Physician or Health Care Provider must indicate a prescription quantity equal to the amount to be dispensed.

Specialty Drugs are not available through the Mail Service Prescription Drug Program.

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

Visit www.blueshieldca.com or call Shield Concierge to get additional information about the Mail Service Prescription Drug Program.

Obtaining Specialty Drugs through the Specialty Drug Program

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

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

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

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

Prior Authorization/Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

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

Blue Shield covers compounded medication(s) when:

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

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

The Member, their Physician or Health Care Provider may request prior authorization for the Drugs listed above or an exception request by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circum-

stances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

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

Step therapy is the process of beginning therapy for a medical condition with Drugs considered first-line treatment or that are more cost-effective, then progressing to Drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, information from the drug manufacturer, and the relative cost of treatment for a condition. If step therapy coverage requirements are not met for a prescription and your Physician believes the medication is Medically Necessary, the prior authorization process may be utilized and timeframes previously described will also apply.

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

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

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

   If the Member agrees to a 15-day trial, the Network Specialty Pharmacy will contact the Member prior to dispensing the remaining 15-day supply to confirm that the Member is tolerating the Specialty Drug. The Member can find a list of Specialty Drugs in the Short Cycle Specialty Drug Program by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Shield Concierge.
4) The Member may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if the Member's Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and the Member is responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.
5) Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
6) The Member may receive up to a 12-month supply of contraceptive Drugs.

7) The Member may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

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

1) Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained for a covered emergency. Nor does it apply to Drugs obtained for an urgently needed service for which a Participating Pharmacy was not reasonably accessible.

2) Any Drug the Member receives while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional Benefits and Hospital Benefits (Facility Services) sections of this Evidence of Coverage.

3) Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities. See the *Hospital Benefits* and *Skilled Nursing Facility Benefits* sections of this Evidence of Coverage.

4) Unless listed as covered under this Outpatient Prescription Drug Benefit, drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs or devices when prescribed by a Physician.

5) Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary and by submitting an exception request to Blue Shield. See the *Prior Authorization/Exception Request Process/Step Therapy* section of this Evidence of Coverage.

6) Drugs for which the Member is not legally obligated to pay, or for which no charge is made.

7) Drugs that are considered to be experimental or investigational.

8) Medical devices or supplies except as listed as covered herein. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits, Durable Medical Equipment Benefits,* and the *Orthotics Benefits* sections of this Evidence of Coverage.

9) Blood or blood products (see the *Hospital Benefits (Facility Services)* section of this Evidence of Coverage).

10) Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, drugs used to slow or reverse the effects of skin aging or to treat hair loss.

11) Medical food, dietary, or nutritional products. See the *Home Health Care Benefits, Home Infusion and Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.

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

13) All Drugs related to assisted reproductive technology.

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

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

- Are FDA-approved,
- Are ordered by a Physician or Health Care Provider,

- Are generally purchased at an outpatient pharmacy, and
- Are self-administered.

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

16) Compounded medication(s) which do not meet all of the following requirements:
    - The compounded medication(s) include at least one Drug,
    - There are no FDA-approved, commercially available, medically appropriate alternatives,
    - The compounded medication is self-administered, and
    - Medical literature supports its use for the diagnosis.
17) Replacement of lost, stolen or destroyed Drugs.
18) If the Member is enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under *Outpatient Prescription Drug Benefits* and are covered under the *Hospice Program Benefits* section of this Evidence of Coverage.
19) Drugs prescribed for treatment of dental conditions. This exclusion does not apply to
    - antibiotics prescribed to treat infection,
    - Drugs prescribed to treat pain, or
    - Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
20) Except for a covered emergency, Drugs obtained from a pharmacy:
    - Not licensed by the State Board of Pharmacy, or
    - Included on a government exclusion list.
21) Immunizations and vaccinations solely for the purpose of travel.
22) Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs.
23) Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Outpatient X-ray, Imaging, Pathology and Laboratory Benefits

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

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

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

Radiological and Nuclear Imaging

The following radiological procedures, when performed on an outpatient, non-emergency basis, must be arranged and authorized through the Member's Primary Care Physician.

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.

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

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

PKU-Related Formulas and Special Food Products Benefits

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

Podiatric Benefits

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

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

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

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

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

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

Preventive Health Benefits

Preventive Health Services are only covered when provided or arranged by the Member's Primary Care Physician.

Preventive Health Services include primary preventive medical and laboratory services 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 item 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 Shield Concierge.

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

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

Professional Benefits

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

1) Physician office visits for examination, diagnosis, and treatment of a medical condition, disease or injury.
2) Specialist office visits for second medical opinion or other consultation and treatment;
3) Mammography and Papanicolaou's tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests;
4) Preoperative treatment;
5) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors;
6) Outpatient surgical procedures.
7) Outpatient routine newborn circumcision within 18 months of birth;
8) Office administered Injectable medications approved by the Food and Drug Administration (FDA) as prescribed or authorized by the Primary Care Physician
9) Outpatient radiation therapy and chemotherapy for cancer, including catheterization, and associated drugs and supplies;
10) Diagnostic audiometry examination.
11) Physician visits to the home.
12) Inpatient medical and surgical Physician services when Hospital or Skilled Nursing Facility services are also covered.
13) Routine newborn care in the Hospital including physical examination of the infant and counseling with the mother concerning the infant during the Hospital stay;
14) Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment.
15) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Primary Care Physician's office is closed and you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit http://www.teladoc.com/bsc. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

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

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

Note: If medications are prescribed, the applicable Copayment or Coinsurance will apply.

16) A Plan 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 Plan Physician at an extended office hours facility will be reimbursed as a Physician office visit. A list of urgent care providers may be found online at www.blueshieldca.com or by calling Shield Concierge.

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

Preventive Health Benefits, *Mental Health, Behavioral Health, and Substance Use Disorder Benefits*, *Hospice Program Benefits*, and *Reconstructive Surgery Benefits* are described elsewhere under *Principal Benefits and Coverages (Covered Services).*

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. Benefits include:

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

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

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

Reconstructive Surgery Benefits

Benefits are provided to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following to: (1) improve function; or (2) create a normal appearance to the extent possible. Benefits include dental and orthodontic services that are an integral part of surgery for cleft palate procedures. Reconstructive Surgery is covered to create a normal appearance only when it offers more than a minimal improvement in appearance.

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

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

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

Benefits are provided for outpatient Physical, Occupational, and Respiratory Therapy for the treatment of functional disability in the performance of activities of daily living. Continued outpatient Benefits

will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous level of functioning or to keep, learn, or improve skills and functioning.

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

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

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

Skilled Nursing Facility Benefits

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

Speech Therapy Benefits (Rehabilitative and Habilitative Services)

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

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

See the *Home Health Care Benefits* and the *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 Transplant

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient. Benefits also include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant bank.

Special Transplant

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield to provide the procedure, (2) prior authorization is obtained, in writing from Blue Shield and (3) the recipient of the transplant is a Subscriber or Dependent. Failure to obtain prior written authorization and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this Benefit:

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

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

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

Pediatric Dental Benefits

(Benefits applicable to Members aged 19 and under)

Blue Shield has contracted with a Dental Plan Administrator (DPA). All pediatric dental Benefits will be administered by the DPA. Pediatric dental Benefits are available for Members through the end of the month in which the Member turns 19. Dental Care Services are delivered to our Members through the DPA's Dental HMO ("DHMO") network of Participating Providers.

If the Member purchased a family dental plan that includes pediatric dental Benefits on the Health Benefits Exchange, the pediatric dental Benefits covered under this Plan will be paid first, and the family dental plan will cover additional dental Benefits not covered under this pediatric dental Benefit and/or cost sharing as described in the Member's family dental plan Evidence of Coverage.

If the Member has any questions regarding the pediatric dental Benefits described in this Evidence of Coverage, needs assistance, or has any problems, they may contact the Dental Member Services Department at: 1-800-605-8202.

Selecting a Dental Provider

A close Dentist-patient relationship is an important element that helps to ensure the best dental care. Each Member is therefore required to select a Dental Provider at the time of enrollment. This decision is an important one because the Member's Dental Provider will:

1) Help the Member decide on actions to maintain and improve dental health.
2) Provide, coordinate and direct all necessary covered Dental Care Services.
3) Arrange referrals to Plan Specialists when required, including the prior Authorization the Member will need.
4) Authorize Emergency Dental Care Services when necessary. Refer to the *Emergency Dental Care Service*s section for more information.

The Dental Provider for the Member must be located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield.

A Dental Provider must also be selected for a newborn or child placed for adoption.

If the Member does not select a Dental Provider at the time of enrollment or seek assistance from the Dental Member Services Department within 15 days of the effective date of coverage, Blue Shield will designate a temporary Dental Provider for the Member, and notify the Member of the designated Dental Provider. This designation will remain in effect until the Member advises Blue Shield of their selection of a different Dental Provider.

The Member should contact Dental Member Services if they needs assistance locating a Dental Provider in the service area. Blue Shield will review and consider the request for services that cannot be reasonably obtained in network. If the request for services from a Non-Plan Provider is approved, the Member will be responsible for the Copayments related to Covered Services. Blue Shield will pay the amount billed for Covered Services (less member Copayment) from the non-Plan Provider. Without this approval, the Member will be responsible for paying the non-Plan Provider directly for the entire amount billed by the Dentist.

Changing Dental Providers

The Member may change Dental Providers without cause at the following times:

1) during Open Enrollment;
2) when the Member's change in residence makes it inconvenient to continue with the same Dental Provider;

3) one other time during the Calendar Year.

If the Member wants to change Dental Providers at any of the above times, the Member must contact Dental Member Services. Before changing Dental Providers, the Member must pay any outstanding Copayment balance owed to their existing Dental Provider. The change will be effective the first day of the month following notice of approval by Blue Shield.

If the Member's Dental Provider ceases to be in the Plan Provider network, Blue Shield will notify the Member in writing. To ensure continuity of care, the Member will temporarily be assigned to an alternate Dental Provider and asked to select a new Dental Provider. If the Member does not select a new Dental Provider within the specified time, their alternate Dental Provider assignment will remain in effect until the Member notifies the Plan of their desire to select a new Dental Provider.

Referral to Plan Specialists

All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, the Member may also be referred to a Plan Specialist outside of the Dental Center if the type of specialty service needed is not available within the Dental Center.

If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and notify the DPA. The DPA then must authorize such referrals. When no Participating Dentist is available to perform the needed service, the Dental Provider will refer the Member to a Non-Participating Dentist after obtaining authorization from the DPA. This Authorization procedure is handled for the Member by their Dental Provider.

Generally, the Member's Dental Provider will refer the Member within the network of Blue Shield Plan Specialists in their area. After the specialty services have been rendered, the Plan Specialist will provide a complete report to the Member's Dental Provider to ensure the Member's dental record is complete.

Timely Access to Dental Care Services

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

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

Note: For availability of interpreter services at the time of the Member's appointment, contact Shield Concierge at the number shown in the "Shield Concierge" section of this booklet. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this EOC.

Payment of Providers

Blue Shield contracts with the DPA to provide services to our Members. A monthly fee is paid to the DPA for each Member. This payment system includes incentives to the DPA to manage all Covered Services provided to Members in an appropriate manner consistent with the Contract.

The Member's Dental Provider must obtain authorization from the DPA before referring the Member to providers outside of the Dental Center.

For more information about this payment system, contact the DPA at the number shown in the Member Services section of this Evidence of Coverage or talk to the Member's Plan Provider.

Relationship with the Member's Dental Provider

The Dentist-patient relationship the Member establishes with the Dental Provider is very important. The best effort of the Dental Provider will be used to ensure that all Medically Necessary and appropriate professional services are provided to the Member in a manner compatible with their wishes.

If the Dentist recommends procedures or treatment which the Member refuses, or the Member and the Dental Provider fails to establish a satisfactory relationship, the Member may select a different Dental Provider. The Plan Member Services can assist the Member with this selection.

The Member's Dental Provider will advise the Member if they believe there is no professionally acceptable alternative to a recommended treatment or procedure. If the Member continues to refuse to follow the recommended treatment or procedure, the Plan Member Services can assist the Member in the selection of another Dental Provider.

If a Member is in need of emergency treatment and is outside the geographic area of their designated Participating Dentist, the Member should first contact the DPA to describe the emergency and receive referral instructions. If the DPA does not have a contracted Dentist in the area, or if the Member is unable to contact the DPA, the Member should contact a Dentist of their choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. The Member will be directly reimbursed for this treatment up to the maximum allowed under their Plan Benefits. Refer to the section titled "Responsibility for Copayments, Charges for non-Covered Services and Emergency Claims" within this Evidence of Coverage.

Note: The DPA will respond to all requests for prior authorization of services as follows:

1) for Emergency Dental Care Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;
2) for other services, within 5 business days from receipt of the request.

If the Member obtains services without prior Authorization from the DPA, the DPA will retrospectively review the services for coverage as Emergency Dental Care Services. If the DPA determines that the situation did not require Emergency Dental Care Services, the Member will be responsible for the entire cost of the services. The DPA will notify the Member of its determination within 30 days from receipt of the claim.

Limitation of Member Liability

The Member shall not be responsible to Participating Dentists for payment of Covered Services. When Covered Services are rendered by a Participating Dentist, the Member is responsible only for the applicable Copayments and charges in excess of Benefit maximums. Members are responsible for the full charges for any non-covered services they obtain.

Responsibility for Copayments and Emergency Dental Care Services Claims

Member Responsibility

The Member shall be responsible to the Participating Dentist and other Plan Providers for payment of the following charges:

1) Any Deductibles and amounts listed under Copayments in the Pediatric Dental section of the Summary of Benefits.
2) Any charges for non-covered services.

All such Copayments and charges for non-covered services are due and payable to the Participating Dentist immediately upon commencement of extended treatments or upon the provision of services. Termination of the Plan shall in no way affect or limit any liability or obligation of the Member to the Participating Dentist for any such Copayments or charges owing.

Emergency Dental Care Services Claims

If Emergency Dental Care Services outside of the service area were received and expenses were incurred by the Member, the Member must submit a complete claim with the Emergency Dental Care Service record (a copy of the Dentist's bill) for payment to the DPA, within 1 year after the treatment date.

Please send this information to:

1-800-605-8202

Blue Shield of California
P.O. Box 30567
Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, Blue Shield will not pay for those Emergency Dental Care Services, unless the claim was submitted as soon as reasonably possible as determined by Blue Shield. If the services are not preauthorized, the DPA will review the claim retrospectively. If the DPA determines that the services were not Emergency Dental Care Services and would not otherwise have been authorized by the DPA, and, therefore, are not Covered Services, it will notify the Member of that determination. The Member is responsible for the payment of such Dental Care Services received. The DPA will notify the Member of its determination within 30 days from receipt of the claim. If the Member disagrees with the DPA's decision, they may appeal using the procedures outlined in the section entitled "Member Services and Grievance Process".

Member Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments by Blue Shield for Covered Services provided.

General Exclusions and Limitations

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

1) Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage or on the Dental Schedule and Limitations Table below;
2) Services of Dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Participating Dentist and authorized by the Plan, or when required in a covered emergency;
4) Any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member's effective date of coverage;
5) Any dental services received subsequent to the time the Member's coverage ends;
6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
8) Procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits or on the Dental Schedule and Limitations Table below;
9) Cosmetic dental care;
10) General anesthesia or intravenous/conscious sedation unless specifically listed as a Benefit on the Summary of Benefits or on the Dental Schedule and Limitations Table below or is given by a Dentist for a covered oral surgery;
11) Hospital charges of any kind;
12) Major surgery for fractures and dislocations;
13) Loss or theft of dentures or bridgework;
14) Malignancies;
15) Dispensing of drugs not normally supplied in a dental office;
16) Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;

17) The cost of precious metals used in any form of dental Benefits;

18) Services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Participating Dentist or for Medically Necessary Dental Services or his or her Participating Dentist is a pedodontist/pediatric Dentist;

19) Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;

20) Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;

21) Treatment for which payment is made by any governmental agency, including any foreign government;

22) Charges for second opinions, unless previously authorized by the DPA;

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

Preventive Exclusions and Limitations (D1000-D1999)

1) Fluoride treatment (D1206 and D1208) is a Benefit only for prescription strength fluoride products;

2) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and

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

Restorative Exclusions and Limitations (D2000-D2999)

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

2) Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;

3) Restorations for primary teeth near exfoliation;

4) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription;

5) Prefabricated crowns for primary teeth near exfoliation;

6) Prefabricated crowns are not a Benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214);

7) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;

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

9) Prefabricated crowns are not a Benefit when a tooth can be restored with an amalgam or resin-based composite restoration;

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

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

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

Endodontic Exclusions and Limitations (D3000-D3999)

1) Endodontic procedures when the prognosis of the tooth is questionable due to non- restorability or periodontal involvement;

2) Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and

3) Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Periodontal Exclusions and Limitations (D4000-D4999)

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

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

1) Prosthodontic services provided solely for cosmetic purposes;

2) Temporary or interim dentures to be used while a permanent denture is being constructed;

3) Spare or backup dentures;

4) Evaluation of a denture on a maintenance basis;

5) Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a Benefit;

6) Partial dentures are not a Benefit to replace missing 3rd molars;

7) Laboratory relines (D5760 and D5761) are not a Benefit for resin based partial dentures (D5211and D5212);

8) Laboratory relines (D5750, D5751, D5760 and D5761) are not a Benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741);

9) Chairside relines (D5730, D5731, D5740 and D5741) are not a Benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761);

10) Tissue conditioning (D5850 and D5851) is only a Benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment; and

11) Tissue conditioning (D5850 and D5851) is a Benefit the same date of service as an immediate prosthesis that required extractions.

Implant Exclusions and Limitations (D6000-D6199)

1) Implant services are a Benefit only when exceptional medical conditions are documented and the services are considered Medically Necessary; and

2) Single tooth implants are not a Benefit.

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

1) Fixed partial dentures (bridgework) are not a Benefit; however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture;

2) Fixed partial dentures are not a Benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;

3) Posterior fixed partial dentures are not a Benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the Member's masticatory ability;

4) Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and

5) Cast resin bonded fixed partial dentures (Maryland Bridges).

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

1) The prophylactic extraction of 3rd molars is not a Benefit;

2) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a Benefit are those TMJ treatment

modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation;

3) TMJ dysfunction procedures solely for the treatment of bruxism is not a Benefit; and

4) Suture procedures (D7910, D7911 and D7912) are not a Benefit for the closure of surgical incisions.

Orthodontic Exclusions and Limitations

Orthodontic procedures are Benefits for Medically Necessary handicapping malocclusion, cleft palate and facial growth management cases for Members under the age of 19 and shall be prior authorized.

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

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

Those immediate qualifying conditions are:

1) Cleft lip and or palate deformities

2) Craniofacial Anomalies including the following:

   a) Crouzon's syndrome,

   b) Treacher-Collins syndrome,

   c) Pierre-Robin syndrome,

   d) Hemifacial atrophy, hemifacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.

3) Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).

4) Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a Benefit of the program.

5) Severe traumatic deviation must be justified by attaching a description of the condition.

6) Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

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

Excluded are the following conditions:

1) Crowded dentitions (crooked teeth)

2) Excessive spacing between teeth

3) Temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies

4) Treatment in progress prior to the effective date of this coverage.

5) Extractions required for orthodontic purposes

6) Surgical orthodontics or jaw repositioning

7) Myofunctional therapy

8) Macroglossia

9) Hormonal imbalances

10) Orthodontic retreatment when initial treatment was rendered under this plan or for changes in Orthodontic treatment necessitated by any kind of accident

11) Palatal expansion appliances

12) Services performed by outside laboratories

13) Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Medical Necessity Exclusion

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

Alternate Benefits Provision

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

Pediatric Dental Benefits Customer Services

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

1-800-605-8202
Blue Shield of California
Dental Plan Administrator
425 Market Street, 15th Floor
San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

Note: Dental Benefit Providers has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. Dental Benefit Providers shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. For additional information regarding the expedited decision process, or if the Member believes that their particular situation qualifies for an expedited decision, please contact the Dental Customer Service Department at the number listed above.

Pediatric Dental Benefits Grievance Process

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

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

1-800-605-8202
Blue Shield of California
Dental Plan Administrator
PO Box 30569
Salt Lake City, UT 84130-0569

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

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

Pediatric Dental Benefits Definitions –

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

Billed Charges — the prevailing rates of the Dental office.

Dental Allowable Amount — the Allowance is:

1) The amount the DPA has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or
2) Such other amount as the Participating Dentist and the DPA have agreed will be accepted as payment for the service(s) rendered; or
3) If an amount is not determined as described in either 1. or 2. above, the amount the DPA determines is appropriate considering the particular circumstances and the services rendered.

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

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

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

1) Dental Care Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards, including services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which, as determined by the DPA, are:
   a) Consistent with the symptoms or diagnosis of the condition; and
   b) Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and
   c) Furnished in a setting appropriate for delivery of the service (e.g., a dentist's office).
2) If there are two (2) or more Medically Necessary Dental Care Services that can be provided for the condition, Blue Shield will provide Benefits based on the most cost-effective service.

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

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

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

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

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

1) placing the Member's health in serious jeopardy;

2) serious impairment to bodily functions;

3) serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

Dental Schedule and Limitations Table

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

Code	Description	Limitation	Cost Share
Diagnostic Procedures (D0100-D0999)			
D0120	Periodic oral evaluation – established patient	once every 6 months, per provider or after 6 months have elapsed following comprehensive oral evaluation (D0150), same provider.	No Charge
D0140	Limited oral evaluation – problem focused	once per Member per provider.	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver		No Charge
D0150	Comprehensive oral evaluation – new or established patient	once per Member per provider for the initial evaluation.	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	once per Member per provider.	No Charge
D0170	Re-evaluation – limited, problem focused (established patient; not post- operative visit)	a Benefit for the ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.	No Charge
D0171	Re-evaluation – post-operative office visit		No Charge
D0180	Comprehensive periodontal evaluation – new or established patient		No Charge
D0190	Screening of a patient	not a Benefit.	Not Covered
D0191	Assessment of a patient	not a Benefit.	Not Covered
D0210	Intraoral – complete series of radiographic images	once per provider every 36 months.	No Charge
D0220	Intraoral – periapical first radiographic image	up to a maximum of 20 periapicals in a 12- month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.	No Charge
D0230	Intraoral – periapical each additional radiographic image	up to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.	No Charge
D0240	Intraoral – occlusal radiographic image	up to a maximum of two in a 6 month period per provider.	No Charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.	No Charge

Code	Description	Limitation	Cost Share
D0251	Extra-oral posterior dental radiographic image	up to a maximum of 4 on the same date of service.	No Charge
D0270	Bitewing – single radiographic image	once per date of service. Not a Benefit for a totally edentulous area.	No Charge
D0272	Bitewings – 2 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral complete series of radiographic images (D0210), same provider; and b. for a totally edentulous area.	No Charge
D0273	Bitewings – 3 radiographic images		No Charge
D0274	Bitewings – 4 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral-complete series of radiographic images (D0210), same provider; b. for Members under the age of 10; and c. for a totally edentulous area.	No Charge
D0277	Vertical bitewings – 7 to 8 radiographic images		No Charge
D0310	Sialography		No Charge
D0320	Temporomandibular joint arthrogram, including injection	limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.	No Charge
D0322	Tomographic survey	up to twice in a 12 month period per provider.	No Charge
D0330	Panoramic radiographic image	once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).	No Charge
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12 month period per provider.	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	up to a maximum of 4 per date of service.	No Charge
D0351	3D photographic image		No Charge
D0419	Assessment of salivary flow by measurement	not a Benefit.	Not Covered
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	not a Benefit.	Not Covered
D0460	Pulp vitality tests		No Charge
D0470	Diagnostic casts	once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment); for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly); and when provided by a certified orthodontist.	No Charge
D0502	Other oral pathology procedures, by report	must be provided by a certified oral pathologist.	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk		No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk		No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk		No Charge
D0999	Unspecified diagnostic procedure, by report		No Charge

Code	Description	Limitation	Cost Share
Preventive Procedures (D1000-D1999)			
D1110	Prophylaxis - adult		No Charge
D1120	Prophylaxis – child	once in a 6 month period.	No Charge
D1206	Topical application of fluoride varnish	once in a 6 month period.	No Charge
D1208	Topical application of fluoride – excluding varnish	once in a 6 month period.	No Charge
D1310	Nutritional counseling for control of dental disease		No Charge
D1320	Tobacco counseling for the control and prevention of oral disease		No Charge
D1330	Oral hygiene instructions		No Charge
D1351	Sealant – per tooth	limited to the first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; and once per tooth every 36 months per provider regardless of surfaces sealed.	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	limited to the for first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed.	No Charge
D1353	Sealant repair – per tooth		No Charge
D1354	Interim caries arresting medicament application - per tooth		No Charge
D1510	Space maintainer-fixed – unilateral – per quadrant	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.	No Charge
D1516	Space maintainer – fixed – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant and for Members under the age of 18 Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1517	Space maintainer – fixed – bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant and for Members under the age of 18 Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge

Code	Description	Limitation	Cost Share
D1520	Space maintainer-removable – unilateral – per quadrant	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1526	Space maintainer – removable – bilateral, maxillary	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1527	Space maintainer – removable – bilateral, mandibular	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge
D1556	Removal of fixed unilateral space maintainer – per quadrant	not a Benefit to the original provider who placed the space maintainer.	No Charge
D1557	Removal of fixed bilateral space maintainer – maxillary	not a Benefit to the original provider who placed the space maintainer.	No Charge
D1558	Removal of fixed bilateral space maintainer – mandibular	not a Benefit to the original provider who placed the space maintainer.	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant		No Charge
Restorative Procedures (D2000-D2999)			
D2140	Amalgam – 1 surface, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$25
D2150	Amalgam – 2 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30
D2160	Amalgam – 3 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$40
D2161	Amalgam – 4 or more surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$45
D2330	Resin-based composite – 1 surface, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30

Code	Description	Limitation	Cost Share
D2331	Resin-based composite – 2 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$45
D2332	Resin-based composite – 3 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$55
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$60
D2390	Resin-based composite crown, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$50
D2391	Resin-based composite – 1 surface, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$30
D2392	Resin-based composite – 2 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$40
D2393	Resin-based composite – 3 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$50
D2394	Resin-based composite – 4 or more surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.	$70
D2542	Onlay - metallic – 2 surfaces	not a Benefit.	Not Covered
D2543	Onlay - metallic – 3 surfaces	not a Benefit.	Not Covered
D2544	Onlay - metallic – 4 or more surfaces	not a Benefit.	Not Covered
D2642	Onlay - porcelain/ceramic – 2 surfaces	not a Benefit.	Not Covered
D2643	Onlay - porcelain/ceramic – 3 surfaces	not a Benefit.	Not Covered
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	not a Benefit.	Not Covered
D2662	Onlay - resin-based composite – 2 surfaces	not a Benefit.	Not Covered
D2663	Onlay - resin-based composite – 3 surfaces	not a Benefit.	Not Covered
D2664	Onlay - resin-based composite – 4 or more surfaces	not a Benefit.	Not Covered
D2710	Crown – resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and b. for use as a temporary crown.	$140
D2712	Crown – 3/4 resin-based composite (indirect)	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and b. for use as a temporary crown.	$190
D2720	Crown - resin with high noble metal	not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D2721	Crown – resin with predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$300
D2722	Crown - resin with noble metal	not a Benefit.	Not Covered
D2740	Crown – porcelain/ceramic substrate	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$300
D2750	Crown - porcelain fused to high noble metal	not a Benefit.	Not Covered
D2751	Crown – porcelain fused to predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$300
D2752	Crown - porcelain fused to noble metal	not a Benefit.	Not Covered
D2753	Crown – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered
D2780	Crown - 3/4 cast high noble metal	not a Benefit.	Not Covered
D2781	Crown – 3/4 cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$300
D2782	Crown - 3/4 cast noble metal	not a Benefit.	Not Covered
D2783	Crown – 3/4 porcelain/ceramic	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$310
D2790	Crown - full cast high noble metal	not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D2791	Crown – full cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.	$300
D2792	Crown - full cast noble metal	not a Benefit.	Not Covered
D2794	Crown – titanium and titanium alloys	not a Benefit.	Not Covered
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider.	$25
D2915	Re-cement or re-bond indirectly fabricated or pre-fabricated post and core		$25
D2920	Re-cement or re-bond crown	the original provider is responsible for all re- cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a Benefit within 12 months of a previous re-cementation by the same provider.	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp		$45
D2929	Prefabricated porcelain/ceramic crown - primary tooth	once in a 12 month period.	$95
D2930	Prefabricated stainless steel crown – primary tooth	once in a 12 month period.	$65
D2931	Prefabricated stainless steel crown – permanent tooth	once in a 36 month period. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$75
D2932	Prefabricated resin crown	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$75
D2933	Prefabricated stainless steel crown with resin window	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.	$80
D2940	Protective restoration	once per tooth in a 6 month period, per provider. Not a Benefit: a. when performed on the same date of service with a permanent restoration or crown, for same tooth; and b. on root canal treated teeth.	$25
D2941	Interim therapeutic restoration – primary dentition		$30
D2949	Restorative foundation for an indirect restoration		$45
D2950	Core buildup, including any pins when required		$20
D2951	Pin retention – per tooth, in addition to restoration	for permanent teeth only; when performed on the same date of service with an amalgam or composite; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves 3 or more connected surfaces and at least 1 cusp; or, for an anterior restoration when extensive coronal destruction involves the incisal angle.	$25

Code	Description	Limitation	Cost Share
D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.	$100
D2953	Each additional indirectly fabricated post – same tooth		$30
D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.	$90
D2955	Post removal		$60
D2957	Each additional prefabricated post – same tooth		$35
D2971	Additional procedures to construct new crown under existing partial denture framework		$35
D2980	Crown repair, necessitated by restorative material failure	limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.	$50
D2999	Unspecified restorative procedure, by report		$40
Endodontics Procedures (D3000-D3999)			
D3110	Pulp cap – direct (excluding final restoration)		$20
D3120	Pulp cap – indirect (excluding final restoration)		$25
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. for a primary tooth with a necrotic pulp or a periapical lesion; c. for a primary tooth that is non-restorable; and d. for a permanent tooth.	$40
D3221	Pulpal debridement, primary and permanent teeth	once per permanent tooth; over-retained primary teeth with no permanent successor. Not a Benefit on the same date of service with any additional services, same tooth.	$40
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	once per permanent tooth. Not a Benefit: a. for primary teeth; b.for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.	$55

Code	Description	Limitation	Cost Share
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.	$55
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	$195
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.	$235
D3330	Endodontic therapy, molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.	$300
D3331	Treatment of root canal obstruction; non-surgical access		$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	not a Benefit.	Not Covered
D3333	Internal root repair of perforation defects		$80
D3346	Retreatment of previous root canal therapy – anterior	once per tooth after more than 12 months has elapsed from initial treatment.	$240
D3347	Retreatment of previous root canal therapy – bicuspid	once per tooth after more than 12 months has elapsed from initial treatment.	$295
D3348	Retreatment of previous root canal therapy – molar	once per tooth after more than 12 months has elapsed from initial treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.	$365
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	once per permanent tooth. Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.	$85
D3352	Apexification/recalcification – interim medication replacement	once per permanent tooth and only following apexification/ recalcification initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.	$45

Code	Description	Limitation	Cost Share
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	not a Benefit.	Not Covered
D3410	Apicoectomy – anterior	for permanent anterior teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.	$240
D3421	Apicoectomy – bicuspid (first root)	for permanent bicuspid teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented, after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.	$250
D3425	Apicoectomy – molar (first root)	for permanent 1st and 2nd molar teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.	$275
D3426	Apicoectomy – (each additional root)	for permanent teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.	$110
D3427	Periradicular surgery without apicoectomy		$160
D3430	Retrograde filling – per root		$90
D3450	Root amputation - per root	not a Benefit.	Not Covered
D3910	Surgical procedure for isolation of tooth with rubber dam		$30
D3920	Hemisection (including any root removal), not including root canal therapy	not a Benefit.	Not Covered
D3950	Canal preparation and fitting of preformed dowel or post	not a Benefit.	Not Covered
D3999	Unspecified endodontic procedure, by report		$100
Periodontics Procedures (D4000-D4999)			
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.	Not Covered
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.	$165
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.	$140
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	not a Benefit.	Not Covered
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	not a Benefit.	Not Covered
D4265	Biologic materials to aid in soft and osseous tissue regeneration	for Members age 13 or older.	$80
D4266	Guided tissue regeneration - resorbable barrier, per site	not a Benefit.	Not Covered
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	not a Benefit.	Not Covered
D4270	Pedicle soft tissue graft procedure	not a Benefit.	Not Covered
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	not a Benefit.	Not Covered
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site	not a Benefit.	Not Covered
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.	Not Covered
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.	Not Covered
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$40
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	for Members age 13 or older.	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	for Members age 13 or older.	$10

Code	Description	Limitation	Cost Share
D4910	Periodontal maintenance	once in a calendar quarter and only in the 24 month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning.	$30
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	for Members age 13 or older.	$350
Prosthodontics, removable Procedures (D5000-D5899)			
D5110	Complete denture – maxillary	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.	$300
D5120	Complete denture – mandibular	once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5751) or chairside reline (D5731) is a Benefit 12 months after the date of service for this procedure.	$300
D5130	Immediate denture – maxillary	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 6 months after the date of service for this procedure.	$300
D5140	Immediate denture – mandibular	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture.	$300
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		$300
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$335

Code	Description	Limitation	Cost Share
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330

Code	Description	Limitation	Cost Share
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.	Not Covered
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.	Not Covered
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	not a Benefit.	Not Covered
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	not a Benefit.	Not Covered
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant	not a Benefit.	Not Covered
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant	not a Benefit.	Not Covered
D5410	Adjust complete denture – maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130)or overdenture-complete (D5863 & D5865); b. same date of service or within 6 months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850); and c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).	$20

Code	Description	Limitation	Cost Share
D5411	Adjust complete denture – mandibular	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture-complete (D5863 & D5865); b. same date of service or within 6 months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851); and c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).	$20
D5421	Adjust partial denture – maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. Same date of service or within 6 months of the date of service of a maxillary partial resin base (5211) or maxillary partial denture cast metal framework with resin denture bases (D5213); b. same date of service or within 6 months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850); and c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D 5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).	$20
D5422	Adjust partial denture – mandibular	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit: a. same date of service or within 6 months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214); b. same date of service or within 6 months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851); and c. same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).	$20

Code	Description	Limitation	Cost Share
D5511	Repair broken complete denture base, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).	$40
D5512	Repair broken complete denture base, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).	$40
D5520	Replace missing or broken teeth – complete denture (each tooth)	up to a maximum of 4, per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$40
D5611	Repair resin denture base, mandibular	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).	$40
D5612	Repair resin denture base, maxillary	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).	$40
D5621	Repair cast framework, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider.	$40
D5622	Repair cast framework, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider.	$40
D5630	Repair or replace broken clasp – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$50
D5640	Replace broken teeth – per tooth	up to a maximum of 4, per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only.	$35
D5650	Add tooth to existing partial denture	once per tooth and up to a maximum of 3, per date of service per provider. Not a Benefit for adding 3rd molars.	$35
D5660	Add clasp to existing partial denture – per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$60
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D5671	Replace all teeth and acrylic on cast metal frame-work (mandibular)	not a Benefit.	Not Covered
D5710	Rebase complete maxillary denture	not a Benefit.	Not Covered
D5711	Rebase complete mandibular denture	not a Benefit.	Not Covered
D5720	Rebase maxillary partial denture	not a Benefit.	Not Covered
D5721	Rebase mandibular partial denture	not a Benefit.	Not Covered
D5730	Reline complete maxillary denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; 12 months after the date of service for a complete (re-mote) denture maxillary (D5110) or overdenture (remote complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (la-boratory) (D5750).	$60
D5731	Reline complete mandibular denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (re-mote) denture- mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).	$60

Code	Description	Limitation	Cost Share
D5740	Reline maxillary partial denture (chairside)	once in a 12 month period; 6 months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions; or 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).	$60
D5741	Reline mandibular partial denture (chairside)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture resin base (D5212) or mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).	$60
D5750	Reline complete maxillary denture (laboratory)	once in a 12 month period; 6 months after the date of service for an immediate denture- maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).	$90
D5751	Reline complete mandibular denture (laboratory)	once in a 12 month period; 6 months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).	$90

Code	Description	Limitation	Cost Share
D5760	Reline maxillary partial denture (laboratory)	once in a 12 month period and 6 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit: a. within 12 months of a reline maxillary partial denture (chairside) (D5740); and b. for maxillary partial denture resin base (D5211).	$80
D5761	Reline mandibular partial denture (laboratory)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit: a. within 12 months of a reline mandibular partial denture (chairside) (D5741); and b. for a mandibular partial denture resin base (D5212).	$80
D5850	Tissue conditioning, maxillary	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); and b. same date of service as a prosthesis that did not require extractions.	$30
D5851	Tissue conditioning, mandibular	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report		$90
D5863	Overdenture – complete maxillary	once in a 5 year period.	$300
D5864	Overdenture – partial maxillary	once in a 5 year period.	$300
D5865	Overdenture – complete mandibular	once in a 5 year period.	$300
D5866	Overdenture – partial mandibular	once in a 5 year period.	$300
D5876	Add metal substructure to acrylic full denture (per arch)	not a Benefit.	Not covered
D5899	Unspecified removable prosthodontic procedure, by report		$350
Maxillofacial Prosthetics Procedures (D5900-D5999)			
D5911	Facial moulage (sectional)		$285
D5912	Facial moulage (complete)		$350

Code	Description	Limitation	Cost Share
D5913	Nasal prosthesis		$350
D5914	Auricular prosthesis		$350
D5915	Orbital prosthesis		$350
D5916	Ocular prosthesis	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	$350
D5919	Facial prosthesis		$350
D5922	Nasal septal prosthesis		$350
D5923	Ocular prosthesis, interim	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).	$350
D5924	Cranial prosthesis		$350
D5925	Facial augmentation implant prosthesis		$200
D5926	Nasal prosthesis, replacement		$200
D5927	Auricular prosthesis, replacement		$200
D5928	Orbital prosthesis, replacement		$200
D5929	Facial prosthesis, replacement		$200
D5931	Obturator prosthesis, surgical	not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).	$350
D5932	Obturator prosthesis, definitive	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).	$350
D5933	Obturator prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).	$150
D5934	Mandibular resection prosthesis with guide flange		$350
D5935	Mandibular resection prosthesis without guide flange		$350
D5936	Obturator prosthesis, interim	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).	$350
D5937	Trismus appliance (not for TMD treatment)		$85
D5951	Feeding aid	for Members under the age of 18 only.	$135
D5952	Speech aid prosthesis, pediatric	for Members under the age of 18 only.	$350
D5953	Speech aid prosthesis, adult	for Members under the age of 18 only.	$350
D5954	Palatal augmentation prosthesis		$135
D5955	Palatal lift prosthesis, definitive	not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).	$350
D5958	Palatal lift prosthesis, interim	not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).	$350
D5959	Palatal lift prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).	$145
D5960	Speech aid prosthesis, modification	twice in a 12 month period. not a Benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).	$145
D5982	Surgical stent		$70
D5983	Radiation carrier		$55

Code	Description	Limitation	Cost Share
D5984	Radiation shield		$85
D5985	Radiation cone locator		$135
D5986	Fluoride gel carrier	a Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.	$35
D5987	Commissure splint		$85
D5988	Surgical splint		$95
D5991	Vesiculobullous disease medicament carrier		$70
D5999	Unspecified maxillofacial prosthesis, by report		$350
Implant Services Procedures (D6000-D6199)			
D6010	Surgical placement of implant body: endosteal implant		$350
D6011	Second stage implant surgery		$350
D6013	Surgical placement of mini implant		$350
D6040	Surgical placement: eposteal implant		$350
D6050	Surgical placement: transosteal implant		$350
D6052	Semi-precision attachment abutment		$350
D6055	Connecting bar – implant supported or abutment supported		$350
D6056	Prefabricated abutment – includes modification and placement		$135
D6057	Custom fabricated abutment – includes placement		$180
D6058	Abutment supported porcelain/ceramic crown		$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)		$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)		$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)		$300
D6062	Abutment supported cast metal crown (high noble metal)		$315
D6063	Abutment supported cast metal crown (predominantly base metal)		$300
D6064	Abutment supported cast metal crown (noble metal)		$315
D6065	Implant supported porcelain/ceramic crown		$340
D6066	Implant supported crown – porcelain fused to high noble alloys		$335
D6067	Implant supported crown – high noble alloys		$340
D6068	Abutment supported retainer for porcelain/ceramic FPD		$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		$290

Code	Description	Limitation	Cost Share
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)		$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)		$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)		$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)		$320
D6075	Implant supported retainer for ceramic FPD		$335
D6076	Implant supported retainer FPD – porcelain fused to high noble alloys		$330
D6077	Implant supported retainer for metal FPD – high noble alloys		$350
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including, cleansing of prosthesis and abutments		$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure		$30
D6082	Implant supported crown – porcelain fused to predominantly base alloys		$335
D6083	Implant supported crown – porcelain fused to noble alloys		$335
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys		$335
D6085	Provisional implant crown		$300
D6086	Implant supported crown – predominantly base alloys		$340
D6087	Implant supported crown – noble alloys		$340
D6088	Implant supported crown – titanium and titanium alloys		$340
D6090	Repair implant supported prosthesis, by report		$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment		$40
D6092	Re-cement or re-bond implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.	$25
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	not a Benefit within 12 months of a previous recementation by the same provider.	$35
D6094	Abutment supported crown – titanium and titanium alloys		$295
D6095	Repair implant abutment, by report		$65
D6096	Remove broken implant retaining screw		$60
D6097	Abutement supported crown – porcelain fused to titanium and titanium alloys		$315
D6098	Implant supported retainer – porcelain fused to predominantly base alloys		$330

Code	Description	Limitation	Cost Share
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys		$330
D6100	Implant removal, by report		$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary		$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular		$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary		$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular		$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary		$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular		$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary		$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular		$350
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys		$330
D6121	Implant supported retainer for metal FPD – predominantly base alloys		$350
D6122	Implant supported retainer for metal FPD – noble alloys		$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys		$350
D6190	Radiographic/surgical implant index, by report		$75
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys		$265
D6195	Abutement supported retainer – porcelain fused to titanium and titanium alloys		$315
D6199	Unspecified implant procedure, by report		$350
Prosthodontics, fixed Procedures (D6200-D6999)			
D6205	Pontic – indirect resin based composite	not a Benefit.	Not Covered
D6210	Pontic – cast high noble metal	not a Benefit.	Not Covered
D6211	Pontic – cast predominately base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300

Code	Description	Limitation	Cost Share
D6212	Pontic – cast noble metal	not a Benefit.	Not Covered
D6214	Pontic – titanium and titanium alloys	not a Benefit.	Not Covered
D6240	Pontic – porcelain fused to high noble metal	not a Benefit.	Not Covered
D6241	Pontic – porcelain fused to predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300
D6242	Pontic – porcelain fused to noble metal	not a Benefit.	Not Covered
D6243	Pontic – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered
D6245	Pontic – porcelain/ceramic	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300
D6250	Pontic – resin with high noble metal	not a Benefit.	Not Covered
D6251	Pontic – resin with predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.	$300

Code	Description	Limitation	Cost Share
D6252	Pontic – resin with noble metal	not a Benefit.	Not Covered
D6545	Retainer – cast metal for resin bonded fixed prosthesis	not a Benefit.	Not Covered
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	not a Benefit.	Not Covered
D6549	Retainer – for resin bonded fixed prosthesis	not a Benefit.	Not Covered
D6608	Retainer onlay – porcelain/ceramic, two surfaces	not a Benefit.	Not Covered
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	not a Benefit.	Not Covered
D6610	Retainer onlay – cast high noble metal, two surfaces	not a Benefit.	Not Covered
D6611	Retainer onlay – cast high noble metal, three or more surfaces	not a Benefit.	Not Covered
D6612	Retainer onlay – cast predominantly base metal, two surfaces	not a Benefit.	Not Covered
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	not a Benefit.	Not Covered
D6614	Retainer onlay – cast noble metal, two surfaces	not a Benefit.	Not Covered
D6615	Retainer onlay – cast noble metal, three or more surfaces	not a Benefit.	Not Covered
D6634	Retainer onlay – titanium	not a Benefit.	Not Covered
D6710	Retainer crown – indirect resin based composite	not a Benefit.	Not Covered
D6720	Retainer crown – resin with high noble metal	not a Benefit.	Not Covered
D6721	Retainer crown – resin with predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6722	Retainer crown – resin with noble metal	not a Benefit.	Not Covered
D6740	Retainer crown – porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6750	Retainer crown – porcelain fused to high noble metal	not a Benefit.	Not Covered
D6751	Retainer crown – porcelain fused to predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6752	Retainer crown – porcelain fused to noble metal	not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	not a Benefit.	Not Covered
D6781	Retainer crown – 3/4 cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6782	Retainer crown – 3/4 cast noble metal	not a Benefit.	Not Covered
D6783	Retainer crown – 3/4 porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6784	Retainer crown – 3/4 titanium and titanium alloys	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6791	Retainer crown – full cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.	$300
D6794	Retainer crown – titanium and titanium alloys	not a Benefit.	Not Covered
D6930	Re-cement or re-bond fixed partial denture	The original provider is responsible for all re- cementations within the first 12 months following the initial placement of a fixed partial denture. Not a Benefit within 12 months of a previous re- cementation by the same provider.	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	not a Benefit within 12 months of initial placement or previous repair, same provider.	$95
D6999	Unspecified fixed prosthodontic procedure, by report		$350
Oral Maxillofacial Prosthetics Procedures (D7000-D7999)			
D7111	Extraction, coronal remnants – deciduous tooth	not a Benefit for asymptomatic teeth.	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	not a Benefit when removed by the same provider who performed the initial tooth extraction.	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	a Benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.	$120
D7220	Removal of impacted tooth – soft tissue	a Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.	$95
D7230	Removal of impacted tooth – partially bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.	$145
D7240	Removal of impacted tooth – completely bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.	$160

Code	Description	Limitation	Cost Share
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.	$175
D7250	Removal of residual tooth roots (cutting procedure)	a Benefit when the root is completely covered by alveolar bone. Not a Benefit to the same provider who performed the initial tooth extraction.	$80
D7260	Oroantral fistula closure	a Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.	$280
D7261	Primary closure of a sinus perforation	a Benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	once per arch regardless of the number of teeth involved and for permanent anterior teeth only.	$185
D7280	Exposure of an unerupted tooth	not a Benefit: a. for Members age 19 or older, or b. for 3rd molars.	$220
D7283	Placement of device to facilitate eruption of impacted tooth	only for Members in active orthodontic treatment. Not a Benefit: a. for Members age 19 years or older; and b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.	$85
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	for the removal of the specimen only and once per arch, per date of service regardless of the areas involved. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.	$180
D7286	Incisional biopsy of oral tissue – soft	for the removal of the specimen only and up to a maximum of 3 per date of service. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous	$110
D7287	Exfoliative cytological sample collection	not a Benefit.	Not Covered
D7288	Brush biopsy - transepithelial sample collection	not a Benefit.	Not Covered
D7290	Surgical repositioning of teeth	for permanent teeth only; once per arch; and only for Members in active orthodontic treatment.	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	once per arch and only for Members in active orthodontic treatment.	$80
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$50

Code	Description	Limitation	Cost Share
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	a Benefit regardless of the number of teeth or tooth spaces.	$120
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	once in a 5 year period per arch.	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch. Not a Benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; and b. on the same date of service with extractions (D7111- D7250) same arch.	$350
D7410	Excision of benign lesion up to 1.25 cm		$75
D7411	Excision of benign lesion greater than 1.25 cm		$115
D7412	Excision of benign lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	$175
D7413	Excision of malignant lesion up to 1.25 cm		$95
D7414	Excision of malignant lesion greater than 1.25 cm		$120
D7415	Excision of malignant lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm		$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm		$185
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		$180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		$250
D7465	Destruction of lesion(s) by physical or chemical method, by report		$40
D7471	Removal of lateral exostosis (maxilla or mandible)	once per quadrant and for the removal of buccal or facial exostosis only.	$140
D7472	Removal of torus palatinus	once in the Member's lifetime.	$145
D7473	Removal of torus mandibularis	once per quadrant.	$140
D7485	Reduction of osseous tuberosity	once per quadrant.	$105
D7490	Radical resection of maxilla or mandible		$350
D7510	Incision and drainage of abscess – intraoral soft tissue	once per quadrant, same date of service.	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	once per quadrant, same date of service.	$70
D7520	Incision and drainage of abscess – extraoral soft tissue		$70

Code	Description	Limitation	Cost Share
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111-D7250).	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111-D7250).	$75
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per quadrant per date of service and only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a Benefit within 30 days of an associated extraction (D7111-D7250).	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket.	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)		$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)		$250
D7630	Mandible – open reduction (teeth immobilized, if present)		$350
D7640	Mandible – closed reduction (teeth immobilized, if present)		$350
D7650	Malar and/or zygomatic arch – open reduction		$350
D7660	Malar and/or zygomatic arch – closed reduction		$350
D7670	Alveolus – closed reduction, may include stabilization of teeth		$170
D7671	Alveolus – open reduction, may include stabilization of teeth		$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	for the treatment of simple fractures only.	$350
D7710	Maxilla – open reduction		$110
D7720	Maxilla – closed reduction		$180
D7730	Mandible – open reduction		$350
D7740	Mandible – closed reduction		$290
D7750	Malar and/or zygomatic arch – open reduction		$220
D7760	Malar and/or zygomatic arch – closed reduction		$350
D7770	Alveolus – open reduction stabilization of teeth		$135
D7771	Alveolus, closed reduction stabilization of teeth		$160
D7780	Facial bones – complicated reduction with fixation and multiple approaches	for the treatment of compound fractures only.	$350
D7810	Open reduction of dislocation		$350
D7820	Closed reduction of dislocation		$80
D7830	Manipulation under anesthesia		$85
D7840	Condylectomy		$350
D7850	Surgical discectomy, with/without implant		$350
D7852	Disc repair		$350

Code	Description	Limitation	Cost Share
D7854	Synovectomy		$350
D7856	Myotomy		$350
D7858	Joint reconstruction		$350
D7860	Arthrotomy		$350
D7865	Arthroplasty		$350
D7870	Arthrocentesis		$90
D7871	Non-arthroscopic lysis and lavage		$150
D7872	Arthroscopy – diagnosis, with or without biopsy		$350
D7873	Arthroscopy – lavage and lysis of adhesions		$350
D7874	Arthroscopy – disc repositioning and stabilization		$350
D7875	Arthroscopy – synovectomy		$350
D7876	Arthroscopy – discectomy		$350
D7877	Arthroscopy – debridement		$350
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.	$120
D7881	Occlusal orthotic device adjustment		$30
D7899	Unspecified TMD therapy, by report	not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.	$350
D7910	Suture of recent small wounds up to 5 cm	not a Benefit for the closure of surgical incisions.	$35
D7911	Complicated suture – up to 5 cm	not a Benefit for the closure of surgical incisions.	$55
D7912	Complicated suture – greater than 5 cm	not a Benefit for the closure of surgical incisions.	$130
D7920	Skin graft (identify defect covered, location and type of graft)	not a Benefit for periodontal grafting.	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site		$80
D7940	Osteoplasty – for orthognathic deformities		$160
D7941	Osteotomy – mandibular rami		$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		$350
D7944	Osteotomy – segmented or subapical		$275
D7945	Osteotomy – body of mandible		$350
D7946	LeFort I (maxilla – total)		$350
D7947	LeFort I (maxilla – segmented)		$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft		$350
D7949	LeFort II or LeFort III – with bone graft		$350
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	not a Benefit for periodontal grafting.	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	only for Members with authorized implant services.	$290
D7952	Sinus augmentation via a vertical approach	only for Members with authorized implant services.	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	not a Benefit for periodontal grafting.	$200

Code	Description	Limitation	Cost Share
D7960	Frenulectomy also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	once per arch per date of service and only when the permanent incisors and cuspids have erupted.	$120
D7963	Frenuloplasty	once per arch per date of service and only when the permanent incisors and cuspids have erupted. Not a Benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.	$120
D7970	Excision of hyperplastic tissue – per arch	once per arch per date of service.	$175
D7971	Excision of pericoronal gingiva		$80
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.	$100
D7979	Non-surgical Sialolithotomy		$155
D7980	Sialolithotomy		$155
D7981	Excision of salivary gland, by report		$120
D7982	Sialodochoplasty		$215
D7983	Closure of salivary fistula		$140
D7990	Emergency tracheotomy		$350
D7991	Coronoidectomy		$345
D7995	Synthetic graft – mandible or facial bones, by report	not a Benefit for periodontal grafting.	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers.	$60
D7999	Unspecified oral surgery procedure, by report		$350
Orthodontics Procedures (D8000-D8999)			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).	$1,000
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.	
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.	
D8660	Pre-orthodontic treatment examination to monitor growth and development	once every 3 months for a maximum of 6 and must be done prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.	
D8670	Periodic orthodontic treatment visit – handicapping malocclusion	once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).	
D8670	Periodic orthodontic treatment visit cleft palate – primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).	

Code	Description	Limitation	Cost Share
D8670	Periodic orthodontic treatment visit cleft palate – mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).	
D8670	Periodic orthodontic treatment visit cleft palate – permanent dentition	up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity)	
D8670	Periodic orthodontic treatment visit facial growth management – primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).	
D8670	Periodic orthodontic treatment visit facial growth management – mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).	
D8670	Periodic orthodontic treatment visit facial growth management – permanent dentition	up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).	
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance - maxillary	once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8697	Repair of orthodontic appliance – mandibular	once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8698	Re-cement or re-bond fixed retainer – maxillary	once per provider.	
D8699	Re-cement or re-bond fixed retainer – mandibular	once per provider.	
D8701	Repair of fixed retainer, includes reattachment – maxillary		
D8702	Repair of fixed retainer, includes reattachment – mandibular		
D8703	Replacement of lost or broken retainer – maxillary	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).	
D8704	Replacement of lost or broken retainer – mandibular	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).	
D8999	Unspecified orthodontic procedure, by report		

Code	Description	Limitation	Cost Share
Adjunctive General Services Procedures (D9000-D9999)			
D9110	Palliative (emergency) treatment of dental pain – minor procedure	once per date of service per provider regardless of the number of teeth and/or areas treated. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.	$30
D9120	Fixed partial denture sectioning	a Benefit when at least one of the abutment teeth is to be retained.	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures	once per date of service per provider and only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.	$10
D9211	Regional block anesthesia		$20
D9212	Trigeminal division block anesthesia		$60
D9215	Local anesthesia in conjunction with operative or surgical procedures		$15
D9222	Deep sedation/analgesia - first 15 minutes	Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$45
D9223	Deep sedation/general anesthesia – each 15 minute increment		$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$15
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes	Not a benefit: a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$60

Code	Description	Limitation	Cost Share
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$60
D9248	Non-intravenous conscious sedation	once per date of service; for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9243); and b. when all associated procedures on the same date of service by the same provider are denied.	$65
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		$50
D9311	Consultation with a medical health professional		No Charge
D9410	House/extended care facility call	once per Member per date of service and only in conjunction with procedures that are payable.	$50
D9420	Hospital or ambulatory surgical center call	a Benefit for each hour or fraction thereof as documented on the operative report.	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	once per date of service per provider. Not a Benefit: a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service; and b. for visits to Members residing in a house/ extended care facility.	$20
D9440	Office visit – after regularly scheduled hours	once per date of service per provider and only with treatment that is a Benefit.	$45
D9450	Case presentation, detailed and extensive treatment planning	not a Benefit.	Not Covered
D9610	Therapeutic parenteral drug, single administration	up to a maximum of 4 injections per date of service. Not a Benefit: a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.	$30
D9612	Therapeutic parenteral drugs, two or more administrations, different medications		$40

Code	Description	Limitation	Cost Share
D9910	Application of desensitizing medicament	once in a 12 month period per provider and for permanent teeth only.	$20
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; and for the removal of bony fragments within 30 days of the date of service of an extraction. Not a Benefit: a. for the removal of bony fragments on the same date of service as an extraction; and b. for routine post- operative visits.	$35
D9942	Repair and/or reline of occlusal guard	not a Benefit.	Not Covered
D9943	Occlusal guard adjustment	not a Benefit.	Not Covered
D9944	Occlusal guard – hard appliance, full arch	not a Benefit.	Not Covered
D9945	Occlusal guard – soft appliance, full arch	not a Benefit.	Not Covered
D9946	Occlusal guard – hard appliance, partial arch	not a Benefit.	Not Covered
D9950	Occlusion analysis – mounted case	once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ dysfunction only; and for permanent dentition. Not a Benefit for bruxism only.	$120
D9951	Occlusal adjustment – limited	once in a 12 month period per quadrant per provider; for Members age 13 and older; and for natural teeth only. Not a Benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.	$45
D9952	Occlusal adjustment – complete	once in a 12 month period following occlusion analysis-mounted case (D9950); for Members age 13 and older; for diagnosed TMJ dysfunction only; and for permanent dentition.	$210
D9995	Teledentistry – synchronous; real-time encounter	not a Benefit.	Not Covered
D9996	Teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review	not a Benefit.	Not Covered
D9997	Dental case management – patients with special health care needs		No Charge
D9999	Unspecified adjunctive procedure, by report		No Charge

Pediatric Vision Benefits

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

Principal Benefits and Coverages for Pediatric Vision Benefits

Blue Shield will pay for Covered Services rendered by VPA Participating Providers as indicated in the Summary of Benefits.

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

1) One comprehensive eye examination in a Calendar Year. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, a determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in the presence of trauma or severe inflammation. In addition, it includes dilation if professionally indicated.

   When contact lenses are selected in lieu of eyeglasses, the comprehensive examination Benefit and Allowance covers in full the fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses or standard Elective Contact Lenses by VPA Participating Providers. For non-standard specialty contact lenses (including, but not limited to, toric, multifocal and gas permeable lenses), the comprehensive examination Benefit and Allowance covers the fitting and evaluation equal to the standard contact lenses fitting and evaluation by VPA Participating Providers. The Member is responsible for the difference between the amount Blue Shield pays and the amount billed by the VPA Participating Provider.

2) One of the following in a Calendar Year:

   a. One pair of spectacle lenses which include choice of glass, plastic or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, and oversized and glass-grey #3 prescription sunglass lenses (Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters),

   b. Elective Contact Lenses (for cosmetic reasons or for convenience), or

   c. Non-Elective (Medically Necessary) Contact Lenses, which are lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus, 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) astigmatism (over 3 diopters), or other conditions as listed in the definition of Non-Elective Contact Lenses.

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

3) One frame in a Calendar Year.

4) The need for Low Vision Testing is triggered during a comprehensive eye exam. This exam may only be obtained from VPA Participating Providers and only once in a consecutive five

Calendar Year period. VPA Participating Providers specializing in low vision care may prescribe optical devices, such as high-power spectacles, magnifiers and telescopes, to maximize the remaining usable vision. One aid per Calendar Year is covered. A report from the provider conducting the initial examination and prior authorization from the VPA is required for both the exam and any prescribed device. Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200.

5) One diabetic management referral per calendar year to a Blue Shield disease management program. The contracted VPA will notify Blue Shield's disease management program subsequent to the annual comprehensive eye exam, when the Member is known to have or be at risk for diabetes.

Important Information about Pediatric Vision Benefits

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

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

Exclusions for Pediatric Vision Benefits

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

1) orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;

2) replacement or repair of lost or broken lenses or frames, except as provided under this Evidence of Coverage;

3) any eye examination required by the employer as a condition of employment;

4) medical or surgical treatment of the eyes (see the *Ambulatory Surgery Center Benefits, Hospital Benefits (Facility Services)* and *Professional Benefits* sections of the Evidence of Coverage);

5) contact lenses, except as specifically provided under this Evidence of Coverage and in the Summary of Benefits;

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

Payment of Benefits for Pediatric Vision Benefits

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

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

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

Choice of Providers for Pediatric Vision Benefits

Members must select a participating ophthalmologist, optometrist, or optician to provide Covered Services under this pediatric vision benefit. A list of VPA Participating Providers in the Member's local area can be obtained by contacting the VPA at 1-877-601-9083.

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

The Subscriber may also obtain a list of VPA Participating Providers online at www.blueshieldca.com.

Time and Payment of Claims

Claims will be paid promptly upon receipt of written proof and determination that Benefits are payable.

Payment of Claims

VPA Participating Providers will submit a claim for Covered Services on line or by claim form obtained from the VPA and are paid directly by Blue Shield of California.

Eligibility Requirements for Pediatric Vision Benefits

The Member must be actively enrolled in this health plan and must be under the age of 19.

Customer Service for Pediatric Vision Benefits

For questions about these pediatric vision Benefits, information about pediatric vision providers, pediatric vision services, or to discuss concerns regarding the quality of care or access to care experienced, the Subscriber may contact:

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

The Subscriber may also contact the VPA at the following telephone numbers:

1-714-619-4660 or
1-877-601-9083

The VPA has established a procedure for Subscribers to request an expedited authorization decision. A Subscriber, Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The VPA shall make a decision and notify the Subscriber and Physician as soon as possible to accommodate the Member's condition, not to exceed 72 hours following the receipt of the request. For additional information regarding the expedited decision process, or if the Subscriber believes a particular situation qualifies for an expedited decision, please contact the VPA Customer Service Department at the number listed above.

Grievance Process for Pediatric Vision Benefits

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

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the Vision Customer Service Department. If the Subscriber wishes, the Vision Customer Service staff will assist in completing

the grievance form. Completed grievance forms should be mailed to the Vision Plan Administrator at the address provided below. The Subscriber may also submit the grievance to the Vision Customer Service Department online at www.blueshieldca.com.

1-877-601-9083
Vision Plan Administrator
P. O. Box 25208
Santa Ana, CA 92799-5208

The Vision Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Shield Concierge section for information on the expedited decision process.

Definitions for Pediatric Vision Benefits

Elective Contact Lenses — prescription lenses that are chosen for cosmetic or convenience purposes. Elective Contact Lenses are not medically necessary

Non-Elective (Medically Necessary) Contact Lenses — lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Contact lenses may also be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Prescription Change – any of the following:

1) change in prescription of 0.50 diopter or more; or
2) shift in axis of astigmatism of 15 degrees; or
3) difference in vertical prism greater than 1 prism diopter; or
4) change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

Vision Plan Administrator (VPA) – Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered under this Benefit through a network of VPA Participating Providers.

VPA Participating Provider – For purposes of this pediatric vision Benefit, VPA participating provider refers to a provider that has contracted with the VPA to provide vision services to Blue Shield Members.

Urgent Services Benefits

To receive urgent care within your Primary Care Physician Service Area, call your Primary Care Physician's office or follow instructions given by your assigned Medical Group/IPA in accordance with the *How to Use This Health Plan* section.

When outside the Plan Service Area, Members may receive care for Urgent Services as follows:

Inside California

For Urgent Services within California but outside the Member's Primary Care Physician Service Area, the Member should, if possible, contact Blue Shield Member Services at the number provided on the back page of this booklet in accordance with the *How to Use This Health Plan* section. Member Services will assist Members in receiving Urgent Services through a Blue Shield of California provider. Members may also locate a Plan Provider by visiting Blue Shield's internet site at www.blueshieldca.com. You are not required to use a Blue Shield of California provider to receive Urgent Services; you may use any provider. However, the services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services.

Outside California or the United States

When temporarily traveling outside California, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard or Blue Shield Global Core Participating Provider. When a BlueCard or Blue Shield Global Core Participating Provider is available, you should obtain Urgent Services and Out-of-Area Follow-up Care

from a Participating Provider whenever possible, but you may also receive care from a non-Participating Provider. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services.

For information on Urgent Services received outside of California see the *Inter-Plan Arrangements* section of the EOC.

Up to two Medically Necessary Out-of-Area Follow-up Care outpatient visits are covered. Authorization by Blue Shield is required for more than two follow-up outpatient visits. Blue Shield may direct the Member to receive the additional follow-up care from their Primary Care Physician.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

1) routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

2) for hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;

3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under *Orthotics Benefits* and *Diabetes Care Benefits;* bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;

4) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided *under Hospice Program Benefits*;

5) Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency;

6) prescription and non-prescription food and nutritional supplements, except as provided under *Home Infusion/Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Products Benefits,* or as provided through a Participating Hospice Agency;

7) hearing aid instruments, examinations for the appropriate type of hearing aid, device checks, electroacoustic evaluation for hearing aids and other ancillary equipment;

8) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;

9) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

10) 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 dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the *Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits* and *Hospital Benefits (Facility Services);*

12) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that

are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Pediatric Dental Benefits and Hospital Benefits (Facility Services);

13) Cosmetic Surgery except for the Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages);

14) for Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

15) for sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

16) any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services of procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm,any type of artificial insemination, services or medications to treat low sperm count, services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield Health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure;

17) home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

18) genetic testing except as described in the sections on Outpatient X-ray, Imaging, Pathology and Laboratory Benefits and the Pregnancy and Maternity Care Benefits;

19) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by non-Plan Providers;

20) services performed in a Hospital by house officers, residents, interns, and other professionals in training without the supervision of an attending physician in association with an accredited clinical education program;

21) services performed by a Close Relative or by a person who ordinarily resides in the Member's home;

22) services (except for services received under the Behavioral Health Treatment benefit under *Mental Health, Behavioral Health, and Substance Use Disorder Benefits)* provided by an individual or entity that:
- is not appropriately licensed or certified by the state to provide health care services;
- is not operating within the scope of such license or certification; or
- does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform the laboratory testing services;

23) massage therapy that is not Physical Therapy or a component of a multiple-modality Rehabilitative Services treatment plan;

24) for or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under *Diabetes Care Benefits or Preventive Health Services.* This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

25) learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclusion shall not apply to Medically Necessary services which Blue Shield is required by law to cover for Severe Mental Illnesses or Serious Emotional Disturbances of a Child;

26) services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under *Clinical Trial for Treatment of Cancer or Life-Threatening Diseases or Conditions Benefits;*

27) drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

28) 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 *Preventive Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits,* and *Prosthetic Appliances Benefits;*

29) patient convenience items such as telephone, television, guest trays, and personal hygiene items;

30) for disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the *Durable Medical Equipment Benefits, Home Health Care, Hospice Program Benefits,* or the *Outpatient Prescription Drug Benefits.*

31) services for which the Member is not legally obligated to pay, or for services for which no charge is made;

32) services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease; and

33) for spinal manipulation and adjustment, except as specifically provided under *Professional Benefits* (other than for *Mental Health, Behavioral Health, and Substance Use Disorder Benefits)* in the Plan Benefits section;

34) transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van);

35) for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Trio+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Primary Care Physician, Emergency Services

or Urgent Services as provided under *Emergency Room Benefits* and *Urgent Services Benefits* in the Plan Benefits section;

36) for inpatient and Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services unless authorized by the MHSA;

37) Drugs dispensed by a Physician or Physician's office for outpatient use; and

See the Grievance Process for information on filing a grievance, the Member's right to seek assistance from the Department of Managed Health Care, and the Member's right to independent medical review.

Medical Necessity Exclusion

The Benefits of this Plan are provided only for services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary and may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

Limitations for Duplicate Coverage

Medicare Eligible Members

1) Blue Shield will provide benefits before Medicare in the following situations:
   a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payer laws).
   b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payer laws).
   c. When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
2) Blue Shield will provide benefits after Medicare in the following situations:
   a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payer laws).
   b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payer laws).
   c. When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
   d. When the Member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

If the Member is a qualified veteran Blue Shield will pay the reasonable value or Blue Shield's Allowed Charges for Covered Services provided at a Veterans Administration facility for a condition that is not related to military service. If the Member is a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or Blue Shield's Allowed Charges for Covered Services provided at a Department of Defense facility, even if provided for conditions related to military service.

Members Covered by Another Government Agency

If the Member is entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and this Blue Shield group plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowed Charges).

Contact Shield Concierge for any questions about how Blue Shield coordinates group plan benefits in the above situations.

Exception for Other Coverage

A Plan Provider may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under this Plan.

Claims and Services Review

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

Reductions - Third Party Liability

If another person or entity, through an act or omission, causes a Member to suffer an injury or illness, and if Blue Shield paid Benefits for that injury or illness, the Member must agree to the provisions listed below. In addition, if the Member is injured and no other person is responsible but the Member receives (or is entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, the Member must agree to the following provisions.

1) All recoveries the Member or his or her representatives obtain (whether by lawsuit, settlement, insurance or otherwise), no matter how described or designated, must be used to reimburse Blue Shield in full for benefits Blue Shield paid. Blue Shield's share of any recovery extends only to the amount of Benefits it has paid or will pay the Member or the Member's representatives. For purposes of this provision, Member's representatives include, if applicable, the Member's heirs, administrators, legal representatives, parents (if the Member is a minor), successors or assignees. This is Blue Shield's right of recovery.
2) Blue Shield is entitled under its right of recovery to be reimbursed for its Benefit payments even if the Member is not "made whole" for all of his or her damages in the recoveries that the Member receives. Blue Shield's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
3) Blue Shield will not reduce its share of any recovery unless, in the exercise of Blue Shield's discretion, Blue Shield agrees in writing to a reduction (a) because the Member does not receive the full amount of damages that the Member claimed or (2) because the Member had to pay attorneys' fees.
4) The Member must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. The Member must not take any action that may prejudice Blue Shield's right of recovery.

If the Member does seek damages for his or her illness or injury, the Member must tell Blue Shield promptly that the Member has made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for, the Member must seek recovery of Blue Shield's Benefit payments and liabilities, and the Member must tell Blue Shield about any recoveries the Member obtains, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of the Member's claim in order to reimburse Blue Shield to the full amount of Benefits Blue Shield has paid or will pay. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code Section 3040.

Blue Shield may request that the Member sign a reimbursement agreement consistent with this provision.

Further, if the Member receives services from a participating Hospital for such injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by Blue Shield

and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

IF THIS PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"), THE MEMBER IS ALSO REQUIRED TO DO THE FOLLOWING:

1) Ensure that any recovery is kept separate from and not comingled with any other funds or the Member's general assets and agree in writing that the portion of any recovery required to satisfy the lien or other right of Recovery of Blue Shield is held in trust for the sole benefit of Blue Shield until such time it is conveyed to Blue Shield;

2) Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the recovery to which Blue Shield is entitled in trust for the sole benefit of Blue Shield and to comply with and facilitate the reimbursement to the plan of the monies owed it.

Coordination of Benefits

Coordination of benefits (COB) is utilized when a Member is covered by more than one group health plan. Payments for allowable expenses will be coordinated between the two plans up to the maximum benefit amount payable by each plan separately. Coordination of benefits ensures that benefits paid by multiple group health plans do not exceed 100% of allowable expenses. The coordination of benefits rules also provide consistency in determining which group health plan is primary and avoid delays in benefit payments. Blue Shield follows the rules for coordination of benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13 to determine the order of benefit payments between two group health plans. The following is a summary of those rules.

1) When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering the Member as an employee will provide its benefits before the plan covering the Member as a Dependent.

2) Coverage for dependent children:

   a. When the parents are not divorced or separated, the plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

   b. When the parents are divorced and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, the plan of the responsible parent is primary.

   c. When the parents are divorced or separated, there is no court decree, and the parent with custody has not remarried, the plan of the custodial parent is primary.

   d. When the parents are divorced or separated, there is no court decree, and the parent with custody has remarried, the order of payment is as follows:

      i. The plan of the custodial parent

      ii. The plan of the stepparent

      iii. The plan of the non-custodial parent.

3) If the above rules do not apply, the plan which has covered the Member for the longer period of time is the primary plan. There may be exceptions for laid-off or retired employees.

4) When Blue Shield is the primary plan, Benefits will be provided without considering the other group health plan. When Blue Shield is the secondary plan and there is a dispute as to which plan is primary, or the primary plan has not paid within a reasonable period of time, Blue Shield will provide Benefits as if it were the primary plan.

5) Anytime Blue Shield makes payments over the amount they should have paid as the primary or secondary plan, Blue Shield reserves the right to recover the excess payments from the other plan or any person to whom such payments were made.

These coordination of benefits rules do not apply to the programs included in the *Limitation for Duplicate Coverage* section.

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

Conditions of Coverage

Eligibility and Enrollment

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by CCSB. In order to enroll in a Trio HMO CCSB Plan, the Employee must live or work in the Trio HMO CCSB Plan Service Area. To learn about the eligibility requirements for this health Plan, please contact the CCSB or the Subscriber's Employer. Eligibility determinations made by the CCSB can be appealed.

An Employee or the Employee's Dependents may enroll when newly qualified as an eligible Employee or during the Employer's annual Open Enrollment Period. Under certain circumstances, an Employee and Dependents may qualify for a Special Enrollment Period. Other than the initial opportunity to enroll, the Employer's annual Open Enrollment period, or a Special Enrollment Period, an Employee or Dependent may not enroll in the health plan offered by the Employer through CCSB.

Please see the definition of Late Enrollee and Special Enrollment Period in the *Definitions* section for details on these rights. For additional information on enrollment periods, please contact CCSB or Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be covered immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by the CCSB within 30 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact the CCSB to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their eligibility under this health plan solely because of age, may be eligible for coverage if they continue to meet the definition of Dependent.

Because eligibility to enroll in this Plan is based on the Employer's participation in CCSB, coverage under this plan will terminate when the Employer ceases to be an Eligible Employer. Employees will receive notice of this termination from CCSB before it becomes effective, and, at that time, will be provided with information about other potential sources of coverage, including access to individual coverage through Covered California.

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

Effective Date of Coverage

Blue Shield will notify the Eligible Employee/Subscriber of the effective date of coverage for the Employee and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the effective date.

Dependents may be enrolled within 31 days of the Employee's eligibility date to have the same effective date of coverage as the Employee. If the Employee or Dependent is considered a Late Enrollee, coverage will become effective the earlier of 12 months from the date a written request for coverage is made or at the Employer's next Open Enrollment Period. CCSB will not consider applications for earlier effective dates unless the Employee or Dependent qualifies for a Special Enrollment Period.

In general, if the Employee or Dependents are Late Enrollees who qualify for a Special Enrollment Period, and the Premium payment is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first day of the month after receipt of payment. If the Premium payment is delivered or postmarked after the 15th of the month, coverage will be effective on the first day of the second month after receipt of payment.

However, if the Late Enrollee qualifies for a Special Enrollment Period as a result of a birth, adoption, foster care, guardianship, marriage or Domestic Partnership and enrollment is requested by the Employee within 60 days of the event, the effective date of enrollment will be as follows:

1) For the case of a birth, adoption, placement for adoption, placement in foster care, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for adoption, placement in foster care or court order of guardianship. If requested by the Subscriber, coverage shall be effective on the first day of the month following the date of birth, adoption, placement for adoption, placement in foster care or court order of guardianship.
2) For marriage or Domestic Partnership the coverage shall be effective on the date of the establishment of marriage or domestic partnership.

Premiums (Dues)

The monthly Premiums for a Subscriber and any enrolled Dependents are stated in the Contract. CCSB will provide information regarding when the Premiums are due and when payments must be made for coverage to remain in effect.

All Premiums required for coverage for the Subscriber and Dependents will be paid by the Employer to CCSB, and CCSB will forward the Premiums to Blue Shield. Any amount the Subscriber must contribute is set by the Employer. The Employer's rates will remain the same during the Contract's term; the term is the 12-month period beginning with the Eligible Employer's effective date of coverage. The Employer will receive notice of changes in Premiums at least 60 days prior to the change. The Employer will notify the Subscriber immediately.

A Subscriber's contribution may change during the contract term (a) if the Employer changes the amount it requires its Employees to pay for coverage; (b) if the Subscriber adds or removes a Dependent from coverage; (c) if a Subscriber moves to a different geographic rating region, or (d) if a Subscriber joins the plan at a time other than during the annual Open Enrollment Period. Please check with CCSB or the Employer on when these contribution changes will take effect.

Grace Period

After payment of the first Premium, the Contractholder is entitled to a grace period of 30 days for the payment of any Premiums due. During this grace period, the Contract will remain in force. However, the Contractholder will be liable for payment of Premiums accruing during the period the Contract continues in force.

Plan Changes

The Benefits and terms of this health plan, including but not limited to, Covered Services, Deductible, Copayment, Coinsurance and annual Out-of-Pocket Maximum amounts, are subject to change at any time. Blue Shield will provide at least 60 days written notice of any such change to the Employer prior to renewal.

Benefits for services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

Renewal of Group Health Service Contract

This Contract has a 12-month term beginning with the eligible Employer's effective date of coverage. So long as the Employer continues to participate in CCSB, Employees and Dependents will have an annual Open Enrollment period of 30 days before the end of the term to make changes to their coverage. The Employer will give notice of the annual Open Enrollment period.

Blue Shield will offer to renew the Employer's Group Health Service Contract except in the following instances:

1) non-payment of Premiums;
2) fraud, misrepresentations or omissions;
3) failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4) termination of plan type by Blue Shield;
5) Employer relocates outside of California; or
6) Employer is an association and association membership ceases.
7) Employer is no longer eligible to purchase this coverage through CCSB.

Termination of Benefits (Cancellation and Rescission of Coverage)

Except as specifically provided under the Extension of Benefits provision, and, if applicable, the Continuation of Group Coverage provision, there is no right to receive Benefits of this health Plan following termination of a Member's coverage.

Cancellation at Member Request

The Member can cancel his or her coverage, including as a result of the Member obtaining other minimum essential coverage, at the end of each month providing his or her Employer with notice of such intent to terminate up to the last day of the month in which the termination is to be effective. If coverage is terminated at a Member's request, coverage will end on the last day of the month in which the notice is received or on a later date requested by the Member as long as that date is the last day of the month. If the Member is newly eligible for Medi-Cal, CHIP, or the Basic Health Plan (if a Basic Health Plan is operating in the service area of Covered California), the last day of coverage is the day before such coverage begins.

Cancellation of Member's Enrollment by CCSB or Blue Shield

The CCSB or Blue Shield may cancel a Member's coverage in this health plan in the following circumstances:

1) The Member is no longer eligible for coverage in this health plan.
2) Non-payment of Premiums by the Employer for coverage of the Member.
3) Termination or decertification of this health plan.
4) The Subscriber changes from one health plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective on the date reflected on the Notice of End of Coverage:

1) Providing false or misleading material information on the enrollment application or otherwise to CCSB, Employer or Blue Shield; see the Cancellation/Rescission for Fraud, or Intentional Misrepresentations of Material Fact provision;
2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
3) Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

If the Employer does not meet the applicable eligibility, participation and contribution requirements of the Contract, Blue Shield will cancel this coverage after 30 days' written notice to the Employer.

Any Premiums paid to Blue Shield for a period extending beyond the cancellation date will be refunded to the Employer. The Employer will be responsible to Blue Shield for unpaid Premiums prior to the date of cancellation.

Blue Shield will honor all claims for Covered Services provided prior to the effective date of cancellation.

See the *Cancellation and Rescission* provision for termination for fraud or intentional misrepresentations of material fact.

Cancellation by the Employer

This health plan may be cancelled by the Employer at any time provided written notice is given to CCSB, all Employees and Blue Shield. The last day of coverage shall be the end of the month in which the Employer provided notice of termination, if the Employer provides notice to the CCSB on or before the fifteenth of the month, or on a case-by-case basis an earlier date upon agreement between the Blue Shield and CCSB. If the Employer does not provide notice to CCSB on or before the fifteenth of the month, the last day of the month following the month in which the qualified employer gave notice of termination, or on a case-by-case basis an earlier date upon agreement between Blue Shield and CCSB.

Cancellation for Employer's Non-Payment of Premiums - Notices

Blue Shield or CCSB may cancel this health plan for non-payment of Premiums. If the Employer fails to pay the required Premiums when due, coverage will terminate pursuant to the rules established by CCSB.

The Employer will be liable for all Premiums accrued while this coverage continues in force including those accrued during the grace period. Blue Shield will send the Employer, enrolled Employees, and Dependents a Notice of End of Coverage no later than five calendar days after the date coverage ends.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to the Employer prior to any rescission. The Employer must provide enrolled Employees with a copy of the Notice of Cancellation, Rescission or Nonrenewal.

In the event the contract is rescinded or cancelled, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellation is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.

If a Member is hospitalized or undergoing treatment for an ongoing condition and the Contract is cancelled for any reason, including non-payment of Premiums, no Benefits will be provided unless the Member obtains an Extension of Benefits. (See the Extension of Benefits provision for more information.)

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents ends at 11:59 p.m. Pacific Time on the earliest of these dates: (1) the date the Employer Group Health Service Contract is discontinued; (2) the last day of the month in which the Subscriber's employment terminates, unless a different date has been agreed to between Blue Shield and the Employer; (3) the date as indicated in the Notice of End of Coverage that is sent to the Employer (see *Cancellation for Non-Payment of Premiums – Notices*); or (4) the last day of the month following the month in which notice is sent by CCSB that the Subscriber and Dependents are ineligible for coverage in CCSB except as provided below.

Even if a Subscriber remains covered, his Dependents' coverage may end if a Dependent become ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage ends on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage ends on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent. Coverage ends on the last day of the month in which the Dependent child becomes ineligible.

In addition, if a written application for the addition of a newborn or a child placed for adoption is not submitted to and received by Blue Shield within the 30 days following the Dependent's birth or placement for adoption, Benefits under this health plan for that child will end on the 31st day after the birth or placement for adoption at 11:59 p.m. Pacific Time.

If the Subscriber ceases work because of retirement, disability, leave of absence, temporary layoff, or termination, he or she should contact the Employer or contact CCSB for information on options for continued group coverage or individual options.

If the Employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave under the terms of such Act(s), a Subscriber's payment of Premiums will keep coverage in force for such period of time as specified in such Act(s). The Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Reinstatement

If the Subscriber had been making contributions toward coverage for the Subscriber and Dependents and voluntarily cancelled such coverage, he or she should contact the Employer regarding reinstatement

options. If reinstatement is not an option, the Subscriber may have a right to re-enroll if the Subscriber or Dependents qualify for a Special Enrollment Period (see Special Enrollment Periods in the Definitions section). The Subscriber or Dependents may also enroll during the annual Open Enrollment Period. Enrollment resulting from a Special Enrollment Period or annual Open Enrollment Period is not reinstatement and may result in a gap in coverage.

Extension of Benefits

If a Member becomes Totally Disabled while validly covered under this health plan and continues to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits, subject to all limitations and restrictions, for Covered Services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; or (3) the date on which a replacement carrier provides coverage to the Member.

No extension will be granted unless Blue Shield receives written certification of such Total Disability from a Physician within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Blue Shield.

Group Continuation Coverage

Please examine your options carefully before declining this coverage.

A Subscriber can continue his or her coverage under this group health plan when the Subscriber's Employer is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Subscriber's Employer should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member may elect to continue group coverage under this Plan if the Member would otherwise lose coverage because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare or has coverage under another group health plan. However, if Medicare entitlement or coverage under another group health plan arises after COBRA coverage begins, it will cease.

Qualifying Event

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

1) With respect to the Subscriber:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.
2) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children (children born to or placed for adoption with the Subscriber or Domestic Partner during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
   a. the death of the Subscriber; or
   b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
   c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or

d. the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or

e. the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

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

Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

3) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

Notification of a Qualifying Event

1) With respect to COBRA enrollees:

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

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

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

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

2) With respect to Cal-COBRA enrollees:

The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership or a child's loss of Dependent status under this plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will, within 14 days, provide written notice to the Member by first class mail of his or her right to continue group coverage under this plan. The Member must then give Blue Shield notice in writing of the Member's election of continuation coverage within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

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

If this plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

Duration and Extension of Group Continuation Coverage

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this plan for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than three years from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Subscriber elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

Notification Requirements

The Employer or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield for more information about continuation of coverage under Cal-COBRA. If the enrollee is eligible and chooses to continue coverage under Cal-COBRA, the enrollee must notify Blue Shield of their Cal-COBRA election at least 30 days before COBRA termination.

Payment of Premiums (Dues)

Premiums for the Member continuing coverage shall be 102 percent of the applicable group Premium rate if the Member is a COBRA enrollee, or 110 percent of the applicable group Premium rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the Premiums for months 19 through 29 shall be 150 percent of the applicable group Premium rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, Premiums for Cal-COBRA coverage shall be 110 percent of the applicable group Premium rate for months 30 through 36.

If the Member is enrolled in COBRA and is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all Premium contributions to Blue Shield in the manner and for the period established under this plan.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premium must be paid within 45 days of the date the Member provided written notification to the plan of the election to continue coverage and be sent to Blue Shield by first-class mail or other reliable means. The Premium payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify the Member from continuation coverage.

Effective Date of the Continuation of Coverage

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

Termination of Group Continuation Coverage

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

1) discontinuance of this Group Health Service Contract (if the Employer continues to provide any group benefit plan for employees, the Member may be able to continue coverage with another plan);
2) failure to timely and fully pay the amount of required Premiums to the COBRA administrator or the Employer or to Blue Shield as applicable. Coverage will end as of the end of the period for which Premiums were paid;
3) the Member becomes covered under another group health plan;
4) the Member becomes entitled to Medicare;
5) the Member commits fraud or deception in the use of the services of this plan.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

Continuation of Group Coverage for Members on Military Leave

Continuation of group coverage is available for Members on military leave if the Member's Employer is subject to the Uniformed Services Employment and Re-employment Rights Act (USERRA). Members who are planning to enter the Armed Forces should contact their Employer for information about their rights under the (USERRA). Employers are responsible to ensure compliance with this act and other state and federal laws regarding leaves of absence including the California Family Rights Act, the Family and Medical Leave Act, Labor Code requirements for Medical Disability.

General Provisions

Plan Service Area

The geographic area served by this Plan is defined as the Plan Service Area. Subscribers and Dependents must live or work within the prescribed Plan Service Area to enroll in this Plan and to maintain eligibility in this Plan. Please see the Plan Service Area chart at the back of this booklet for additional information on the geographic area served by this Plan. For specific information on the boundaries of the Plan Service Area members may call Shield Concierge at the number provided on the back page of this Evidence of Coverage.

Liability of Subscribers in the Event of Non-Payment by Blue Shield

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield and its Plan Providers stipulates that the Subscriber shall not be responsible to the Plan Provider for compensation for any services to the extent that they are provided in the Member's group contract. Plan Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments and Coinsurance, and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability.

If services are provided by a non-Plan provider, the Member is responsible for all amounts Blue Shield does not pay.

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

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar

charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

No Maximum Lifetime Benefits

There is no maximum limit on the aggregate payments made by Blue Shield for Covered Services provided under this Group Health Service Contract.

No Annual Dollar Limits on Essential Health Benefits

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

Payment of Providers

Blue Shield generally contracts with groups of Physicians to provide services to Members. A fixed, monthly fee is paid to the groups of Physicians for each Member whose Primary Care Physician is in the group. This payment system, capitation, includes incentives to the groups of Physicians to manage all services provided to Members in an appropriate manner consistent with the contract.

Members who want to know more about this payment system, may contact Shield Concierge at the number provided on the back page of this Evidence of Coverage or talk to their Plan Provider.

PLEASE READ THE FOLLOWING INFORMATION EXPLAINING FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Facilities

The Plan has established a network of Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners in the Member's Primary Care Physician Service Area.

The Primary Care Physician(s) the Subscriber and Dependents select will provide telephone access 24 hours a day, seven days a week so that Member's can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the plan network provide access to 24-hour Emergency Services. The list of the Hospitals, Physicians and Participating Hospice Agencies in the Member's Primary Care Physician Service Area indicates the location and phone numbers of these Providers. Contact Shield Concierge at the number provided on the back page of this Evidence of Coverage for information on Plan Non-Physician Health Care Practitioners in the Member's Primary Care Physician Service Area.

For Urgent Services when the Member is within the United States, simply call toll-free 1-800-810-BLUE (2583) 24 hours a day, seven days a week. For Urgent Services outside the United States, call collect 1-804-673-1177 24 hours a day. Blue Shield will identify the Member's closest BlueCard Program provider. Urgent Services when the Member is outside the BlueCard Service Area are available through the Blue Shield Global Core. For Urgent Services when the Member is within California, but outside of the Primary Care Physician Service Area, the Member should, if possible, contact Shield Concierge at the number provided on the back page of this Evidence of Coverage in accordance with the How to Use This Health Plan section. For urgent care services when the Member is within the Primary Care Physician Service Area, contact the Primary Care Physician or follow instructions provided by the Member's assigned Medical Group/IPA.

Independent Contractors

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

Non-Assignability

Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield. Possession of a Blue Shield ID card confers no right to services or other Benefits of this Plan. To be entitled to services, the Member must be a Subscriber, or Dependent who has been accepted by the Employer and enrolled by Blue Shield and who has maintained enrollment under the terms of this Contract.

Plan Providers are paid directly by Blue Shield or the Medical Group/IPA. The Member or the provider of service may not request that payment be made directly to any other party.

If the Member receives services from a non-Plan provider, payment will be made directly to the Subscriber, and the Subscriber is responsible for payment to the non-Plan provider. The Member or the provider of service may not request that the payment be made directly to the provider of service.

Plan Interpretation

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

Public Policy Participation Procedure

This procedure enables Members to participate in establishing the public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of Members who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, §1369).

At least one third of the Board of Directors of Blue Shield of California is comprised of Subscribers who are not Employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: 1-510-607-2065

Please follow the following procedure:

1) Recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of the letter.
2) Please include name, address, phone number, Subscriber number, and group number with each communication.
3) The public policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with the letter.
4) Public policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes within 10 business days after the minutes have been approved.

Confidentiality of Personal and Health Information

Blue Shield protects the privacy of individually identifiable personal information, including Protected Health Information. Individually identifiable personal information includes health, financial, and/or demographic information - such as name, address, and social security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Shield Concierge at the number listed in the back of this Evidence of Coverage, or by accessing Blue Shield's internet site at www.blueshieldca.com and printing a copy.

Members who are concerned that Blue Shield may have violated their privacy rights, or who disagree with a decision Blue Shield made about access to their individually identifiable personal information, may contact Blue Shield at:

Correspondence Address:

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

Access to Information

Blue Shield may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in their possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

Grievance Process

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

Medical Services

The Member, a designated representative, or a provider on behalf of the Member, may contact Shield Concierge by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the Plan at the telephone number as noted on the back page of this Evidence of Coverage. If the telephone inquiry to Shield Concierge does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Shield Concierge Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from Shield Concierge. The completed form should be submitted to Shield Concierge Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Member may also submit the grievance online by visiting our web site at www.blueshieldca.com.

For all grievances except denial of coverage for a Non-Formulary Drug: Blue Shield will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days. See the previous Shield Concierge section for information on the expedited decision process.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health care services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Shield Concierge.

For grievances due to denial of coverage for a Non-Formulary Drug: If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Shield Concierge.

For all grievances: The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction.

Mental Health, Behavioral Health, and Substance Use Disorder Services

Members, a designated representative, or a provider on behalf of the Member may contact the MHSA by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the MHSA at the telephone number provided below. If the telephone inquiry to

the MHSA's Customer Service Department does not resolve the question or issue to the Member's satisfaction, the Member may submit a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Department. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms must be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting www.blueshieldca.com.

1-877-263-9952
Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

The MHSA will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the Customer Service section for information on the expedited decision process.

If the grievance involves an MHSA Non-Participating Provider, the Member should contact Customer Service as shown on the back page of this Evidence of Coverage.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other health care services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE NOTE: If the Employer's group health Plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of the Member's claim have been completed and the claim has not been approved. Additionally, the Member and the Member's plan may have other voluntary alternative dispute resolution options, such as mediation.

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Shield Concierge. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures

or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Shield Concierge.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-844-515-9068** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website, **(www.dmhc.ca.gov)**, has complaint forms, IMR application forms, and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for the Subscriber or their Dependents and the Subscriber feels that such action was due to reasons of health or utilization of benefits, the Subscriber or their Dependents may request a review by the Department of Managed Health Care Director.

Shield Concierge

For questions about services, providers, Benefits, how to use this plan, or concerns regarding the quality of care or access to care, contact Shield Concierge. Shield Concierge can answer many questions over the telephone. Contact Information is provided on the last page of this Evidence of Coverage.

For all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, MHSA Participating Providers, or Mental Health, Behavioral Health, and Substance Use Disorder Benefits. Members may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952
Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

Definitions

When the following terms are capitalized in this Evidence of Coverage, they will have the meaning set forth 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 considered ADL.

Allowed Charges —

- For a Plan Provider: the amounts a Plan Provider agrees to accept as payment from Blue Shield.
- For a non-Plan Provider: the amounts paid by Blue Shield when services from a non-Plan Provider are covered and are paid as a Reasonable and Customary Charge.

Ambulatory Surgery Center — an Outpatient surgery facility which:

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

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

Anticancer Medications — Drugs used to kill or slow the growth of cancerous cells.

ASH Participating Provider— a Physician or Health Care Provider under contract with ASH Plans to provide Covered Services to Members.

Bariatric Surgery Services Provider — a contracting Hospital, Ambulatory Surgery Center, or a Physician that has been designated by Blue Shield to provide bariatric surgery services to Members who are residents of designated counties in California.

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

Benefits (Covered Services) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

BlueCard Service Area – the United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.

Blue Shield of California — a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this Evidence of Coverage, as Blue Shield.

Brand Drugs — Drugs which are FDA approved after a new drug application and/or registered under a brand or trade name by its manufacturer.

CCSB — Covered California for Small Business ("CCSB") operated by Covered California where an Eligible Employer can provide its employees and their Dependents with access to one or more health plans.

Calendar Year — the 12-month consecutive period beginning on January 1 and ending on December 31 of the same calendar year.

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

Coinsurance — the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Continuous Nursing Services — Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

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

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

Covered Services (Benefits) — those Medically Necessary supplies and services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Creditable Coverage —

1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or

similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2) The Medicare Program pursuant to Title XVIII of the Social Security Act.

3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as Medi-Cal in California).

4) Any other publicly sponsored program of medical, Hospital or surgical care, provided in this state or elsewhere.

5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq.

6) A medical care program of the Indian Health Service or of a tribal organization.

7) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.

8) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.

9) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).

10) Any other Creditable Coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial 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 Member 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 the Member must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Group Health Service Contract.

Dependent — an individual who is enrolled and maintains coverage under this Agreement, and who meets one of the following eligibility requirements, as:

1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.

2) A Dependent Domestic Partner is an individual is meets the definition of Domestic Partner as defined in this Agreement.

3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and

c. thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:

   i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

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

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

1) Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

2) The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

4) Both partners are capable of consenting to the domestic partnership; and

5) The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this Plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code).

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 individual's home is not available or is unsuitable.

Drugs — Drugs are:

1) FDA-approved medications that require a prescription either by California or Federal law;

2) Insulin;

3) Pen delivery systems for the administration of insulin, as Medically Necessary;

4) Diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets);

5) Over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;

6) Contraceptive drugs and devices, including:
   - diaphragms,
   - cervical caps,
   - contraceptive rings,
   - contraceptive patches,
   - oral contraceptives,
   - emergency contraceptives, and
   - female OTC contraceptive products when ordered by a Physician or Health Care Provider;

7) Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers.

Emergency Medical Condition (including a psychiatric emergency) — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Services — the following services provided for an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, and
2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the Member.

'Stabilize' means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

'Post-Stabilization Care' means Medically Necessary services received after the treating Physician determines the Emergency Medical Condition is stabilized.

Emergency Services will be reviewed retrospectively by Blue Shield to determine whether the services were for an Emergency Medical Condition. If the Member reasonably should have known that an Emergency Medical Condition did not exist, the services will not be covered.

Employee — an individual employed by an employer who has been deemed eligible by CCSB and who has been offered health insurance coverage by such Eligible Employer through CCSB.

Employer (Contractholder) — a small employer that has been deemed eligible by CCSB and elects to make, at a minimum, all full-time employees of such employer eligible for one or more health plans in the small group market offered through CCSB.

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

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Formulary — A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

Generic Drugs — Drugs that are approved by the Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug.

Group Health Service Contract (Contract) — the contract for health coverage between Blue Shield and the Employer (Contractholder) that establishes the Benefits that Subscribers and Dependents are entitled to receive.

Habilitative Services (Habilitation Services) — Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both.

Health Care Provider — An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor; optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

HMO Provider — a Medical Group or IPA, and all associated Physicians and Plan Specialists, that participate in the HMO Plan and for Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, an MHSA Participating Provider.

Home Health Aide — an individual who has successfully completed a state-approved training program, is employed by a home health agency or hospice program, and provides personal care services in the patient's home.

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

Hospital — an entity which is:

1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and which provides 24-hour a day nursing service by registered nurses; or
2) a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

A facility which is principally a rest home, nursing home, or home for the aged, is not included in this definition.

Host Blue — the local Blue Cross and/or Blue Shield Licensee in a geographic area outside of California, within the BlueCard Service Area.

Independent Practice Association (IPA) — a group of Physicians with individual offices who form an organization in order to contract, manage, and share financial responsibilities for providing Benefits to Members.

Infertility —

1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Intensive Outpatient Program — an outpatient mental health, behavioral health, or substance use disorder treatment program utilized when a patient's condition requires structure, monitoring,

and medical/psychological intervention at least three hours per day, three days per week.

Inter-Plan Arrangements – Blue Shield's relationships with other Blue Cross and/or Blue Shield Licensees, governed by the Blue Cross Blue Shield Association.

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage. An eligible Employee or Dependent who is a Late Enrollee may qualify for a Special Enrollment Period. If the eligible Employee or Dependent does not qualify for a Special Enrollment Period, the Late Enrollee may only enroll during the Annual Open Enrollment period.

Medical Group — an organization of Physicians who are generally located in the same facility and provide Benefits to Members.

Medical Necessity (Medically Necessary) — Benefits 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 and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are:
   a. consistent with Blue Shield medical policy;
   b. consistent with the symptoms or diagnosis;
   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider;
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient; and
   e. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.
2) 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 a 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.
3) Inpatient services which are not Medically Necessary include hospitalization:
   a. for diagnostic studies that could have been provided on an Outpatient basis;
   b. for medical observation or evaluation;
   c. for personal comfort;
   d. in a pain management center to treat or cure chronic pain; or
   e. for inpatient Rehabilitative Services that can be provided on an outpatient basis.
4) Blue Shield reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member — an individual who is enrolled and maintains coverage in a health plan through CCSB as either an eligible Employee or an eligible Employee's Dependent.

Mental Health Condition — mental disorders listed in the Fourth Edition of Diagnostic & Statistical Manual ("DSM"), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Service Administrator (MHSA) — The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver Blue Shield's Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

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

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services.

Network Specialty Pharmacy — select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.

Non-Participating Pharmacy — a pharmacy which does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.

Non-Physician Health Care Practitioner — a health care professional who is not a Physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals, or Blue Shield to provide Covered Services to Members when referred by a Primary Care Physician. For all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Non-Preferred Drugs — Drugs determined by Blue Shield's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Preferred Drugs and are always subject to the Non-Preferred Copayment or Coinsurance.

Occupational Therapy — treatment under the direction of a Physician and provided by a certified occupational therapist or other appropriately licensed Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Office Visits for Outpatient Mental Health and Substance Use Disorder Services — professional (Physician) office visits for the diagnosis and treatment of Mental Health and Substance Use Disorder Conditions, including the individual, Family or group setting.

Open Enrollment Period - the period each year established by the Employer during which an eligible Employee or Dependent may enroll or change coverage in this health plan through CCSB.

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

Other Outpatient Mental Health Services and Behavioral Health Treatment — Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions including, but not limited to, the following:

1) Partial Hospitalization
2) Intensive Outpatient Program
3) Electroconvulsive Therapy
4) Transcranial Magnetic Stimulation
5) Behavioral Health Treatment
6) Psychological Testing.

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

Out-of-Area Covered Health Care Services – Medically Necessary Emergency Services, Urgent Services, or Out-of-Area Follow-up Care provided outside the Plan Service Area.

Out-of-Area Follow-up Care — non-emergent Medically Necessary services to evaluate the Member's progress after Emergency or Urgent Services provided outside the service area.

Out-of-Pocket Maximum — the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered and charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.

Outpatient Department of a Hospital — any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.

Outpatient Facility — a licensed facility which provides medical and/or surgical services on an outpatient basis. The term does not include a Physician's office or a Hospital.

Outpatient Substance Use Disorder Services — Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions including, but not limited to, the following:

1) Professional (Physician) office visits
2) Partial Hospitalization
3) Intensive Outpatient Program
4) Office-Based Opioid Detoxification and/or Maintenance Therapy.

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

Partial Hospitalization Program (Day Treatment) — an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Patients may be admitted directly to this level of care, or transferred from inpatient care following stabilization.

Participating Hemophilia Infusion Provider — a hemophilia infusion provider that has an agreement with Blue Shield to furnish blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

A participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

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

Participating Pharmacy — a pharmacy which has agreed to a contracted rate for covered Drugs for Blue Shield Members. These pharmacies participate in the Blue Shield Pharmacy Network. Retail pharmacy participation may be at either Level A or Level B.

Period of Care — the timeframe the Primary Care Physician certifies or recertifies that the Member requires and remains eligible for Hospice care, even if the Member lives longer than one year. A Period of Care begins the first day the Member receives Hospice services and ends when the certified timeframe has elapsed.

Physical Therapy — treatment provided by a physical therapist, occupational therapist, or other appropriately licensed Health Care Provider. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

Plan — the Blue Shield Trio HMO CCSB Health Plan and/or Blue Shield of California.

Plan Hospital — a Hospital licensed under applicable state law contracting specifically with Blue Shield to provide Benefits to Members under the Plan.

Note: This definition does not apply to Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services. See above for MHSA Participating Providers for Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services.

Plan Provider — a provider who has an agreement with Blue Shield to provide Plan Benefits to Members and an MHSA Participating Provider.

Plan Service Area — that geographic area served by the Plan.

Plan Specialist — a Physician other than a Primary Care Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide Covered Services to Members either according to an authorized referral by a Primary Care Physician, or according to the Trio+ Specialist program, or for OB/GYN Physician services. For all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, this definition includes Mental Health Service Administrator (MHSA) Participating Providers.

Preferred Drugs — Drugs listed on Blue Shield's Formulary and determined by Blue Shield's Pharmacy and Therapeutics Committee as products that have a clear advantage over Non-Formulary Drug alternatives.

Premium (Dues) — the monthly prepayment that is made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Group Health Service Contract.

Preventive Health Services — primary preventive medical services, including related laboratory services, for early detection of disease as specifically described in the Principal Benefits and Coverages section of this Evidence of Coverage.

Primary Care Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a Primary Care Physician to provide primary care to Members and to refer, authorize, supervise, and coordinate the provision of all Benefits to Members in accordance with the contract.

Primary Care Physician Service Area — that geographic area served by the Member's Primary Care Physician's Medical Group or IPA.

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

Psychological Testing — testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

Reasonable and Customary Charge —

1) In California: The lower of: (a) the provider's billed charge, or (b) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a non-Plan provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered.
2) Outside of California: The lower of: (a) the provider's billed charge, or, (b) the amount, if any, established by the laws of the state to be paid for Emergency Services.

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

Rehabilitative Services — Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, in order to restore an individual's ability to function to the maximum extent practical. Rehabilitative Services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Resident of California - an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Residential Care — Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

Respiratory Therapy — treatment, under the direction of a Physician and provided by a respiratory therapist or other appropriately licensed or

certified Health Care Provider to preserve or improve a patient's pulmonary function.

Schedule II Controlled Substance — prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence.

Serious Emotional Disturbances of a Child — a minor under the age of 18 years who:

1) has 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) meets 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 six months or are likely to continue for more than one year without treatment;
    b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, 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.

Skilled Nursing — services performed by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Public Health as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.

Special Enrollment Period — a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, this health plan through CCSB outside of the initial and annual Open Enrollment Periods. An eligible Employee or an Employee's Dependent has a 30-day Special Enrollment Period, unless otherwise noted, if any of the following occurs:

1) An Employee or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis or rescission.
2) An Employee loses Medi-Cal coverage for pregnancy-related services or loses access to CHIP unborn child coverage due to the birth of the child.
3) An Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan's coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an Employer's contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.
4) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The health benefit plan shall enroll such a Dependent child within 30 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party or the employer, as

described in Sections 3751.5 and 3766 of the Family Code.

5) An Employee or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility and requests enrollment within 60 days of the loss of coverage.

6) An Employee or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal premium assistance program and requests enrollment within 60 days of the notice of eligibility for these premium assistance programs.

7) An Employee who declined coverage, or an Employee enrolled in this Plan, subsequently acquires Dependent(s) through marriage, establishment of Domestic Partnership, birth, adoption, placement for adoption or placement in foster care.

8) An Employee loses a Dependent or a Dependent is no longer considered the Employee's Dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if an Employee, or the Employee's Dependent, dies.

9) An Employee's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of CCSB, or the U.S. Department of Health and Human Services (HHS), its instrumentalities, a QHP issuer, or a non-Covered California entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by Covered California. In such cases, CCSB may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

10) An Employee or Dependent adequately demonstrates to CCSB that the health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Employee or Dependent.

11) An Employee or Dependent gains access to new health plans as a result of a permanent move and:

   a) Had minimum essential coverage for one or more days during the 60 days preceding the date of the move; or

   b) Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the move.

12) An Employee or Dependent has been released from incarceration.

13) An Employee or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

14) An Employee or Dependent demonstrates to CCSB, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as CCSB may provide.

15) An Employee or Dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the health benefit plan.

16) An Employee or Dependent is a member of an Indian tribe which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, as described in Title 25 of the United States Code Section 1603 (Special enrollment period is limited to once per month for this event).

17) An Employee or Dependent is a victim of domestic abuse or spousal abandonment, as specified in 26 CFR Section 1.36B-2T(b)(2)(ii) through (v), is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal abandonment who is on the

same application as the victim may enroll in coverage at the same time as the victim.

18) A qualified Employee or Dependent—

a) Applies for coverage through Covered California during the annual open enrollment period or due to a qualifying event, is assessed by Covered California as potentially eligible for Medi-Cal or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medi-Cal or CHIP by the California Department of Health Care Services either after open enrollment has ended or more than 30 days after the qualifying event; or

b) Applies for Medi-Cal or CHIP coverage during the annual open enrollment period, and is determined ineligible for Medi-Cal or CHIP after open enrollment has ended.

19) The Employee or his or her Dependent, adequately demonstrates to CCSB that a material error related to plan benefits, service area, or premium influenced the individual's decision to purchase a QHP through Covered California.

20) An Employee or Dependent qualifies for continuation coverage as a result of a qualifying event, as described in the *Group Continuation Coverage* section of this Evidence of Coverage.

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

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

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

Specialist — Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

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

Speech Therapy — treatment under the direction of a 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 Rehabilitative Services provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, Physical, Occupational or Speech Therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber — an eligible Employee who is enrolled and maintains coverage under the Group Health Service Contract.

Substance Use Disorder Condition — drug or alcohol abuse or dependence.

Substance Use Disorder Services — services provided to treat a Substance Use Disorder Condition.

Terminal Disease or Terminal Illness (Terminally Ill) — a medical condition resulting in a life

expectancy of one year or less, if the disease follows its natural course.

Total Disability (or Totally Disabled) —

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

Urgent Services — those Covered Services rendered outside of the Primary Care Physician Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the Primary Care Physician Service Area.

This Evidence of Coverage should be retained for your future reference as a Member of the Blue Shield Trio HMO Health Plan.

Should you have any questions, please call Shield Concierge at the number provided on the back page of this Evidence of Coverage.

Blue Shield of California
601 12th Street
Oakland, CA 94607

Handy Numbers

If your Family has more than one Blue Shield HMO Primary Care Physician, list each Family member's name with the name of his or her Physician.

*Family Member*_____

Primary Care Physician _____

*Phone Number*_____

*Family Member*_____

Primary Care Physician _____

*Phone Number*_____

*Family Member*_____

Primary Care Physician _____

*Phone Number*_____

Important Numbers:

Hospital _____

Pharmacy _____

*Police Department*_____

Ambulance _____

*Poison Control Center*_____

Fire Department _____

*General Emergency*_____ *911* _____

HMO Shield Concierge
Department (See back page of this Evidence of Coverage) _____

For Mental Health Services and information, call the MHSA at 1-877-263-9952.

Contacting Blue Shield of California

For information contact your appropriate Blue Shield of California location.

Members may call Shield Concierge toll free at 1-844-515-9068.

The hearing impaired may call Shield Concierge through Blue Shield's toll-free TTY number at 711.

Please direct correspondence to:

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

Trio HMO Service Area Chart

The Trio HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio HMO Service Area may change. To verify Service Area information, you can access Blue Shield's Internet site at http://www.blueshieldca.com or call Shield Concierge at the telephone number provided at the back of this booklet.

Alameda County (only those Zip Codes shown here)	**Alameda County (only those Zip Codes shown here)** *continued*	**Contra Costa County (only those Zip Codes shown here)**
94501	94608	94505
94502	94609	94506
94505	94610	94507
94514	94611	94509
94536	94612	94511
94537	94613	94513
94538	94614	94514
94539	94615	94516
94540	94617	94517
94541	94618	94518
94542	94619	94519
94543	94620	94520
94544	94621	94521
94545	94622	94522
94546	94623	94523
94550	94624	94524
94551	94649	94525
94552	94659	94526
94555	94660	94527
94557	94661	94528
94560	94662	94529
94566	94666	94530
94568	94701	94531
94577	94702	94547
94578	94703	94548
94579	94704	94549
94580	94705	94551
94586	94706	94553
94587	94707	94556
94588	94708	94561
94601	94709	94563
94602	94710	94564
94603	94712	94565
94604	94720	94569
94605	95377	94570
94606	95391	94572
94607		94575

You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

TRIO HMO SERVICE AREA CHART

The Trio HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio HMO Service Area may change. To verify Service Area information, you can access Blue Shield's Internet site at http://www.blueshieldca.com or call Shield Concierge at the telephone number provided at the back of this booklet.

Contra Costa County (only those Zip Codes shown here) *continued*	**Kern County (only those Zip Codes shown here)** *continued*	**Kern County (only those Zip Codes shown here)** *continued*
94582	93226	93502
94583	93240	93504
94595	93241	93505
94596	93250	93516
94597	93251	93518
94598	93252	93531
94706	93255	93560
94707	93263	93561
94708	93268	93596
94801	93276	**Kings County (only those Zip Codes shown here)**
94802	93280	93202
94803	93283	93212
94804	93285	93230
94805	93287	93245
94806	93301	93631
94807	93302	**Los Angeles County (only those Zip Codes shown here)**
94808	93303	90001
94820	93304	90002
94850	93305	90003
El Dorado County (only those Zip Codes shown here)	93306	90004
95664	93307	90005
95672	93308	90006
95682	93309	90007
95762	93311	90008
Fresno County (only those Zip Codes shown here)	93312	90009
93245	93313	90010
93618	93314	90011
93631	93380	90012
Kern County (only those Zip Codes shown here)	93383	90013
93203	93384	90014
93205	93385	90015
93206	93386	90016
93215	93387	90017
93216	93388	90018
93220	93389	90019
93224	93390	90020
93225	93501	90021

You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

TRIO HMO SERVICE AREA CHART

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Los Angeles County (only those Zip Codes shown here) *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*
90022	90062	90212
90023	90063	90213
90024	90064	90220
90025	90065	90221
90026	90066	90222
90027	90067	90223
90028	90068	90224
90029	90069	90230
90030	90070	90231
90031	90071	90232
90032	90072	90233
90033	90073	90239
90034	90074	90240
90035	90075	90241
90036	90076	90242
90037	90077	90245
90038	90078	90247
90039	90079	90248
90040	90080	90249
90041	90081	90250
90042	90082	90251
90043	90083	90254
90044	90084	90255
90045	90086	90260
90046	90087	90261
90047	90088	90262
90048	90089	90263
90049	90090	90264
90050	90091	90265
90051	90093	90266
90052	90094	90267
90053	90095	90270
90054	90096	90272
90055	90099	90274
90056	90189	90275
90057	90201	90277
90058	90202	90278
90059	90209	90280
90060	90210	90290
90061	90211	90291

You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

TRIO HMO SERVICE AREA CHART

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Los Angeles County (only those Zip Codes shown here) *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*
90292	90603	90746
90293	90604	90747
90294	90605	90748
90295	90606	90749
90296	90607	90755
90301	90608	90801
90302	90609	90802
90303	90610	90803
90304	90637	90804
90305	90638	90805
90306	90639	90806
90307	90640	90807
90308	90650	90808
90309	90651	90809
90310	90652	90810
90311	90660	90813
90312	90661	90814
90401	90662	90815
90402	90670	90822
90403	90671	90831
90404	90701	90832
90405	90702	90833
90406	90703	90834
90407	90706	90835
90408	90707	90840
90409	90710	90842
90410	90711	90844
90411	90712	90846
90501	90713	90847
90502	90714	90848
90503	90715	90853
90504	90716	90895
90505	90717	90899
90506	90723	91001
90507	90731	91003
90508	90732	91006
90509	90733	91007
90510	90734	91008
90601	90744	91009
90602	90745	91010

You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

TRIO HMO SERVICE AREA CHART

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Los Angeles County (only those Zip Codes shown here) *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*
91011	91185	91330
91012	91188	91331
91016	91189	91333
91017	91199	91334
91020	91201	91335
91021	91202	91337
91023	91203	91340
91024	91204	91341
91025	91205	91342
91030	91206	91343
91031	91207	91344
91040	91208	91345
91041	91209	91346
91042	91210	91350
91043	91214	91351
91046	91221	91352
91066	91222	91353
91077	91224	91354
91101	91225	91355
91102	91226	91356
91103	91301	91357
91104	91302	91361
91105	91303	91364
91106	91304	91365
91107	91305	91367
91108	91306	91371
91109	91307	91372
91110	91308	91376
91114	91309	91380
91115	91310	91381
91116	91311	91382
91117	91313	91383
91118	91316	91384
91121	91321	91385
91123	91322	91386
91124	91324	91387
91125	91325	91390
91126	91326	91392
91129	91327	91393
91182	91328	91394
91184	91329	91395

You and your eligible Dependents must live or work in the Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

TRIO HMO SERVICE AREA CHART

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Los Angeles County (only those Zip Codes shown here) *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*	**Los Angeles County (only those Zip Codes shown here)** *continued*
91396	91606	91768
91401	91607	91769
91402	91608	91770
91403	91609	91771
91404	91610	91772
91405	91611	91773
91406	91612	91775
91407	91614	91776
91408	91615	91778
91409	91616	91780
91410	91617	91788
91411	91618	91789
91412	91702	91790
91413	91706	91791
91416	91711	91792
91423	91714	91793
91426	91715	91801
91436	91716	91802
91470	91722	91803
91482	91723	91804
91495	91724	91896
91496	91731	91899
91499	91732	93510
91501	91733	93563
91502	91734	**Marin County (only those Zip Codes shown here)**
91503	91735	94901
91504	91740	94903
91505	91741	94904
91506	91744	94912
91507	91745	94913
91508	91746	94914
91510	91747	94915
91521	91748	94920
91522	91749	94924
91523	91750	94925
91526	91754	94930
91601	91755	94933
91602	91756	94937
91603	91765	94938
91604	91766	94939
91605	91767	94940

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TRIO HMO SERVICE AREA CHART

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Marin County (only those Zip Codes shown here) *continued*	**Orange County (only those Zip Codes shown here)** *continued*	**Orange County (only those Zip Codes shown here)** *continued*
94941	90624	92648
94942	90630	92649
94945	90631	92650
94946	90632	92651
94947	90633	92652
94948	90638	92653
94949	90680	92654
94950	90720	92655
94956	90721	92656
94957	90740	92657
94960	90742	92658
94963	90743	92659
94964	92602	92660
94965	92603	92661
94966	92604	92662
94970	92605	92663
94971	92606	92672
94973	92607	92673
94974	92609	92674
94976	92610	92675
94977	92612	92676
94978	92614	92677
94979	92615	92678
94998	92616	92679
Nevada County (only those Zip Codes shown here)	92617	92683
95712	92618	92684
95924	92619	92685
95945	92620	92688
95946	92623	92690
95949	92624	92691
95959	92625	92692
95960	92626	92693
95975	92627	92694
95986	92628	92697
Orange County (only those Zip Codes shown here)	92629	92698
90620	92630	92701
90621	92637	92702
90622	92646	92703
90623	92647	92704

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Orange County (only those Zip Codes shown here) *continued*	**Orange County** (only those Zip Codes shown here) *continued*	**Placer County** (only those Zip Codes shown here) *continued*
92705	92838	95713
92706	92840	95746
92707	92841	95747
92708	92842	95765
92711	92843	**Riverside County** (only those Zip Codes shown here)
92712	92844	91752
92728	92845	92201
92735	92846	92202
92780	92850	92203
92781	92856	92210
92782	92857	92211
92799	92859	92220
92801	92861	92223
92802	92862	92230
92803	92863	92234
92804	92864	92235
92805	92865	92236
92806	92866	92240
92807	92867	92241
92808	92868	92247
92809	92869	92248
92811	92870	92253
92812	92871	92255
92814	92885	92258
92815	92886	92260
92816	92887	92261
92817	92899	92262
92821	**Placer County** (only those Zip Codes shown here)	92263
92822	95602	92264
92823	95603	92270
92825	95604	92276
92831	95648	92282
92832	95650	92320
92833	95658	92501
92834	95661	92502
92835	95663	92503
92836	95677	92504
92837	95678	92505

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Riverside County (only those Zip Codes shown here) *continued*	**Riverside County (only those Zip Codes shown here)** *continued*	**Sacramento County (only those Zip Codes shown here)** *continued*
92506	92586	94249
92507	92587	94250
92508	92589	94252
92509	92590	94254
92513	92591	94256
92514	92592	94257
92516	92593	94258
92517	92595	94259
92518	92596	94261
92519	92599	94262
92521	92860	94263
92522	92877	94267
92530	92878	94268
92531	92879	94269
92532	92880	94271
92543	92881	94273
92544	92882	94274
92545	92883	94277
92546	**Sacramento County (only those Zip Codes shown here)**	94278
92548	94203	94279
92549	94204	94280
92551	94205	94282
92552	94206	94283
92553	94207	94284
92554	94208	94285
92555	94209	94287
92556	94211	94288
92557	94229	94289
92562	94230	94290
92563	94232	94291
92564	94234	94293
92567	94235	94294
92570	94236	94295
92571	94237	94296
92572	94239	94297
92581	94240	94298
92582	94244	94299
92583	94245	95608
92584	94247	95609
92585	94248	95610

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TRIO HMO SERVICE AREA CHART

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Sacramento County (only those Zip Codes shown here) *continued*	**Sacramento County (only those Zip Codes shown here)** *continued*	**San Bernardino County (only those Zip Codes shown here)** *continued*
95611	95826	91761
95615	95827	91762
95621	95828	91763
95624	95829	91764
95626	95830	91784
95628	95831	91785
95630	95832	91786
95632	95833	92256
95638	95834	92268
95639	95835	92284
95652	95836	92286
95655	95837	92301
95660	95838	92305
95662	95840	92307
95670	95841	92308
95671	95842	92313
95673	95843	92314
95683	95851	92315
95693	95852	92316
95741	95853	92317
95742	95860	92318
95757	95864	92321
95758	95865	92322
95759	95866	92324
95763	95867	92325
95811	95894	92329
95812	95899	92331
95813		92333
95814	**San Bernardino County (only those Zip Codes shown here)**	92334
95815	91701	92335
95816	91708	92336
95817	91709	92337
95818	91710	92339
95819	91729	92340
95820	91730	92341
95821	91737	92342
95822	91739	92344
95823	91743	92345
95824	91758	92346
95825	91759	92350

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San Bernardino County (only those Zip Codes shown here) *continued*	**San Bernardino County (only those Zip Codes shown here)** *continued*	**San Diego County (only those Zip Codes shown here)** *continued*
92352	92427	92007
92354	**San Diego County (only those Zip Codes shown here)**	92008
92356	91901	92009
92357	91902	92010
92358	91903	92011
92359	91905	92013
92368	91906	92014
92369	91908	92018
92371	91909	92019
92372	91910	92020
92373	91911	92021
92374	91912	92022
92375	91913	92023
92376	91914	92024
92377	91915	92025
92378	91916	92026
92382	91917	92027
92385	91921	92028
92386	91931	92029
92391	91932	92030
92392	91933	92033
92393	91935	92036
92394	91941	92037
92395	91942	92038
92397	91943	92039
92399	91944	92040
92401	91945	92046
92402	91946	92049
92403	91948	92051
92404	91950	92052
92405	91951	92054
92406	91962	92055
92407	91963	92056
92408	91976	92057
92410	91977	92058
92411	91978	92059
92413	91979	92060
92415	91980	92061
92418	91987	92064
92423	92003	92065

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San Diego County (only those Zip Codes shown here) *continued*	**San Diego County (only those Zip Codes shown here)** *continued*	**San Diego County (only those Zip Codes shown here)** *continued*
92067	92122	92173
92068	92123	92174
92069	92124	92175
92071	92126	92176
92072	92127	92177
92074	92128	92178
92075	92129	92179
92078	92130	92182
92079	92131	92186
92081	92132	92187
92082	92134	92190
92083	92135	92191
92084	92136	92192
92085	92137	92193
92088	92138	92195
92091	92139	92196
92092	92140	92197
92093	92142	92198
92096	92143	92199
92101	92145	**San Francisco County (only those Zip Codes shown here)**
92102	92147	94102
92103	92149	94103
92104	92150	94104
92105	92152	94105
92106	92153	94107
92107	92154	94108
92108	92155	94109
92109	92158	94110
92110	92159	94111
92111	92160	94112
92112	92161	94114
92113	92163	94115
92114	92165	94116
92115	92166	94117
92116	92167	94118
92117	92168	94119
92118	92169	94120
92119	92170	94121
92120	92171	94122
92121	92172	94123

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San Francisco County (only those Zip Codes shown here) *continued*	**San Joaquin County (only those Zip Codes shown here)** *continued*	**San Joaquin County (only those Zip Codes shown here)** *continued*
94124	95205	95378
94125	95206	95385
94126	95207	95391
94127	95208	95632
94128	95209	95686
94129	95210	95690
94130	95211	**San Luis Obispo County (only those Zip Codes shown here**
94131	95212	93401
94132	95213	93402
94133	95214	93403
94134	95215	93405
94137	95219	93406
94139	95220	93407
94140	95227	93408
94141	95230	93409
94142	95231	93410
94143	95234	93412
94144	95236	93420
94145	95237	93421
94146	95240	93422
94147	95241	93423
94151	95242	93424
94158	95253	93426
94159	95258	93428
94160	95267	93430
94161	95269	93432
94163	95296	93433
94164	95297	93435
94172	95304	93442
94177	95320	93443
94188	95330	93444
San Joaquin County (only those Zip Codes shown here)	95336	93445
94514	95337	93446
95201	95361	93447
95202	95366	93448
95203	95376	93449
95204	95377	93451

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San Luis Obispo County (only those Zip Codes shown here) *continued*	**San Mateo County (only those Zip Codes shown here)** *continued*	**Santa Clara County (only those Zip Codes shown here)** *continued*
93453	94303	95023
93461	94401	95026
93465	94402	95030
93475	94403	95031
93483	94404	95032
San Mateo County (only those Zip Codes shown here	94497	95033
94002	**Santa Clara County (only those Zip Codes shown here**	95035
94005	94022	95036
94010	94023	95037
94011	94024	95038
94014	94035	95042
94015	94039	95044
94016	94040	95046
94017	94041	95050
94018	94042	95051
94019	94043	95052
94020	94085	95053
94021	94086	95054
94025	94087	95055
94026	94088	95056
94027	94089	95070
94028	94301	95071
94030	94302	95076
94037	94303	95101
94038	94304	95103
94044	94305	95106
94060	94306	95108
94061	94309	95109
94062	94550	95110
94063	95002	95111
94064	95008	95112
94065	95009	95113
94066	95011	95115
94070	95013	95116
94074	95014	95117
94080	95015	95118
94083	95020	95119
94128	95021	95120

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Santa Clara County (only those Zip Codes shown here) *continued*	**Santa Clara County (only those Zip Codes shown here)** *continued*	**Stanislaus County (only those Zip Codes shown here** *continued*
95121	95193	95329
95122	95194	95350
95123	95196	95351
95124	**Santa Cruz County (only those Zip Codes shown here)**	95352
95125	95001	95353
95126	95003	95354
95127	95005	95355
95128	95006	95356
95129	95007	95357
95130	95010	95358
95131	95017	95361
95132	95018	95363
95133	95019	95367
95134	95033	95368
95135	95041	95380
95136	95060	95381
95138	95061	95382
95139	95062	95386
95140	95063	95387
95141	95064	95397
95148	95065	**Tulare County (only those Zip Codes shown here)**
95150	95066	93212
95151	95067	93218
95152	95073	93219
95153	95076	93221
95154	95077	93223
95155	**Solano County (only those Zip Codes shown here)**	93227
95156	94503	93235
95157	94510	93237
95158	94589	93244
95159	94592	93247
95160	95620	93256
95161	**Stanislaus County (only those Zip Codes shown here)**	93257
95164	95307	93260
95170	95313	93267
95172	95316	93270
95173	95319	93271
95190	95323	93272
95191	95326	93274
95192	95328	93277

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Tulare County (only those Zip Codes shown here) *continued*	**Ventura County (only those Zip Codes shown here)** *continued*	
93282	93032	
93286	93033	
93291	93034	
93292	93035	
93603	93036	
93615	93040	
93618	93041	
93631	93042	
93647	93043	
93670	93044	
93673	93060	
Ventura County (only those Zip Codes shown here)	93061	
91319	93062	
91320	93063	
91358	93064	
91359	93065	
91360	93066	
91361	93094	
91362	93099	
91377	**Yolo County (only those Zip Codes shown here)**	
93001	95605	
93002	95606	
93003	95607	
93004	95612	
93005	95616	
93006	95617	
93007	95618	
93009	95627	

93010	95637	
93011	95645	
93012	95653	
93015	95691	
93016	95694	
93020	95695	
93021	95697	
93022	95698	
93023	95776	
93024	95798	
93030	95799	
93031	95937	

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blue of california

Infertility Services Rider

Group Rider
HMO

Additional Blue Shield Infertility Benefits Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Infertility services Benefit.

Benefits	Your Payment	
	When using a Participating Provider	**When using a Non-Participating Provider**
Infertility Services *Services are not subject to any applicable Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.*	50% of the allowable amount	Not covered
Assisted Reproductive Technology (ART) Procedures and Associated Services	**Lifetime Benefit Maximums**	
Natural artificial inseminations *Without ovum [oocyte or ovarian tissue (egg)] stimulation*	6/lifetime	
Stimulated artificial inseminations *With ovum [oocyte or ovarian tissue] stimulation*	3/lifetime	
Gamete intrafallopian transfer (GIFT)	1/lifetime	
Cryopreservation of embryos, oocytes, ovarian tissue, sperm *Retrieved from a Member. Includes one retrieval and a year of storage per person*	1/lifetime	

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

Introduction

The Member is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician, to a Member for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Benefits

Benefits are provided for a Member who has a current diagnosis of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Member is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered or prescribed by the provider to induce fertilization. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

Benefits are only provided for services received from Participating Providers.

Exclusions

No Benefits are provided for:

- ART and associated services related to intracytoplasmic sperm injection (ICSI);
- ART and associated services related to zygote intrafallopian transfer (ZIFT);
- ART and associated services related to in vitro fertilization (IVF);
- Services received from Non-Participating Providers;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this Infertility Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this Infertility Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspiration (MESA), percutaenous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Member had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; or
- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Member who has diagnosed Infertility as defined at the time services are provided.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníít nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíílnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់ៈ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल कर। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)