blue of california

Blue Shield Platinum 90 HMO 0/15 + Child Dental INF

Período de cobertura: del 1/1/2017 en adelante

Resumen de beneficios y cobertura: Qué cubre y cuánto cuesta este plan **Cobertura para:** Persona + Familia | **Tipo de plan:** HMO

Esto es solo un resumen. Si desea obtener más detalles acerca de su cobertura y los costos, puede consultar todos los términos en los documentos de su póliza o plan por medio de Internet en www.blueshieldca.com/bsca/bsc/public/employer/DisplayDocument?fileName=201701A49314.pdf o por teléfono al **1-855-258-3744**.

Preguntas importantes	Respuestas	Conceptos importantes:
¿Cuál es el deducible general?	**$0**	Consulte el cuadro que comienza en la página 3 para conocer los costos de los servicios que cubre este plan.
¿Hay otros deducibles para servicios específicos?	No.	No debe alcanzar deducibles para servicios específicos, pero consulte el cuadro que comienza en la página 3 para conocer otros costos de los servicios que cubre este plan.
¿Hay un límite de desembolso en mis gastos?	Sí. Para proveedores del plan: **$4,000** por persona/**$8,000** por familia.	El **límite de desembolso** es el monto máximo que usted puede pagar durante un período de cobertura (normalmente, un año) por la parte del costo de los servicios cubiertos que le corresponda a usted. Este límite lo ayuda a planificar los gastos de atención de la salud.
¿Qué no se incluye en el límite de desembolso?	Las primas, algunos copagos, los costos compartidos para determinados servicios enumerados en el contrato de cobertura formal y la atención de la salud que no cubra este plan.	Aunque usted pague estos gastos, estos no cuentan para el **límite de desembolso**.
¿Hay un límite anual global sobre lo que paga el plan?	No.	El cuadro que comienza en la página 3 describe los límites en el monto que pagará el plan por servicios cubiertos *específicos*, tales como visitas al consultorio.
¿Utiliza este plan una red de proveedores?	Sí. Este plan de salud utiliza la red de proveedores de Trio ACO HMO. Para obtener una lista de proveedores del plan, visite www.blueshieldca.com **o llame al 1-855-258-3744**.	Si utiliza un médico u otro **proveedor** de atención de la salud dentro de la red, este plan pagará una parte o la totalidad de los costos de los servicios cubiertos. Tenga en cuenta que su médico u hospital **dentro de la red** pueden utilizar un **proveedor** fuera de la red para prestar algunos servicios. Los planes usan los términos dentro de la red, **preferido** o participante para referirse a los **proveedores** incluidos en su **red**. Consulte el cuadro que comienza en la página 3 para saber cómo paga este plan a los

Preguntas importantes	Respuestas	Conceptos importantes:
		diferentes tipos de **proveedores**.
¿Necesito una derivación para atenderme con un especialista?	Sí. Los miembros necesitan aprobación por escrito para ver a un especialista, excepto los especialistas en obstetricia/ginecología (OB/GYN, por sus siglas en inglés) o los pediatras que presten servicios como médicos de atención primaria. Los miembros pueden derivarse a sí mismos utilizando la opción de autoderivación Access+ Self Referral o para los servicios de OB/GYN. Para obtener más detalles, consulte el contrato de cobertura formal.	El plan pagará una parte o la totalidad de los costos de los servicios cubiertos en la consulta con un **especialista**, pero solo si usted obtiene el permiso del plan antes de la consulta con el **especialista**.
¿Hay algún servicio que este plan no cubra?	Sí.	En la página 16 se indican algunos de los servicios que no cubre este plan. Consulte los documentos de su póliza o plan para obtener información adicional acerca de los **servicios excluidos**.

- Los **copagos** son las cantidades fijas en dólares (por ejemplo, $15) que usted paga por un servicio de atención de la salud cubierto, generalmente cuando recibe el servicio.
- El **coseguro** es *su* participación en los costos de un servicio cubierto; se calcula como un porcentaje de la **cantidad permitida** que se paga por el servicio. Por ejemplo, si la **cantidad permitida** del plan para una noche de hospitalización es de $1,000, su pago de **coseguro** del 20% equivaldría a $200. Esto puede cambiar si no ha alcanzado su **deducible**.
- La cantidad que el plan paga por los servicios cubiertos se basa en la **cantidad permitida**. Si un **proveedor** fuera de la red cobra más que la **cantidad permitida**, es posible que usted tenga que pagar la diferencia. Por ejemplo, si un hospital fuera de la red cobra $1,500 por una noche de hospitalización y la **cantidad permitida** es de $1,000, es posible que tenga que pagar $500 de diferencia. (Esto se denomina **facturación del saldo**).
- Este plan puede motivarlo a que acuda a **proveedores** del plan al cobrarle **deducibles**, **copagos** y **coseguros** más bajos.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
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	$15 de copago/visita	Sin cobertura	Para otros servicios recibidos durante la visita al consultorio, es posible que se aplique un costo compartido adicional del miembro.
	Visita a un especialista	$40 de copago/visita	Sin cobertura	Para otros servicios recibidos durante la visita al consultorio, es posible que se aplique un costo compartido adicional del miembro. $40 de copago por visita al especialista mediante autoderivación Access+ Specialist Self Referral.
	Visita al consultorio de otro médico	Acupuntura: $15 de copago/visita	Sin cobertura	----------Ninguna----------
	Atención preventiva/pruebas de detección/inmunizaciones	Sin cargo	Sin cobertura	Los servicios de salud preventivos únicamente están cubiertos cuando son proporcionados por proveedores del plan. La cobertura de los servicios cumple con los requisitos de la Affordable Care Act (ACA, Ley de Atención Médica Económica) y las leyes de California. Para obtener más detalles, consulte el contrato de su plan.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si se realiza una prueba	Pruebas de diagnóstico (radiografías, análisis de sangre)	Análisis de laboratorio y patología en un centro independiente: $20 de copago/visita Radiografías y diagnóstico por imágenes en un centro de radiología independiente: $40 de copago/visita Otros exámenes de diagnóstico en un centro independiente: $40 de copago/visita Otros exámenes de diagnóstico en un hospital para pacientes ambulatorios: $40 de copago/visita	Sin cobertura	Los beneficios de esta sección corresponden a servicios de salud de diagnóstico no preventivos. Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa para los procedimientos sin carácter de emergencia puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Diagnóstico por imágenes (tomografía computarizada, tomografía por emisión de positrones e imágenes por resonancia magnética)	Diagnóstico por imágenes radiológicas y de medicina nuclear en un centro de radiología independiente: $150 de copago/visita Diagnóstico por imágenes radiológicas y de medicina nuclear (tomografías computarizadas, imágenes por resonancia magnética, angiografías por resonancia magnética, tomografías por emisión de positrones [CT, MRI, MRA y PET, respectivamente, por sus siglas en inglés], etc.) en un hospital para pacientes ambulatorios: $150 de copago/visita	Sin cobertura	Los beneficios de esta sección corresponden a servicios de salud de diagnóstico no preventivos. Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa para los procedimientos sin carácter de emergencia puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si necesita medicamentos para tratar su enfermedad o afección Hay más información disponible sobre la **cobertura de medicamentos recetados** en www.blueshieldca.com/bsca/pharmacy.	Medicamentos de nivel 1	Farmacias al por menor: $5 de copago/receta Farmacias de servicio por correo: $10 de copago/receta	Sin cobertura	Farmacias al por menor: Cubre un suministro de hasta 30 días. Farmacias de servicio por correo: Cubre un suministro de hasta 90 días, excepto en el caso de los medicamentos especializados. Para determinados medicamentos del formulario y no pertenecientes al formulario, se necesita autorización previa. El Programa de medicamentos especializados de ciclo corto de Blue Shield permite que, en el caso de las recetas iniciales para determinados medicamentos de nivel 4, se despache un suministro de prueba de 15 días. En tales situaciones, el costo compartido de medicamento de nivel 4 se calculará de manera proporcional. Se necesita autorización previa.
	Medicamentos de nivel 2	Farmacias al por menor: $15 de copago/receta Farmacias de servicio por correo: $30 de copago/receta	Sin cobertura	
	Medicamentos de nivel 3	Farmacias al por menor: $25 de copago/receta Farmacias de servicio por correo: $50 de copago/receta	Sin cobertura	
	Medicamentos de nivel 4	Farmacias al por menor y farmacias especializadas de la red: 10% de coseguro hasta un máximo de $250/receta Farmacias de servicio por correo: 10% de coseguro hasta un máximo de $500/receta	Sin cobertura	
Si se somete a una cirugía ambulatoria	Tarifa del centro de atención (p. ej., centro quirúrgico ambulatorio)	$250 de copago/cirugía	Sin cobertura	----------Ninguna----------
	Honorarios del médico/cirujano	$40 de copago/visita	Sin cobertura	----------Ninguna----------

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si necesita atención médica inmediata	Servicios de la sala de emergencias	Tarifa de la sala de emergencias (ER, por sus siglas en inglés): $150 de copago/visita Tarifa del médico de la sala de emergencias: Sin cargo	Tarifa de la sala de emergencias: $150 de copago/visita Tarifa del médico de la sala de emergencias: Sin cargo	Exención del copago si hay ingreso hospitalario; se aplican los beneficios estándar de un centro hospitalario para pacientes internados. Esto corresponde únicamente al cargo del hospital/centro de atención.
	Transporte médico de emergencia	$150 de copago/transporte	$150 de copago/transporte	----------Ninguna----------
	Atención urgente	Dentro del área de servicio del plan: $15 de copago/visita Fuera del área de servicio del plan: $15 de copago/visita	Dentro del área de servicio del plan: Sin cobertura Fuera del área de servicio del plan: $15 de copago/visita	Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
En caso de hospitalización	Tarifa del centro de atención (p. ej., la habitación del hospital)	$250 de copago/día hasta un máximo de 5 días/ingreso	Sin cobertura	No se cobra ningún copago adicional después de 5 días en un hospital como paciente internado. Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa para los procedimientos sin carácter de emergencia puede generar la falta de pago de beneficios.
	Honorarios del médico/cirujano	$40 de copago/visita	Sin cobertura	----------Ninguna----------

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si necesita atención para tratar trastornos mentales, trastornos conductuales o trastornos por el uso de sustancias adictivas	Servicios de salud mental/conductual para pacientes ambulatorios	Servicios de salud mental de rutina para pacientes ambulatorios: $15 de copago/visita Servicios de salud mental que no son de rutina para pacientes ambulatorios: Sin cargo	Sin cobertura	Servicios de salud mental de rutina para pacientes ambulatorios: Los servicios incluyen visitas al consultorio del profesional/médico. Servicios de salud mental que no son de rutina para pacientes ambulatorios: Los servicios incluyen tratamiento de salud conductual, terapia electroconvulsiva, programas intensivos para pacientes ambulatorios, programas de hospitalización parcial y estimulación magnética transcraneal. En los programas de hospitalización parcial se pueden aplicar copagos y cargos del centro más elevados por episodio de atención. Se necesita autorización previa del administrador de servicios de salud mental (MHSA, por sus siglas en inglés) para los servicios de salud mental que no son de rutina para pacientes ambulatorios. La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Servicios de salud mental/conductual para pacientes internados	Servicios hospitalarios de salud mental para pacientes internados: $250 de copago/día hasta un máximo de 5 días/ingreso Servicios residenciales de salud mental: $250 de copago/día hasta un máximo de 5 días/ingreso Servicios de salud mental para pacientes internados brindados por un médico: $40 de copago/visita	Sin cobertura	No se cobra ningún copago adicional después de 5 días en un hospital/residencia como paciente internado. Se necesita autorización previa del administrador de servicios de salud mental (MHSA). La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Servicios para pacientes ambulatorios con trastornos por el uso de sustancias adictivas	Servicios de rutina para el tratamiento de pacientes ambulatorios con trastornos por el uso de sustancias adictivas: $15 de copago/visita Servicios que no son de rutina para el tratamiento de pacientes ambulatorios con trastornos por el uso de sustancias adictivas: Sin cargo	Sin cobertura	Servicios de rutina para el tratamiento de pacientes ambulatorios con trastornos por el uso de sustancias adictivas: Los servicios incluyen visitas al consultorio del profesional/médico. Servicios que no son de rutina para el tratamiento de pacientes ambulatorios con trastornos por el uso de sustancias adictivas: Los servicios incluyen programas de hospitalización parcial, programas intensivos para pacientes ambulatorios y tratamiento de mantenimiento y/o de desintoxicación de opioides en el consultorio. En los programas de hospitalización parcial se pueden aplicar copagos y cargos del centro más elevados por episodio de atención. Se necesita autorización previa del administrador de servicios de salud mental (MHSA) para los servicios que no son de rutina para el tratamiento de pacientes ambulatorios con trastornos por el uso de sustancias adictivas. La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Servicios para pacientes internados con trastornos por el uso de sustancias adictivas	Servicios hospitalarios para pacientes internados con trastornos por el uso de sustancias adictivas: $250 de copago/día hasta un máximo de 5 días/ingreso Servicios residenciales para pacientes con trastornos por el uso de sustancias adictivas: $250 de copago/día hasta un máximo de 5 días/ingreso Servicios para pacientes internados con trastornos por el uso de sustancias adictivas brindados por un médico: $40 de copago/visita	Sin cobertura	No se cobra ningún copago adicional después de 5 días en un hospital/residencia como paciente internado. Se necesita autorización previa del administrador de servicios de salud mental (MHSA). La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si está embarazada	Atención prenatal y posnatal	Visitas al consultorio del médico para la atención previa a la concepción y al nacimiento: Sin cargo Visita al consultorio del médico para la atención después del nacimiento, primera visita: Sin cargo	Sin cobertura	----------Ninguna----------
	Parto y todos los servicios para las pacientes internadas	$250 de copago/día hasta un máximo de 5 días/ingreso	Sin cobertura	No se cobra ningún copago adicional después de 5 días en un hospital como paciente internado.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
Si necesita ayuda para su recuperación u otros cuidados de salud especiales	Atención de la salud a domicilio	$20 de copago/visita	Sin cobertura	Cobertura limitada a 100 visitas por miembro por año civil. Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa puede generar la falta de pago de beneficios.
	Servicios de rehabilitación	Visita al consultorio: $15 de copago/visita Servicios hospitalarios para pacientes ambulatorios: $15 de copago/visita	Sin cobertura	Cobertura para los servicios de fisioterapia, terapia ocupacional y terapia respiratoria.
	Servicios de habilitación	Visita al consultorio: $15 de copago/visita Servicios hospitalarios para pacientes ambulatorios: $15 de copago/visita	Sin cobertura	
	Atención de enfermería especializada	$150 de copago/día hasta un máximo de 5 días/ingreso	Sin cobertura	No se cobra ningún copago adicional después de 5 días como paciente internado. Cobertura limitada a 100 días por miembro por período de beneficios junto con los servicios de un hospital/centro de enfermería especializada independiente. Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa puede generar la falta de pago de beneficios.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Equipo médico duradero	10% de coseguro	Sin cobertura	Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa puede generar la falta de pago de beneficios.
	Cuidados para pacientes terminales	Sin cargo	Sin cobertura	Se necesita autorización previa del médico de atención primaria y del plan médico. La omisión de la autorización previa puede generar la falta de pago de beneficios.
Si su hijo/a necesita atención dental o de la vista	Examen de la vista	Sin cargo	Sin cobertura	Cobertura limitada a un examen de la vista integral por año civil. Servicios brindados por el administrador del plan de la vista (VPA, por sus siglas en inglés) de Blue Shield.
	Anteojos	Sin cargo	Sin cobertura	Cobertura limitada a un par de anteojos (armazón y lentes) o a un par de lentes de contacto en lugar de los anteojos por año civil. Hay cantidades mayores disponibles para determinados tipos de lentes de contacto. Servicios brindados por el administrador del plan de la vista (VPA) de Blue Shield.

Situación médica común	Servicios que puede necesitar	Su costo si acude a un proveedor del plan	Su costo si acude a un proveedor no perteneciente al plan	Limitaciones y excepciones
	Chequeo dental	Sin cargo	Sin cobertura	Los miembros disponen de beneficios dentales infantiles hasta que termine el mes en que cumplen 19 años. La cobertura para chequeos dentales está limitada a 2 visitas por cada período de doce meses. Para obtener más detalles, consulte el contrato de su plan.

Servicios excluidos y otros servicios cubiertos:

Servicios que su plan NO cubre **(Esta no es una lista completa. Revise los documentos de su póliza o plan para conocer otros servicios excluidos).**		
• Atención quiropráctica	• Atención a largo plazo	• Atención de los pies de rutina (a menos que sea para el tratamiento de la diabetes)
• Cirugía estética	• Atención sin carácter de emergencia cuando viaje fuera de los Estados Unidos	• Programas para la pérdida de peso
• Atención dental (adultos)	• Servicio de enfermería privado	
• Audífonos	• Atención de la vista de rutina (adultos)	

Otros servicios cubiertos **(Esta no es una lista completa. Revise los documentos de su póliza o plan para conocer otros servicios cubiertos y los costos de esos servicios).**		
• Acupuntura	• Atención dental (niños) (dos chequeos dentales por cada período de doce meses)	• Atención de la vista de rutina (niños) (un examen de la vista integral por año civil)
• Cirugía bariátrica (se necesita autorización	• Tratamiento para la esterilidad (se brinda	

previa del médico de atención primaria y del plan médico; la omisión de dicha autorización puede generar la falta de pago de beneficios)	cobertura solo para el diagnóstico y el tratamiento de la causa de la esterilidad)

Sus derechos a continuar con su cobertura:

Si usted pierde la cobertura de un plan, entonces, en función de cada caso, las leyes federales y estatales pueden brindarle medidas de protección que le permitan mantener su cobertura de salud. Dichos derechos podrán ser de duración limitada y se le exigirá que pague una **prima**, que puede ser considerablemente mayor que la prima que usted paga mientras está cubierto por el plan. También se pueden aplicar otras limitaciones a sus derechos a continuar con su cobertura.

Para obtener más información sobre sus derechos a continuar con su cobertura, comuníquese con el plan al **1-855-258-3744**. También puede comunicarse con su departamento estatal de seguros, la Employee Benefits Security Administration (Administración para la Seguridad de los Beneficios del Empleado) del U.S. Department of Labor (Departamento de Trabajo de los Estados Unidos) al 1-866-444-3272, o bien visitar www.dol.gov/ebsa, o llamar al U.S. Department of Health and Human Services (Departamento de Salud y Servicios Humanos de los Estados Unidos) al 1-877-267-2323, extensión 61565, o ingresar en www.cciio.cms.gov.

Sus derechos a reclamos y apelaciones:

Si tiene una queja o no está conforme con la negación de la cobertura de alguna reclamación correspondiente a su plan, puede presentar una **apelación** o un **reclamo**. Si tiene preguntas acerca de sus derechos o esta notificación, o si necesita asistencia, puede llamar al 1-888-319-5999 o a la Employee Benefits Security Administration del Department of Labor al 1-866-444-EBSA (3272), o bien visitar www.dol.gov/ebsa/healthreform. Además, un programa de asistencia al consumidor puede ayudarlo a presentar su **apelación**. Comuníquese 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 visite http://www.healthhelp.ca.gov.

¿Brinda esta cobertura una cobertura esencial mínima?

Conforme a la Ley de Atención Médica Económica (en adelante, la ley "Affordable Care Act"), la mayoría de las personas deben tener una cobertura de atención de la salud que se considere una "cobertura esencial mínima". **Este plan o póliza efectivamente proporciona cobertura esencial mínima.**

¿Cumple esta cobertura con el estándar de valor mínimo?

La ley Affordable Care Act establece un estándar de valor mínimo de beneficios que debe ofrecer un plan de salud. El estándar de valor mínimo equivale al 60% (valor actuarial). **Esta cobertura de salud efectivamente cumple con el estándar de valor mínimo correspondiente a los beneficios que ofrece.**

Servicios de acceso a idiomas:

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

Tagalo (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chino (中文): 如果需要中文的帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198.

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

Coreano (한국어): 한국어 도움이 필요하시면, 1-866-346-7198 로 전화하십시오.

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

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

Japonés (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。

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

Panyabí (پنجابی): پنجابی وچ مدد لئی مہربانی کر کے 1-866-346-7198 تے کال کرو۔

Jemer (ភាសាខ្មែរ): សម្រាប់ជំនួយជាភាសាខ្មែរ សូមទាក់ទងមកលេខ 1-866-346-7198.

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

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

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

Tailandés (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทย โปรดโทร 1-866-346-7198.

Para ver ejemplos de cómo este plan podría cubrir costos usando una situación médica ficticia, consulte la siguiente página.

Acerca de estos ejemplos de cobertura:

Estos ejemplos muestran cómo este plan podría cubrir la atención médica en determinadas situaciones. Utilice estos ejemplos para ver, en general, cuánta protección financiera podría obtener el paciente ejemplificado si recibiera cobertura según los diferentes planes.

Estos ejemplos no son estimadores de costos.

No use estos ejemplos para calcular sus costos reales de este plan. La atención real y los costos serán diferentes de estos ejemplos.

Consulte la página siguiente para obtener información importante sobre estos ejemplos.

Va a ser mamá
(parto normal)

- **Tarifa de los proveedores:** $7,540
- **El plan paga** $6,430
- **El paciente paga** $1,110

Costos de atención ejemplificados:

Gastos hospitalarios (madre)	$2,700
Atención de obstetricia de rutina	$2,100
Gastos hospitalarios (bebé)	$900
Anestesia	$900
Pruebas de laboratorio	$500
Recetas	$200
Servicios de radiología	$200
Vacunas, otros servicios preventivos	$40
Total	**$7,540**

El paciente paga:

Deducibles	$0
Copagos	$960
Coseguro	$0
Límites o exclusiones	$150
Total	**$1,110**

Control de la diabetes tipo 2
(mantenimiento de rutina de una afección controlada)

- **Tarifa de los proveedores:** $5,400
- **El plan paga** $4,700
- **El paciente paga** $700

Costos de atención ejemplificados:

Recetas	$2,900
Equipo y suministros médicos	$1,300
Consultas y procedimientos en el consultorio	$700
Educación	$300
Pruebas de laboratorio	$100
Vacunas, otros servicios preventivos	$100
Total	**$5,400**

El paciente paga:

Deducibles	$0
Copagos	$490
Coseguro	$130
Límites o exclusiones	$80
Total	**$700**

Preguntas y respuestas acerca de los ejemplos de cobertura:

¿Cuáles son algunas de las hipótesis en las que se basan los ejemplos de cobertura?

- Los costos no incluyen **primas**.
- Los costos de atención ejemplificados se basan en promedios nacionales suministrados por el U.S. Department of Health and Human Services y no son específicos de una determinada área geográfica o de un plan de salud.
- La afección del paciente no era una afección excluida o preexistente.
- Todos los servicios y tratamientos comenzaron y terminaron en el mismo período de cobertura.
- No hay otros gastos médicos para ninguno de los miembros cubiertos por este plan.
- Los gastos de desembolso se basan únicamente en el tratamiento de la afección que menciona el ejemplo.
- El paciente recibió toda la atención de **proveedores** dentro de la red. Si el paciente hubiera recibido atención de **proveedores** fuera de la red, los costos habrían sido más altos.
- Los pagos del plan y del paciente se basan en una sola persona inscrita en el plan o la póliza.

¿Qué muestra un ejemplo de cobertura?

En cada situación de tratamiento, los ejemplos de cobertura lo ayudan a ver cómo calcular los **deducibles**, los **copagos** y los **coseguros**. Esto también lo ayuda a ver qué gastos podrían correr por su cuenta debido a que el servicio o el tratamiento no está cubierto o el pago es limitado.

¿El ejemplo de cobertura prevé mis propias necesidades de atención?

✘ **No**. Los tratamientos que se muestran son solo ejemplos. La atención que usted recibiría por esta afección podría ser diferente según las indicaciones de su médico, su edad, la gravedad de su afección y muchos otros factores.

¿El ejemplo de cobertura prevé mis futuros gastos?

✘ **No**. Los ejemplos de cobertura no son estimadores de costos. Usted no puede usar los ejemplos para calcular los costos de una afección real. Se usan únicamente con fines comparativos. Sus propios costos serán diferentes en función de la atención que reciba, los precios de los **proveedores** y el reembolso que permita su plan de salud.

¿Puedo usar los ejemplos de cobertura para comparar planes?

✓ **Sí.** Cuando mire el "Resumen de beneficios y cobertura" de otros planes, encontrará los mismos ejemplos de cobertura. Cuando compare los planes, observe la casilla "El paciente paga" en cada ejemplo. Cuanto más baja sea esa cifra, más amplia será la cobertura del plan.

¿Hay otros costos que debería considerar al comparar los planes?

✓ **Sí.** Un costo importante es la **prima** que usted paga. Por lo general, cuanto más baja sea su **prima**, más altos serán los gastos de desembolso que usted deberá pagar; estos gastos incluyen **copagos**, **deducibles** y **coseguros**. También debe considerar las contribuciones de cuentas, tales como cuentas de ahorros para gastos médicos (HSA, por sus siglas en inglés), arreglos de gastos flexibles (FSA, por sus siglas en inglés) o cuentas de reembolsos de gastos médicos (HRA, por sus siglas en inglés), que lo ayudarán a pagar sus gastos de desembolso.

Preguntas: Llame al **1-855-258-3744** o visítenos en www.blueshieldca.com.
Si alguno de los términos subrayados en este formulario no le queda claro, consulte el Glosario. Puede ver el Glosario en www.dol.gov/ebsa/healthreform o llamar al **1-855-258-3744** para solicitar una copia.

Blue Shield of California is an independent member of the Blue Shield Association.

Blue Shield Platinum 90 HMO 0/15 + Child Dental

Evidence of Coverage

Group

An independent member of the Blue Shield Association

blue of california

FOR SMALL BUSINESS

Blue Shield of California

Evidence of Coverage

Blue Shield Platinum 90 HMO 0/15 + 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 Blue Shield Customer Service (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 Blue Shield's Customer Service telephone number provided on the back page of this Evidence of Coverage to ensure that you can obtain the health care services that you need.

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

The Trio Accountable Care Organization (ACO) 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 Personal Physician.

Notice About Health Information Exchange Participation: Blue Shield participates in the **California Integrated Data Exchange (Cal INDEX)** Health Information Exchange ("HIE") making its Members' health information available to Cal INDEX for access by their authorized health care providers. Cal INDEX 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 Cal INDEX HIE to support the provision of safe, high-quality care.

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

Every Blue Shield Member has the right to direct Cal INDEX not to share their health information with their health care providers. Although opting out of Cal INDEX 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 Cal INDEX. No doctor or hospital participating in Cal INDEX will deny medical care to a patient who chooses not to participate in the Cal INDEX HIE.

Members who do not wish to have their healthcare information displayed in Cal INDEX, should fill out the online form at **www.calindex.org/opt-out** or call Cal INDEX 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 Personal 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 Personal Physician.
13) Communicate with and receive information from Customer Service 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 Personal 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 Personal 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 Personal 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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Summary of Benefits

The Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage. It sets forth the Member's share-of-costs for Covered Services under the benefit plan. Please read both documents carefully for a complete description of provisions, benefits, exclusions, and other important information pertaining to this benefit plan.

This health plan uses an Accountable Care Organization (ACO) HMO for its Provider Network within a specific Service Area. 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 Personal Physician and within the Trio ACO HMO Provider Network to be covered.

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

Summary of Benefits

HMO Plan

Calendar Year Medical Deductible	Member Deductible Responsibility
Calendar Year Medical Deductible	None

Calendar Year Out-of-Pocket Maximum[1]	Member Maximum Calendar Year Out-of-Pocket Amount[1,2]
Calendar Year Out-of-Pocket Maximum	$4,000 per Member/$8,000 per Family

Maximum Lifetime Benefits	Maximum Blue Shield Payment
Lifetime Benefit Maximum	No maximum

Benefit	Member Copayment[2]
Access+ Specialist Benefits The Access+ Specialist benefit allows a Member to arrange an office visit within their Personal Physician's Medical Group/IPA without a referral from their Personal Physician. See the Access+ Specialist and Access+ Satisfaction sections of the Evidence of Coverage for details. Your Personal Physician's Medical Group/IPA must be an Access+ Provider for you to use this Benefit. Refer to the HMO Physician and Hospital Directory or call Blue Shield to determine whether your Personal Physician's Medical Group/IPA is an Access+ Provider.	
Laboratory services	$20 per visit
Conventional x-ray	$40 per visit
Office visit	$40 per visit
Acupuncture Benefits	
Acupuncture services – office location	$15 per visit
Allergy Testing and Treatment Benefits	
Allergy serum purchased separately for treatment	10%
Primary Care Physician office visits (includes visits for allergy serum injections)	$15 per visit
Specialist Physician office visits (includes visits for allergy serum injections)	$40 per visit
Ambulance Benefits	
Emergency or authorized transport	$150
Ambulatory Surgery Center Benefits Note: Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient ambulatory surgery services may also be obtained from a Hospital or an Ambulatory Surgery Center that is affiliated with a Hospital, and will be paid according to the Hospital Benefits (Facility Services) section of this Summary of Benefits.	
Ambulatory Surgery Center outpatient surgery facility services	$250 per surgery
Ambulatory Surgery Center outpatient surgery Physician services	$40 per visit
Chiropractic Benefits	
Chiropractic services – office location	Not covered
Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits	
Clinical Trial for Treatment of Cancer or Life Threatening Conditions Covered Services for Members who have been accepted into an approved clinical trial when prior authorized by Blue Shield.	Services for routine patient care will be paid on the same basis and at the same Benefit levels as other Covered Services.
Diabetes Care Benefits	
Devices, equipment and supplies	10%
Diabetes self-management training – office location	You pay nothing
Durable Medical Equipment Benefits	
Breast pump	You pay nothing
Other Durable Medical Equipment	10%

Benefit	Member Copayment[2]
Emergency Room Benefits	
Emergency Room Physician services not resulting in admission Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and not covered.	You pay nothing
Emergency Room Physician services resulting in admission Note: Billed as part of inpatient Hospital services.	You pay nothing
Emergency Room services not resulting in admission Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, Benefits may be denied and not covered.	$150 per visit
Emergency Room services resulting in admission Note: Billed as part of inpatient Hospital services	$250 per day[3]
Family Planning Benefits Note: Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the applicable facility benefit in the Summary of Benefits will also apply, except for insertion and/or removal of intrauterine device (IUD), an intrauterine device (IUD), and tubal ligation.	
Counseling and consulting (Including Physician office visit for diaphragm fitting, injectable contraceptives or implantable contraceptives.)	You pay nothing
Diaphragm fitting procedure	You pay nothing
Implantable contraceptives	You pay nothing
Infertility services[1]	50%
Injectable contraceptives	You pay nothing
Insertion and/or removal of intrauterine device (IUD)	You pay nothing
Intrauterine device (IUD)	You pay nothing
Tubal ligation	You pay nothing
Vasectomy	$250 per surgery
Home Health Care Benefits	
Home health care agency services (Including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist or occupational therapist.) Up to a maximum of 100 visits per Member, per Calendar Year, by home health care agency providers. If your benefit plan has a Calendar Year Medical Deductible, the number of visits starts counting toward the maximum when services are first provided even if the Calendar Year Medical Deductible has not been met.	$20 per visit
Medical supplies	You pay nothing

Benefit	Member Copayment[2]
Home Infusion/Home Injectable Therapy Benefits	
Hemophilia home infusion services Services provided by a hemophilia infusion provider and prior authorized by Blue Shield. Includes blood factor product.	You pay nothing
Home infusion/home intravenous injectable therapy provided by a Home Infusion Agency Note: Non-intravenous self-administered injectable drugs are covered under the Outpatient Prescription Drug Benefit.	You pay nothing
Home visits by an infusion nurse Hemophilia home infusion nursing visits are not subject to the Home Health Care and Home Infusion/Home Injectable Therapy Benefits Calendar Year visit limitation.	$20 per visit
Hospice Program Benefits Covered Services for Members who have been accepted into an approved Hospice Program. The Hospice Program Benefit must be prior authorized by Blue Shield and must be received from a Participating Hospice Agency.	
24-hour continuous home care	You pay nothing
Short-term inpatient care for pain and symptom management	You pay nothing
Inpatient respite care	You pay nothing
Pre-hospice consultation	You pay nothing
Routine home care	You pay nothing
Hospital Benefits (Facility Services)	
Inpatient Facility Services Semi-private room and board, services and supplies, including Subacute Care.	$250 per day[3]
Inpatient skilled nursing services, including Subacute Care Up to a maximum of 100 days per Member, per Benefit Period, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility. If your benefit plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	$150 per day[3]
Inpatient services to treat acute medical complications of detoxification	$250 per day[3]
Outpatient dialysis services	10%
Outpatient Facility services	$250 per surgery
Outpatient services for treatment of illness or injury, radiation therapy, chemotherapy, and supplies	10%

Benefit	Member Copayment[2]
Medical Treatment for the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits Treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated, and orthognathic surgery for skeletal deformity.	
Ambulatory Surgery Center outpatient surgery facility services	$250 per surgery
Inpatient Hospital services	$250 per day[3]
Office location	$15 per visit
Outpatient department of a Hospital	$250 per surgery

Benefit	Member Copayment[2]
Mental Health, Behavioral Health, and Substance Use Disorder Benefits[4] All Services provided through Blue Shield's Mental Health Service Administrator (MHSA).	
Mental Health and Behavioral Health - Inpatient Services	
Inpatient Hospital services	$250 per day[3]
Inpatient Professional (Physician) services	$40 per visit
Residential care	$250 per day[3]
Mental Health and Behavioral Health – Routine Outpatient Services	
Professional (Physician) office visits	$15 per visit
Mental Health and Behavioral Health – Non-Routine Outpatient Services	
Behavioral Health Treatment in home or other non-institutional setting	You pay nothing
Behavioral Health Treatment in an office-setting	You pay nothing
Electroconvulsive therapy (ECT)[6]	You pay nothing
Intensive Outpatient Program[6]	You pay nothing
Partial Hospitalization Program[5]	You pay nothing
Psychological testing to determine mental health diagnosis (outpatient diagnostic testing) Note: For diagnostic laboratory services, see the "Outpatient diagnostic laboratory services including Papanicolaou test" section of this Summary of Benefits. And for diagnostic X-ray and imaging services, see the "Outpatient diagnostic X-ray and imaging services, including mammography" section of this Summary of Benefits.	You pay nothing
Transcranial magnetic stimulation	You pay nothing
Substance Use Disorder – Inpatient Services	
Inpatient Hospital services	$250 per day[3]
Inpatient Professional (Physician) services – Substance Use Disorder	$40 per visit
Residential care	$250 per day[3]
Substance Use Disorder – Routine Outpatient Services	
Professional (Physician) office visits	$15 per visit
Substance Use Disorder – Non-Routine Outpatient Services	
Intensive Outpatient Program[6]	You pay nothing
Office-based opioid detoxification and/or maintenance therapy	You pay nothing
Partial Hospitalization Program[5]	You pay nothing

Benefit	Member Copayment[2]
Orthotics Benefits	
Office visits	$15 per visit
Orthotic equipment and devices	You pay nothing

Benefit	Member Copayment[9,10]
Outpatient Prescription Drug (Pharmacy) Benefits [7,10,11]	
Retail Pharmacies (up to 30-day supply)	
Contraceptive Drugs and Devices[8]	You pay nothing
Tier 1 Drugs	$5 per prescription
Tier 2 Drugs	$15 per prescription
Tier 3 Drugs	$25 per prescription
Tier 4 Drugs (excluding Specialty Drugs)	10% up to $250 per prescription
Mail Service Pharmacies (up to 90-day supply)	
Contraceptive Drugs and Devices[8]	You pay nothing
Tier 1 Drugs	$10 per prescription
Tier 2 Drugs	$30 per prescription
Tier 3 Drugs	$50 per prescription
Tier 4 Drugs (excluding Specialty Drugs)	10% up to $500 per prescription
Network Specialty Pharmacies	
Tier 4 Drugs	10% up to $250 per prescription
Oral Anticancer Medications	10% up to $200 per prescription for 30-day supply

Benefit	Member Copayment[2]
Outpatient X-Ray, Imaging, Pathology, and Laboratory Benefits Note: Benefits are for diagnostic, non-preventive health services and for diagnostic radiological procedures, such as CT scans, MRIs, MRAs and PET scans, etc. For Benefits for Preventive Health Services, see the "Preventive Health Benefits" section of this Summary of Benefits.	
Diagnostic laboratory services, including Papanicolaou test, from an Outpatient Laboratory Center Note: Participating Laboratory Centers may not be available in all areas. Laboratory services may also be obtained from a Hospital or from a laboratory center that is affiliated with a Hospital.	$20 per visit
Diagnostic laboratory services, including Papanicolaou test, from an outpatient department of a Hospital	$20 per visit
Diagnostic X-ray and imaging services, including mammography, from an Outpatient Radiology Center Note: Participating Radiology Centers may not be available in all areas. Radiology services may also be obtained from a Hospital or from a radiology center that is affiliated with a Hospital.	$40 per visit
Diagnostic X-ray and imaging services, including mammography, from an outpatient department of a Hospital	$40 per visit
Outpatient diagnostic testing – Other Testing in an office location 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 test, EEG and EMG.	$40 per visit
Outpatient diagnostic testing – Other Testing in an outpatient department of a Hospital 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 test, EEG and EMG.	$40 per visit
Radiological and Nuclear Imaging services Services provided in the outpatient department of a Hospital or at a Free Standing Radiology Center. Prior authorization is required.	$150 per visit
PKU Related Formulas and Special Food Products Benefits	
PKU	You pay nothing

Benefit	Member Copayment[2]
Pregnancy and Maternity Care Benefits Note: Routine newborn circumcision is only covered as described in the Covered Services section of the Evidence of Coverage. Services will be covered as any other surgery and paid as noted in this Summary of Benefits.	
Inpatient Hospital services for normal delivery, Cesarean section, and complications of pregnancy	$250 per day[3]
Delivery and all inpatient physician services	$40 per visit
Prenatal and preconception Physician office visit: initial visit	You pay nothing
Prenatal and preconception Physician office visit: subsequent visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy	You pay nothing
Postnatal Physician office visit: initial visit	You pay nothing
Abortion services Copayment/Coinsurance shown is for physician services in the office or outpatient facility. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility Copayment/Coinsurance may apply.	$250 per surgery
Preventive Health Benefits	
Preventive Health Services See Preventive Health Services, in the Principal Benefits and Coverages (Covered Services) section of the Evidence of Coverage, for more information.	You pay nothing
Professional Benefits	
Inpatient Physician services	$40 per visit
Outpatient Physician services, other than an office setting	$40 per visit
Physician home visits	$40 per visit
Primary Care Physician office visits For mammography and Papanicolaou test, a woman may self-refer to an OB-Gyn or family practice Physician in the Personal Physician's Medical Group/IPA.	$15 per visit
Other practitioner office visit	$15 per visit
Specialist Physician office visits See also the section "Access+ Specialist Benefits" of this Summary of Benefits.	$40 per visit
Teladoc consultation Teladoc consultation services provide confidential consultations using a network of board certified Physicians when your Personal Physician's office is closed and you need quick access to a Physician. Teladoc Physicians are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. over secure video, 7 days a week. See Professional Benefits in the Principal Benefits and Coverages (Covered Services) section of the Evidence of Coverage for detailed information.	$5 per consultation

Benefit	Member Copayment[2]
Prosthetic Appliance Benefits	
Office visits	$15 per visit
Prosthetic equipment and devices	You pay nothing
Reconstructive Surgery Benefits For Physician services for these Benefits, see the "Professional Benefits" section of this Summary of Benefits	
Ambulatory Surgery Center outpatient surgery facility services	$250 per surgery
Inpatient Hospital services	$250 per day[3]
Outpatient department of a Hospital	$250 per surgery
Rehabilitation and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy) Rehabilitation and Habilitative Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.	
Office location	$15 per visit
Outpatient department of a Hospital	$15 per visit

Benefit	Member Copayment [2]
Skilled Nursing Facility (SNF) Benefits	
Skilled nursing services by a free-standing Skilled Nursing Facility Up to a maximum of 100 days per Member, per Benefit Period, except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all skilled nursing services whether rendered in a Hospital or a free-standing SNF. If your benefit plan has a Calendar Year Medical Deductible, the number of days counts towards the day maximum even if the Calendar Year Medical Deductible has not been met.	$150 per day[3]
Speech Therapy Benefits Speech Therapy Services may also be obtained from a Hospital or SNF as part of an inpatient stay in one of those facilities. In this instance, Covered Services will be paid as specified under the applicable section, Hospital Benefits (Facility Services) or Skilled Nursing Facility Benefits, of this Summary of Benefits.	
Office location	$15 per visit
Outpatient department of a Hospital	$15 per visit
Transplant Benefits – Tissue and Kidney Organ Transplant Benefits for transplant of tissue or kidney.	
Hospital services	$250 per day[3]
Professional (Physician) services	$40 per visit
Transplant Benefits – Special Blue Shield requires prior authorization for all Special Transplant Services, and all services must be provided at a Special Transplant Facility designated by Blue Shield. See the Transplant Benefits – Special Transplants section of the Principal Benefits (Covered Services) section in the Evidence of Coverage for important information on this Benefit.	
Facility services in a Special Transplant Facility	$250 per day[3]
Professional (Physician) services	$40 per visit
Urgent Services Benefits	
Urgent Services Inside the Personal Physician's Service Area and not rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	Not covered
Urgent Services Inside the Personal Physician's Service Area and rendered or referred by the Personal Physician or Personal Physician's Medical Group/IPA	$15 per visit
Urgent Services Outside the Personal Physician's Service Area	$15 per visit

Benefit	Member Copayment [2]
Pediatric Vision Benefits Pediatric vision benefits are available for members through the end of the month in which the member turns 19. All Services provided through Blue Shield's Vision Plan Administrator (VPA)[16]	
Comprehensive examination[12] One comprehensive eye examination per Calendar Year. Includes dilation, if professionally indicated.	
Ophthalmologic New Patient (S0620) Established Patient (S0621)	You pay nothing
Optometric New Patient (92002/92004) Established Patient (92012/92014)	You pay nothing
Eyewear/materials One pair of eyeglasses (frames and lenses) or one pair of contact lenses per Calendar Year (unless otherwise noted) as follows:	
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 sunglass. Polycarbonate lenses are covered in full for eligible Members.	
Single Vision (V2100-V2199)	You pay nothing
Lined Bifocal (V2200-V2299)	You pay nothing
Lined Trifocal (V2300-V2399)	You pay nothing
Lenticular (V2121, V2221, V2321)	You pay nothing
Optional Lenses and Treatments	
Ultraviolet Protective Coating (standard only)	You pay nothing
Standard Progressive Lenses	$55
Premium Progressive Lenses	$95
Anti-Reflective Lens Coating (standard only)	$35
Photochromic – Glass Lenses	$25
Photochromic – Plastic Lenses	$25
High-Index Lenses	$30
Polarized Lenses	$45
Frames[13]	
Collection frames	You pay nothing
Non-Collection frames	Up to $150
Contact Lenses[14]	
Non-Elective (Medically Necessary) – Hard or soft	You pay nothing
Elective (Cosmetic/Convenience) – Standard hard (V2500, V2510)	You pay nothing
Elective (Cosmetic/Convenience) – Standard soft (V2520) One pair per month, up to 6 months, per Calendar Year.	You pay nothing
Elective (Cosmetic/Convenience) – Non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	You pay nothing
Elective (Cosmetic/Convenience) – Non-standard soft (V2521-V2523) One pair per month, up to 3 months, per Calendar Year.	You pay nothing
Supplemental Low-Vision Testing and Equipment[15]	35%
Diabetes Management Referral	You pay nothing

Benefit	Member Copayment [2]
Pediatric Dental Benefits[17] Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19.	
Diagnostic and Preventive Care Services[18]	
Oral Exam	You pay nothing
Preventive – Cleaning	You pay nothing
Preventive – X-ray	You pay nothing
Sealants per Tooth	You pay nothing
Topical Fluoride Application	You pay nothing
Space Maintainers – Fixed	You pay nothing
Basic Services[19]	
Amalgam Fill – One Surface	$25
Major Services – Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery[20]	
Root Canal – Molar	$300
Gingivectomy per Quad	$150
Extraction – Single Tooth Exposed Root or Erupted	$65
Extraction – Complete Bony	$160
Crown – Porcelain with Metal	$300
Orthodontia Services[20]	
Medically Necessary Orthodontia	$350

Summary of Benefits

Endnotes:

1. For an individual on a family coverage plan, a Member can receive 100% benefits for covered services once the individual out-of-pocket maximum is met in a calendar year and before the family out-of-pocket maximum is met.
   Copayments or Coinsurance for Covered Services accrue to the Calendar Year Out-of-Pocket Maximum, except Copayments or Coinsurance for Covered Services listed in the following sections of this Summary of Benefits:
   - Charges in excess of specified benefit maximums
   - Family planning benefits: infertility services

   Note: Copayments, Coinsurance, and charges for services not accruing to the Calendar Year Out-of-Pocket Maximum continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.
2. Any Coinsurance is calculated based on the Allowed Charge unless otherwise specified.
3. The Member's Copayment is per day up to a maximum of 5 days per admission. After 5 days, there is no additional Copayment for the remainder of the inpatient stay.
4. Prior authorization from the MHSA is required for all non-Emergency or non-Urgent Inpatient Services, and Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services. No prior authorization is required for Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services – Professional (Physician) Office Visit.
5. For Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment and Outpatient Substance Use Disorder Services - Partial Hospitalization Program Services, an episode of care is the date from which the patient is admitted to the Partial Hospitalization Program and ends on the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute an episode of care. If the patient needs to be readmitted at a later date, then this would constitute another episode of care.
6. The Member's Copayment or Coinsurance includes both outpatient facility and Professional (Physician) Services.
7. This benefit plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this benefit plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
8. There is no Copayment or Coinsurance for contraceptive drugs and devices, however, if a Brand contraceptive drug is selected when a Generic Drug equivalent is available, the Member is responsible for the difference between the cost to Blue Shield for the Brand contraceptive drug and its Generic Drug equivalent. If the Brand contraceptive drug is Medically Necessary, it may be covered without a Copayment or Coinsurance with prior authorization. The difference in cost does not accrue to the Calendar Year Pharmacy Deductible, Medical Deductible, or Out-of-Pocket Maximum.
9. Copayment or Coinsurance is calculated based on the contracted rate.
10. Copayment or Coinsurance is per prescription up to a 30-day supply (up to 90-day supply for mail order).
11. Blue Shield's Short Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the EOC. In such circumstances, the applicable Specialty Drug Copayment or Coinsurance will be pro-rated.
12. The comprehensive examination Benefit and Allowance does not include fitting and evaluation fees for contact lenses.
13. This Benefit covers Collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "Collection" but are required to maintain a comparable selection of frames that are covered in full.
    For non-Collection frames the allowable amount is up to $150; however, if (a) the Participating Provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the Participating Provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating Providers using wholesale pricing are identified in the provider directory.
    If frames are selected that are more expensive than the allowable amount established for this Benefit, the Member is responsible for the difference between the allowable amount and the provider's charge.
14. Contact lenses are covered in lieu of eyeglasses once per Calendar Year. See the Definitions section in the Evidence of Coverage for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses.
15. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

16. All vision services must be provided through a participating vision care provider. For a list of participating vision providers, members can search in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, co-payments and coinsurance for covered vision services from participating vision providers accrue to the calendar year out-of-pocket maximum. Costs for non-covered services, services from non-participating vision providers, charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.

17. Pediatric dental benefits are available through a DHMO network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this DHMO network. For a list of participating dentists, members can search in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator. Members should contact Dental Plan Member Services if they need assistance locating a Dental Plan Provider in the Service Area. Refer to the *Evidence of Coverage* and Summary of Benefits for details. The Plan will review and consider the request for services that cannot be reasonably obtained in network. Any calendar year pediatric dental services copayments for covered dental services from participating dentists accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services received from participating dentists. Costs for non-covered services, services from non-participating dentists, charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.

18. Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

19. Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the Member will be responsible for the difference in cost between the Posterior composite resin and amalgam filling.

20. Medically Necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a Limited Oral Evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) Score sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for medically necessary orthodontic services (see list of qualifying conditions below). Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.

    Those immediate qualifying conditions are:

    a. Cleft lip and or palate deformities
    b. Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
    c. 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).
    d. 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.
    e. Severe traumatic deviation must be justified by attaching a description of the condition.
    f. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.
    g. The remaining conditions must score 26 or more to qualify (based on the HDL Index).

Benefit Plans may be modified to ensure compliance with state and federal requirements.

Introduction to the Blue Shield of California Health Plan

Trio ACO 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 ACO HMO participate in accountable care organization collaborations with Blue Shield.

It is important for Members to review the list of providers within the Trio ACO 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 Personal 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 Personal 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 Blue Shield Customer Service 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 Personal Physician

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

The Member's Personal 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 Personal Physician at the time of enrollment, Blue Shield will designate a Personal Physician and the Member will be notified. This designation will remain in effect until the Member requests a change.

A Personal 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 Personal Physician. For the month of birth, the Personal Physician must be in the same Medical Group or Independent Practice Association (IPA) as the mother's Personal 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 Personal Physician selected must be a Physician in the same Medical Group or IPA as the Subscriber. If a Personal Physician is not selected for the child, Blue Shield will designate a Personal 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 Personal Physician for the child after the first month, see the section below on *Changing Personal 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.

Personal Physician Relationship

The Physician-patient relationship is an important element of an HMO Plan. The Member's Personal 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 Personal Physician fail to establish a satisfactory relationship or disagree on a recommended course of treatment, the Member may contact Customer Service at the number provided on the back page of this Evidence of Coverage for assistance in selecting a new Personal Physician.

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

Role of the Personal Physician

The Personal 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, Access+ 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 Personal 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 Personal Physician without a referral from the Personal 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 Personal 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 Access+ Specialist feature described later in this section.

Referral to Specialty Services

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

When the Personal 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 Personal 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 Personal 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 Personal 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 Personal Physicians contract with a Medical Group or IPA to share administrative and authorization responsibilities (some Personal Physicians contract directly with Blue Shield). The Personal 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 Personal 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 Personal 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 Personal Physician and Medical Group/IPA are listed on the Member's identification (ID) card.

Changing Personal Physicians or Designated Medical Group or IPA

The Trio ACO HMO Plan offers a limited selection of IPAs and Medical Groups from which Members must choose. Members may change their Personal Physician to another Personal 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 ACO 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 Personal Physician or to receive Covered Services.

In scenarios where there is only one (1) IPA or Medical Group, Members may not change their Trio ACO 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 Personal Physician. If the selected Medical Group/IPA does not have an affiliation with the Member's Personal Physician, a change in Medical Group/IPA may also require the Member to select a new Personal Physician.

Changes in Medical Group/IPA or Personal Physician are effective the first day of the month following notice of approval by Blue Shield. Once the change of Personal Physician is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN services and Access+ 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 Access+ Specialist visits, new authorizations must be obtained. Members may call Customer Service for assistance with Personal 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 Personal Physician or Medical Group/IPA during an on-going course of treatment may interrupt care. For this reason, the effective date of a Personal 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 Personal 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 Customer Service at the number provided on the back page of this Evidence of Coverage.

If a Member's Personal Physician terminates participation in the Plan, Blue Shield will notify the Member in writing and designate a new Personal Physician who is immediately available to provide the Member's medical care. Members may also make their own selection of a new Personal 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.

Access+ Specialist

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

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

An Access+ 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 Personal Physician referral

An Access+ Specialist visit does not include:

1) Services which are not otherwise covered;
2) Services provided by a non-Access+ 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 Personal Physician;
12) OB/GYN services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician.

Access+ 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 Customer Service 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 Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services, except for Access+ 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 Personal 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 Personal Physician, may also contact the MHSA directly for information and to select an MHSA Participating Provider by calling 1-877-263-9952. Your Personal 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. 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. Non-Routine Outpatient Mental Health Services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the 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 Non-Routine 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 by a Terminated Provider

Members who (1) are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; (2) are children from birth to 36 months of age; or (3) have received authorization from a terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield provider network. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a terminated provider.

Continuity of Care for New Members by Non-Contracting Providers

Newly covered Members who (1) are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; (2) are children from birth to 36 months of age; or (3) have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with the non-contracting provider who was providing services to the Member at the time the Member's coverage became effective under this Plan. Contact Customer Service to receive information regarding eligibility criteria and the written policy and procedure for requesting continuity of care from a non-contracting provider.

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 Personal Physician to another Physician for a second medical opinion. The Member's Personal Physician may also offer a referral to another Physician for a second opinion.

If the second opinion involves care provided by the Member's Personal 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 ACO 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 your Personal Physician Service Area.

Urgent Services are defined as those Covered Services rendered outside of the Personal 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 Personal 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 Personal Physician Service Area

If you require urgent care for a condition that could reasonably be treated in your Personal 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 Personal 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 Personal Physician Service Area.

Outside of California

The Blue Shield Trio ACO 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. You can receive urgent care services from any provider; however, using the *BlueCard*® Program, described herein, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Out-of-Area Follow-up Care is covered and services may be received through the *BlueCard* Program participating provider network or from any provider. However, 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 the Personal Physician.

Within California

If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Customer Service at the number provided on the back page of this booklet for assistance in receiving Urgent Services through a Blue Shield of California Plan Provider. You may also locate a Plan Provider by visiting our web site at www.blueshieldca.com. However, you are not required to use a Blue Shield of California Plan Provider to receive Urgent Services; you may use any provider. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Follow-up care is also covered through a Blue Shield of California Plan Provider and may also be received from any provider. However, when outside your Personal Physician Service Area 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 the Personal Physician.

If services are not received from a Blue Shield of California Plan 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 Personal Physician Service Area within California will be reviewed retrospectively for coverage.

When you receive covered Urgent Services outside your Personal 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 for Emergency Services received anywhere in the world for emergency care of an illness or injury.

For Emergency Services from a 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 Personal Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization.

An emergency means 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.

If a Member receives non-authorized services under circumstances that were not a situation in which a reasonable person would believe that an emergency condition existed, the Member will be responsible for the cost of those services.

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 Personal 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.

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.

There is an individual Deductible within the Family Calendar Year Medical Deductible. This means:

1) Blue Shield will pay Benefits for that individual Member of a Family who meets the individual Calendar Year Medical Deductible amount prior to the Family Calendar Year Medical Deductible being met.

2) If the Family has 2 Members, each Member must meet the individual Deductible amount to satisfy the Family Calendar Year Medical Deductible.

3) If the Family has 3 or more Members, the Family Calendar Year Medical Deductible can be satisfied by 2 or more Members.

Once the respective Deductible is reached, Covered Services are paid at the Allowed Charges, less any applicable Copayment and 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 De-

ductible 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.

Drugs in Tier 1, and Contraceptive drugs and devices are not subject to the Calendar Year Pharmacy Deductible. The Calendar Year Pharmacy Deductible applies to all other Drugs.

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 applicable Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum.

There is an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means:

1) The Out-of-Pocket Maximum will be met for that individual Member of a Family who meets the individual Calendar Year Out-of-Pocket Maximum amount prior to the Family Calendar Year Out-of-Pocket Maximum being met.
2) If the Family has 2 Members, each Member must meet the individual Out-of-Pocket Maximum amount to satisfy the Family Calendar Year Out-of-Pocket Maximum.
3) If the Family has 3 or more Members, the Family Calendar Year Out-of-Pocket Maximum can be satisfied by 2 or more Members.

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% for the remainder of the Calendar Year.

Charges for services that are not covered 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 Personal Physician and adjacent sections above, in general all services must be prior authorized by the Personal Physician or Medical Group/IPA. In addition, as designated in Prior Authorization for Mental Health, Behavioral Health Treatment, and Substance Use Disorder Services above, non-emergency inpatient and non-routine 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 Personal Physician, Medical Group/IPA, or the MHSA:

1) Emergency Services;
2) Urgent Services;
3) Access+ 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 Personal Physician's Medical Group/IPA; and,
6) Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient 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 Personal Physician or the MHSA and the services are prior authorized by the Personal 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 for payment of services if they are a Benefit of the Plan. When Covered Services are rendered by a Plan Provider, 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.

Inter-Plan Programs

Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

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

BlueCard Program

Under the *BlueCard*® Program, when you obtain Covered Services within the geographic area served by a Host Plan, Blue Shield will remain responsible for fulfilling our contractual obligations. However the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The *BlueCard* Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member copayment and deductible amounts, if any, as stated in this Evidence of Coverage.

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

1) The billed covered charges for your covered services; or

2) The negotiated price that the Host Plan makes available to Blue Shield.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types

of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

Claims for Emergency Services are paid based on the Allowed Charges as defined in this Evidence of Coverage.

Claims for Emergency and Out-of-Area Urgent Services

Emergency

If Emergency Services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the Emergency Service record for payment to the Plan, within one year after the first provision of Emergency Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Emergency Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services received were for a medical condition for which a reasonable person would not reasonably believe that an emergency condition existed and would not otherwise have been authorized, and, therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. In the event covered medical transportation services are obtained in such an emergency situation, the Blue Shield Trio ACO HMO Health Plan shall pay the medical transportation provider directly.

Out-of-Area Urgent Services

If out-of-area Urgent Services were received from a non-participating *BlueCard* Program provider, the Member must submit a complete claim with the Urgent Service record for payment to the Plan, within one year after the first provision of Urgent Services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those Urgent Services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. If the Plan determines that the services would not have been authorized, and therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

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 Customer Service 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 Personal 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 Personal Physician, an Obstetrical/Gynecological Physician within the Member's Medical Group/IPA, an Access+ 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. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.

When appropriate, the Personal 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 standards, 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

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.

Allergy Testing and Treatment Benefits

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

Ambulance Benefits

Benefits are provided for (1) 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) authorized ambulance transportation to or from one facility to another.

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 Personal 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 Conditions Benefits

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition when prior authorized through the Member's Personal Physician, and:

1) the clinical trial has a therapeutic intent and the Personal Physician 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 participant or beneficiary; and
2) the Hospital and/or Physician conducting the clinical trial is a Plan Provider, unless the protocol for the trial is not available through a Plan Provider.

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

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

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

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

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

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

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

Diabetes Care Benefits

Diabetes Equipment

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item, 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 Personal 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, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

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

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, 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. If there are two or more professionally recognized DME items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

No DME Benefits are provided for the following:

1) rental charges in excess of the purchase cost;
2) replacement of 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 (e.g., suture removal, wound check, etc.) must be authorized by Blue Shield or obtained through the Member's Personal Physician.

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

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 Customer Service 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.

Family Planning and Infertility 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.

Benefits for Infertility are provided when authorized by the Access+ HMO Personal Physician and the Access+ HMO and provided to a Member who is covered within and has a current diagnosis of Infertility with the intention of resulting in conception in that person. Subject to the Co-payments stated herein, only the following procedures are covered:

1) Six natural (without ovum (oocyte or ovarian tissue (egg)) stimulation) artificial inseminations;
2) Three stimulated (with ovum (oocyte or ovarian tissue) stimulation) artificial inseminations;
3) One gamete intrafallopian transfer (GIFT);

4) Cryopreservation of sperm/ oocytes /embryos when retrieved from a Member. Benefits include cryopreservation Services for a condition which the treating Physician anticipates will cause Infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures). Benefits are limited to one retrieval and one year of storage per person per lifetime.

The Copayment as shown on the Summary of Benefits is for all professional and Hospital Services, ambulatory surgery center and ancillary services used in connection with any procedure covered under this Benefit, drugs for the treatment of Infertility that are self-administered, and injectable drugs administered or prescribed by the provider during a course of treatment to induce fertilization. Procedures must be consistent with established medical practice in the treatment of Infertility and authorized by the Access+ HMO Personal Physician and Access+ HMO.

Home Health Care Benefits

Benefits are provided for home health care services when ordered and authorized through the Member's Personal 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 four 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 Personal 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, medica-

tions injected or administered intravenously and related laboratory services when prescribed by the Personal 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. Shift care and private duty nursing must be prior authorized by Blue Shield.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. A list of Participating Hemophilia Infusion Provider is available online at www.blueshieldca.com. Members may also verify this information by calling Customer Service 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 Personal 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 Personal 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 manage-

ment 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 Personal 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 Skilled Nursing care (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 Personal 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 Personal Physician.

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

1) Dialysis services.

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

3) Surgery.

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

5) Routine newborn circumcision within 18 months of birth.

Covered Physical Therapy, Occupational Therapy and Speech Therapy services provided in an outpatient Hospital setting are described under the *Rehabilitation and Habilitative Benefits (Physical, Occupational and Respiratory Therapy)* and *Speech Therapy Benefits* 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, and Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services must be prior authorized by the MHSA.

Mental Health and Behavioral Health – Routine Outpatient Services

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

Mental Health and Behavioral Health – Non-Routine 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. Non-Routine 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. Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when prior authorized 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 or; 2. Preferred Brand Name Drugs or; 3. Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
Tier 3	1. Non-preferred Brand Name Drugs or; 2. Recommended by 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. Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2. Self administration requires training, clinical monitoring or; 3. Drug was manufactured using biotechnology or; 4. Plan cost (net of rebates) is >$600.

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Phar-

macy by visiting https://www.blueshieldca.com/bsca/pharmacy/home.sp or by calling Customer Service at the number listed on the Identification Card. If the Member obtains Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny the claim, unless it is for Emergency Services.

Blue Shield negotiates contracted rates with Participating Pharmacies for 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. Drugs in Tier 1 are not subject to, and will not accrue to, the Calendar Year Pharmacy Deductible.

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

Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when Medically Necessary and when prior authorized by Blue Shield. If prior authorized, 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 prior authorization is not obtained, the Member is responsible for paying 100% of the cost of the Drug(s).

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

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

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

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

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

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

  Blue Shield of California
  Argus Health Systems, Inc.
  P.O. Box 419019,
  Dept. 191
  Kansas City, MO 64141

- Blue Shield will reimburse the Member based on the price the Member paid for the Drugs,

minus any applicable Deductible and Copayment or Coinsurance.

Claim forms may be obtained by calling Customer Service 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 Customer Service to get additional information about the Mail Service Prescription Drug Program.

Obtaining Specialty Drugs through the Specialty Drug Program

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

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

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

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

Prior Authorization/Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

1) Some Formulary, preferred, non-preferred, compound Drugs, and most Specialty Drugs;
2) Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;
3) Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance;
4) When 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 circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

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

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

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

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

1) Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days, the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

2) Blue Shield has a Short Cycle Specialty Drug Program. With the Member's agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for an initial prescription. This program allows the Member to receive a 15-day supply of the Specialty Drug and determine whether the Member will tolerate it before he or she obtains the full 30-day supply. This program can help the Member save out of pocket expenses if the Member cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact the Member to discuss the advantages of the program, which the Member can elect at that time. The Member or their Physician may choose a full 30-day supply for the first fill.

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

3) 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 Coin-

surance. Refill authorizations cannot be combined to reach a 90-day supply.

4) 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.

5) 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.

5) Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary and prior authorization is obtained from 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 for the treatment of Infertility, except Drugs for the treatment of Infertility that are self-administered. Injectable drugs administered or prescribed by the Member's Physician during a course of treatment to induce fertilization are also covered as described in the *Family Planning and Infertility Benefits* section of this Evidence of Coverage.

14) Appetite suppressants or drugs for body weight reduction. These Drugs may be cov-

ered 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 Personal 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 Personal 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 Dis-

ease 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 Customer Service.

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 Personal 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) 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 Personal 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 on-

line on Teladoc's website at no charge or can be printed, completed and mailed or faxed to Teladoc. Teladoc consultation services are not intended to replace services from your Personal Physician but are a supplemental service. You do not need to contact your Personal Physician before using Teladoc consultation services.

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

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

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-hour 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 Customer Service.

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. If there are two or more professionally recognized appliances equally appropriate for a condition, Benefits will be based on the most cost-effective appliance. Benefits include:

1) Blom-Singer and artificial larynx prostheses for speech following a laryngectomy (covered as a surgical professional benefit);
2) artificial limbs and eyes;
3) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;
4) Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or 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.

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

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

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

Benefits for Speech Therapy are described in the *Speech Therapy Benefits* section.

See the *Home Health Care Benefits* and *Hospice Program Benefits* sections for information on coverage for Rehabilitation/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

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

Continued outpatient Benefits will be provided as long as treatment is Medically Necessary, pursuant to the treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records may be reviewed periodically for Medical Necessity.

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

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 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.

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 272590
Chico, CA 95927-2590

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 not appearing on the Summary of Benefits or on the Dental Schedule and Limitations Table below;
2) Dental services in excess of the limits specified in the Limitations section of this Evidence of Coverage or on the Dental Schedule and Limitations Table below;
3) Services of Dentists or other practitioners of healing arts not associated with the Plan, except upon referral arranged by a Participating Dentist and authorized by the Plan, or when required in a covered emergency;
4) Any dental services received or costs that were incurred in connection with any dental procedures started prior to the Member's effective date of coverage. This exclusion does not apply to Covered Services to treat complications arising from services received prior to the Member's effective date of coverage;
5) Any dental services received subsequent to the time the Member's coverage ends;
6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed;
7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
8) Procedures, appliances, or restorations to correct congenital or developmental malformations unless specifically listed in the Summary of Benefits or on the Dental Schedule and Limitations Table below;
9) Cosmetic dental care;
10) General anesthesia or intravenous/conscious sedation unless specifically listed as a Benefit on the Summary of Benefits or on the Dental Schedule and Limitations Table below or is given by a Dentist for a covered oral surgery;
11) Hospital charges of any kind;
12) 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 treatment is Dentally Necessary 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) Charges for saliva testing when caries management procedures D0601, D0602 and D0603 are performed;

24) 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 Mmedically Nnecessary; 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.

Dental or Medical Necessity Exclusion

All services must be of Dental or Medical Necessity. The fact that a Dentist or other Plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Dental or 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 for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Member Service section for information on the expedited decision process.

Pediatric Dental Benefits Definitions –

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

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.

Dental Necessity (Dentally Necessary) — Benefits are provided only for Services that are Dentally Necessary as defined in this Section.

1) Services which are Dentally 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 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 Dentally Necessary 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 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
D0180	Comprehensive periodontal evaluation – new or established patient		No Charge
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

Code	Description	Limitation	Cost Share
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.	No Charge
D0251	Extraoral 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
D0290	Posterior - anterior or lateral skull and facial bone survey radiographic image	limited to the survey of trauma or pathology; up to a maximum of 3 per date of service.	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	Cephalometric radiographic image	twice in a 12 month period per provider.	No Charge
D0350	Oral/Facial photographic images	up to a maximum of 4 per date of service.	No Charge
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
D0999	Unspecified diagnostic procedure, by report		No Charge

Code	Description	Limitation	Cost Share
Preventive Procedures (D1000-D1999)			
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 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
D1510	Space maintainer-fixed – unilateral	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.	No Charge
D1515	Space maintainer-fixed – bilateral	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant and for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1520	Space maintainer-removable – unilateral	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge

Code	Description	Limitation	Cost Share
D1525	Space maintainer-removable – bilateral	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing; b. for upper and lower anterior teeth; and c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.	No Charge
D1550	Re-cementation of space maintainer	once per provider, per applicable quadrant or arch for Members under the age of 18.	No Charge
D1555	Removal of fixed space maintainer	not a Benefit to the original provider who placed the space maintainer.	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
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

Code	Description	Limitation	Cost Share
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
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
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
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
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

Code	Description	Limitation	Cost Share
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
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
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
D2910	Recement inlay, onlay, or partial coverage restoration	once in a 12 month period, per provider.	$25
D2915	Recement cast or prefabricated post and core		$25
D2920	Recement 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
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

Code	Description	Limitation	Cost Share
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
D2950	Core buildup, including any pins		$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
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
D2970	Temporary crown (fractured tooth)	once per tooth, per provider and for permanent teeth only. Not a Benefit on the same date of service as: a. palliative (emergency) treatment of dental pain- minor procedure (D9110); and b. office visit for observation (during regularly scheduled hours) - no other services performed (D9430).	$55
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
Endodontic Procedures (D3000-D3999)			
D3110	Pulp cap – direct (excluding final restoration)		$20
D3120	Pulp cap – indirect (excluding final restoration)		$25

Code	Description	Limitation	Cost Share
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction 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
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

Code	Description	Limitation	Cost Share
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		No Charge
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/Pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection 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/Pulpal regeneration – 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
D3410	Apicoectomy/Periradicular surgery – 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

Code	Description	Limitation	Cost Share
D3421	Apicoectomy/Periradicular surgery – 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/Periradicular surgery – 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/Periradicular surgery – (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
D3430	Retrograde filling – per root		$90
D3910	Surgical procedure for isolation of tooth with rubber dam		$30
D3999	Unspecified endodontic procedure, by report		$100
Periodontal 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
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.	$165
D4260	Osseous surgery (including flap entry 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 flap entry 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
D4265	Biologic materials to aid in soft and osseous tissue regeneration	for Members age 13 or older.	$80
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

Code	Description	Limitation	Cost Share
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
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
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)	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

Code	Description	Limitation	Cost Share
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$300
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$300
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$335

Code	Description	Limitation	Cost Share
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$335
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 (D5860); 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 (D5510) and replace missing or broken teeth complete denture (D5520).	$20
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 (D5860); 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 (D5510) and replace missing or broken teeth complete denture (D5520).	$20

Code	Description	Limitation	Cost Share
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 (D5610), repair cast framework (D5620), 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 (D5610), repair cast framework (D5620), 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
D5510	Repair broken complete denture base	once per arch 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

Code	Description	Limitation	Cost Share
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
D5610	Repair resin denture base	once 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. 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
D5620	Repair cast framework	once per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.	$40
D5630	Repair or replace broken clasp	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	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
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 (D5860) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (laboratory) (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 (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote) complete (D5860) 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 (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote) complete (D5860) 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 (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) complete (D5860) 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
D5860	Overdenture – complete, by report	once in a 5 year period.	$300
D5862	Precision attachment, by report		$90
D5899	Unspecified removable prosthodontic procedure, by report		$350
Maxillofacial Prosthetics Procedures (D5900-D5999)			
D5911	Facial moulage (sectional)		$285

Code	Description	Limitation	Cost Share
D5912	Facial moulage (complete)		$350
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

Code	Description	Limitation	Cost Share
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
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	Topical Medicament Carrier		$70
D5999	Unspecified maxillofacial prosthesis, by report		$350
Implant Service Procedures (D6000-D6199)			
D6010	Surgical placement of implant body: endosteal implant		$350
D6040	Surgical placement: eposteal implant		$350
D6050	Surgical placement: transosteal implant		$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 porcelain fused to metal crown (titanium, titanium alloy, high noble metal)		$335

Code	Description	Limitation	Cost Share
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)		$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
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 for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)		$330
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)		$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis		$30
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	Recement implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.	$25
D6093	Recement 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)		$295
D6095	Repair implant abutment, by report		$65
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

Code	Description	Limitation	Cost Share
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
D6190	Radiographic/Surgical implant index, by report		$75
D6194	Abutment supported retainer crown for FPD (titanium)		$265
D6199	Unspecified implant procedure, by report		$350
Fixed Prosthodontic Procedures (D6200-D6999)			
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
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
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
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
D6721	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
D6740	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
D6751	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
D6781	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
D6783	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
D6791	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
D6930	Recement 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 and Maxillofacial Surgery 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

Code	Description	Limitation	Cost Share
D7210	Surgical removal of 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
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	Surgical 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	Surgical access of an unerupted tooth	not a Benefit: a. for Members age 21 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 21 years or older; and b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.	$85

Code	Description	Limitation	Cost Share
D7285	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	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
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
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

Code	Description	Limitation	Cost Share
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	Surgical 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
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

Code	Description	Limitation	Cost Share
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 surgical 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
D7854	Synovectomy		$350
D7856	Myotomy		$350
D7858	Joint reconstruction		$350
D7860	Arthrostomy		$350
D7865	Arthroplasty		$350
D7870	Arthrocentesis		$90
D7871	Non-arthroscopic lysis and lavage		$150
D7872	Arthroscopy – diagnosis, with or without biopsy		$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions		$350

Code	Description	Limitation	Cost Share
D7874	Arthroscopy – surgical: disc repositioning and stabilization		$350
D7875	Arthroscopy – surgical: synovectomy		$350
D7876	Arthroscopy – surgical: discectomy		$350
D7877	Arthroscopy – surgical: debridement		$350
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.	$120
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
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 mandible or facial bones – 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 with bone or bone substitute 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
D7960	Frenulectomy also knows 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

Code	Description	Limitation	Cost Share
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.	$100
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 Handicapping malocclusion	once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).	$1,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate	for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per Member per phase of treatment.	
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management	for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per Member per phase of treatment.	
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.	
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.	
D8660	Pre-orthodontic treatment visit	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 (as part of contract) 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 (as part of contract) 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 (as part of contract) 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 (as part of contract) 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 (as part of contract) 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 (as part of contract) 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 (as part of contract) 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).	
D8691	Repair of orthodontic appliance	once per appliance. Not a Benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8692	Replacement of lost or broken retainer	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).	
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	once per provider.	
D8999	Unspecified orthodontic procedure, by report		

Code	Description	Limitation	Cost Share
Adjunctive 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
D9220	Deep sedation/general anesthesia – first 30 minutes	deleted CDT code in 2016.	---
D9221	Deep sedation/general anesthesia – each additional 15 minutes	deleted CDT code in 2016– replaced with D9223.	---
D9223	Deep sedation/general anesthesia – each 15 minute increment		$45
D9230	Inhalation of nitrous oxide/anxiolysis analgesia	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 (D9220 and D9221), 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.	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	deleted CDT code in 2016.	---
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	deleted CDT code in 2016– replaced with D9243.	---

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 (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
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 (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9241 and D9242); 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
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

Code	Description	Limitation	Cost Share
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 (D9220 and D9221), 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.	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications		$40
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
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
D9999	Unspecified adjunctive procedure, by report		No Charge

Pediatric Vision Benefits

Blue Shield covers pediatric vision Benefits for individuals up to 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 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.

2) One of the following in a Calendar Year:

   a. One pair of spectacle lenses,

   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 Participating Providers and only once in a consecutive five Calendar Year period. 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 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 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 Participating Provider, the Subscriber should identify the Member as a Blue Shield /VPA Member.

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

Choice of Providers for Pediatric Vision Benefits

Members must select a participating ophthalmologist, optometrist, or optician to provide Covered Services under this pediatric vision benefit. A list of 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 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 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

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 for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

Definitions for Pediatric Vision Benefits

Elective Contact Lenses — prescription lenses that are chosen for cosmetic or convenience pur-

poses. 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 Participating Providers.

VPA Participating Provider – For purposes of this pediatric vision Benefit, 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 Personal Physician Service Area, call your Personal 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 Personal 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 Plan 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 Plan 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. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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* Program participating provider. When a *BlueCard* Program participating provider is available, you should obtain out-of-area urgent or follow-up care from a participating provider whenever possible, but you may also receive care from a non-*BlueCard* participating provider. If you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by the Plan to determine whether the services were Urgent Services. See *Claims for Emergency and Out-of-Area Urgent Services* in the How to Use This Health Plan section for additional information. Note: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

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 Personal Physician.

Benefits will also be provided for Covered Services received from any provider outside of the United States, Puerto Rico and U.S. Virgin Islands for

emergency care of an illness or injury. If you need urgent care while out of the country, contact the *BlueCard* Worldwide Service Center through the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week. For inpatient Hospital care, contact the *BlueCard* Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim. When you receive services from a Physician, you will have to pay the doctor and then submit a claim. A claim must be submitted as described in *Claims for Emergency and Out-of-Area Urgent Services* in the How to *Use This Health Plan* section. See *BlueCard Program* in the *How to Use This Health Plan* section for additional information.

Members before traveling abroad may call their local Member Services office for the most current listing of providers or they can go on line at www.bcbs.com and select "Find a Doctor or Hospital" and "*BlueCard* Worldwide". However, a Member is not required to receive Urgent Services outside of the United States, Puerto Rico and U.S. Virgin Islands from a listed provider.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

1) routine physical examinations, except as specifically listed under *Preventive Health Benefits,* or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;
2) for hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
3) routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; 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) services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided *under Hospice Program Benefits*;
6) services in connection with private duty nursing, except as provided under *Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits,* and except as provided through a Participating Hospice Agency;
7) prescription and non-prescription food and nutritional supplements, except as provided under *Home Infusion/Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Products Benefits,* or as provided through a Participating Hospice Agency;
8) hearing aids;
9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;
10) surgery to correct refractive error (such as but

not limited to radial keratotomy, refractive keratoplasty);

11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;

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

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

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

15) 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.

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

17) for Infertility services:

    a) 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;

    b) for collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the Member;

    c) through Intracytoplasmic sperm injection (ICSI);

    d) through Zygote intrafallopian transfer (ZIFT) and in vitro fertilization (IVF);

    e) not specifically listed as a covered Service in the Family Planning and Infertility Services section;

    f) for or incident to a condition which the person anticipates may cause Infertility in the future except as described in the Benefit for cryopreservation of sperm/oocytes/ovarian tissue/embryos;

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

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

20) 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;

21) services performed in a Hospital by house officers, residents, interns, and others in training;

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

23) services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under *Mental Health, Behavioral Health, and Substance Use Disorder Benefits*;

24) massage therapy that is not Physical Therapy or a component of a multiple-modality rehabilitation treatment plan;

25) 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.* 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) 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;

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

28) 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;

29) 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;*

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

31) 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.*

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

33) 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

34) 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;

35) for transportation services other than provided under *Ambulance Benefits* in the Plan Benefits section;

36) for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician, Emergency Services or Urgent Services as provided under *Emergency Room Benefits* and *Urgent Services Benefits* in the Plan Benefits section;

37) for inpatient and Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services unless authorized by the MHSA;

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

39) services not specifically listed as a Benefit.

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 Customer Service 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 ACO HMO CCSB Plan, the Employee must live or work in the Trio ACO 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 eligible 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 60 days from the date of birth, adoption or placement for adoption. If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, children may be eligible and may be enrolled as a Dependent of either parent, but not both. Please contact 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.

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, with 14 days' notice to CCSB or Blue Shield. If coverage is terminated at a Member's request, coverage will end at 11:59 p.m. Pacific Time on (a) the cancellation date specified by the Member if the Member gave 14 days' notice; (b) fourteen days after the cancellation is requested, if the Member gave less than 14 days' notice; or (c) a date Blue Shield specifies if the Member gave less than 14 days' notice and the Member requested an earlier termination effective date. If the Member is newly eligible for Medi-Cal, 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 immediately upon giving written notice to the Subscriber and Employer:

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 to become effective upon receipt, or on a later date as may be specified by the notice.

Cancellation for Employer's Non-Payment of Premiums - 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 mail the Employer a Cancellation Notice (or Notice Confirming Termination of Coverage). The Employer must provide enrolled Employees with a copy of the Notice Confirming Termination of Coverage.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield may cancel or rescind the Contract for fraud or intentional misrepresentation of material fact by the Employer, or with respect to coverage of Employees or Dependents, for fraud or intentional misrepresentation of material fact by the Employee, Dependent, or their representative. A rescission voids the Contract retroactively as if it was never effective; Blue Shield will provide written notice to the Employer prior to any rescission.

In the event the contract is rescinded or cancelled, either by Blue Shield or the Employer, it is the Employer's responsibility to notify each enrolled Employee of the rescission or cancellation. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

If a Member is hospitalized or undergoing treatment for an ongoing condition and the Contract is cancelled for any reason, including non-payment of 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 Confirming Termination 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 60 days following the Dependent's birth or place-

ment 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 termi-

nate 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 Customer Service 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, Coinsurance, 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 Personal 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 Customer Service 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 Personal Physician Service Area.

The Personal 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 Personal Physician Service Area indicates the location and phone numbers of these Providers. Contact Customer Service 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 Personal 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 U.S. are available through the *BlueCard* Worldwide Network. For Urgent Services when the Member is within California, but outside of the Personal Physician Service Area, the Member should, if possible, contact Blue Shield Cus-

tomer Service 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 Personal Physician Service Area, contact the Personal 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 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
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

Please follow the following procedure:

1) Recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of 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 Customer Service at the number listed in the back of this Evidence of Coverage, or by accessing Blue Shield's internet site at www.blueshieldca.com 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 the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the Plan at the telephone number as noted on the back page of this Evidence of Coverage. If the telephone inquiry to Customer Service does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P.O. Box 5588, El Dorado Hills, CA 95762-0011. The Member may also submit the grievance online by visiting 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 Customer Service 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 fol-

lowing the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact Customer Service.

For grievances due to denial of coverage for a Non-Formulary Drug: If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, the Member, representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. For additional information, please contact Customer Service.

For all grievances: The grievance system allows Subscribers to file grievances within 180 days following any incident or action that is the subject of the Member's dissatisfaction.

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 for at least 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 the Blue Shield Customer Service Department as shown on the back page of this Evidence of Coverage.

Members can request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The MHSA shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay, or other healthcare services. For additional information regarding the expedited decision process, or to request an expedited decision be made for a particular issue, please contact the MHSA at the number listed above.

PLEASE NOTE: If 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 ex-

ternal 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 Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review. The Member and the Member's Physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

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 **(711)** for the hearing and speech impaired. The Department's Internet Web site, **(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.

Customer Service

For questions about services, providers, Benefits, how to use this plan, or concerns regarding the quality of care or access to care, contact Blue Shield's Customer Service Department. Customer Service can answer many questions over the telephone. Contact Information is provided on the last page of this Evidence of Coverage.

For all Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health Services, Behavioral Health Treatment, and Substance

Use Disorder Services, MHSA Participating Providers, or Mental Health, Behavioral Health, and Substance Use Disorder Benefits. Members may contact the MHSA at the telephone number or address which appear below:

1-877-263-9952
Blue Shield of California
Mental Health Service Administrator
P.O. Box 719002
San Diego, CA 92171-9002

Definitions

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.

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.

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.

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 (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;

   b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and

   c. thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:

      i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

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

Domestic Partner — an individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

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, and disposable hypodermic insulin needles and syringes;

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) Inhalers and inhaler spacers for the management and treatment of asthma.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifest-

ing 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 means the following with respect to 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.

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. Benefits are provided for Formulary Drugs. Non-Formulary Drugs are covered with prior authorization from Blue Shield.

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 per-

son 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.

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 — the Member must be actively trying to conceive and has;

1) the presence of a demonstrated condition recognized by a licensed Physician as a cause of not being able to conceive; or
2) for women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
3) for women over age 35, failure to achieve a successful pregnancy (live birth) after six months or more of regular unprotected intercourse; or
4) failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a Physician (The initial six cycles are not a benefit of this Plan); or
5) three or more pregnancy losses.

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.

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; and,
   b. consistent with the symptoms or diagnosis; and,
   c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and,
   d. furnished at the most appropriate level which can be provided safely and effectively to the patient.
2) If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide benefits based on the most cost-effective service.
3) Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in 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.
4) 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 Rehabilitation that can be provided on an outpatient basis.
5) 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 Personal 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.

Non-Routine 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.

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.

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.

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

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 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.

Period of Care — the timeframe the Personal 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.

Personal Physician — a general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a Personal 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.

Personal Physician Service Area — that geographic area served by the Member's Personal Physician's Medical Group or IPA.

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 ACO 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 Personal 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 Personal Physician, or according to the Access+ 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.

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.

Rehabilitation — 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. Rehabilitation 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.

Routine Outpatient Mental Health Services and Behavioral Health Treatment — professional (Physician) office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including the individual, Family or group setting.

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 60-day Special Enrollment Period if any of the following occurs:

1) An Employee or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis.

2) 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.

3) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The health benefit plan shall enroll such a Dependent child within 60 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.

4) 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.

5) 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.

6) An Employee who declined coverage, or an Employee enrolled in this plan, subsequently acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption, placement for adoption or placement in foster care.

7) 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, HHS, or any of their instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to cor-

rect or eliminate the effects of such error, misrepresentation, or inaction.

8) An Employee or Dependent adequately demonstrates to CCSB or Covered California 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.

9) An Employee or Dependent gains access to new health plans as a result of a permanent move.

10) An Employee or Dependent demonstrates to CCSB or Covered California, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as Covered California may provide.

11) An Employee or Dependent has been released from incarceration.

12) 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.

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 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.

15) 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 rehabilitation provided in a Hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, Physical, Occupa-

tional 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 Personal 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 Personal Physician Service Area.

This Evidence of Coverage should be retained for your future reference as a Member of the Blue Shield Trio ACO HMO Health Plan.

Should you have any questions, please call the Blue Shield of California Customer Service Department at the number provided on the back page of this Evidence of Coverage.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

Notice of the Availability of Language Assistance Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Spanish

免費語言服務：您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-346-7198與我們聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198 번으로 문의해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。Japanese

خدمات جانبی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। Punjabi

លេខាកម្មភាពឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-346-7198. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Hmong

Handy Numbers

If your Family has more than one Blue Shield HMO Personal Physician, list each Family member's name with the name of his or her Physician.

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Family Member _____

Personal Physician _____

Phone Number _____

Important Numbers:

Hospital _____

Pharmacy _____

Police Department _____

Ambulance _____

Poison Control Center _____

Fire Department _____

General Emergency _____ *911* _____

HMO Customer Service
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 Customer Service (Shield Concierge) toll free at 1-844-515-9068.

The hearing impaired may call Blue Shield's Customer Service Department 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 ACO HMO Service Area Chart

The Trio ACO HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio ACO 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 Customer Service at the telephone number provided at the back of this booklet.

Alameda County (only those Zip Codes shown here)	**Contra Costa County (only those Zip Codes shown here)** *continued*	**Kern County (only those Zip Codes shown here)** *continued*
94550	94583	93305
94551	94595	93306
94566	94596	93307
94568	94597	93308
94588	94598	93309
Contra Costa County (only those Zip Codes shown here)	**El Dorado County (only those Zip Codes shown here)**	93311
94506	95664	93312
94507	95672	93313
94509	95682	93314
94511	95762	93380
94513	**Kern County (only those Zip Codes shown here)**	93383
94514	93203	93384
94516	93205	93385
94517	93206	93386
94518	93215	93387
94519	93216	93388
94520	93220	93389
94521	93224	93390
94522	93225	93501
94523	93226	93502
94524	93240	93504
94526	93241	93505
94527	93250	93516
94528	93251	93518
94529	93252	93531
94531	93255	93560
94548	93263	93561
94549	93268	93596
94553	93276	**Los Angeles County (only those Zip Codes shown here)**
94556	93280	90001
94561	93283	90002
94563	93285	90003
94564	93287	90004
94565	93301	90005
94570	93302	90006
94575	93303	90007
94582	93304	90008

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 ACO HMO SERVICE AREA CHART

The Trio ACO HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio ACO 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 Customer Service at the telephone number provided at the back of this booklet.

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*
90009	90049	90090
90010	90050	90091
90011	90051	90093
90012	90052	90094
90013	90053	90095
90014	90054	90096
90015	90055	90099
90016	90056	90189
90017	90057	90201
90018	90058	90202
90019	90059	90209
90020	90060	90210
90021	90061	90211
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

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TRIO ACO 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*
90264	90411	90712
90265	90501	90713
90266	90502	90714
90267	90503	90715
90270	90504	90716
90272	90505	90717
90274	90506	90723
90275	90507	90731
90277	90508	90732
90278	90509	90733
90280	90510	90734
90290	90601	90744
90291	90602	90745
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

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 ACO 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*
90846	91110	91307
90847	91114	91308
90848	91115	91309
90853	91116	91310
90895	91117	91311
90899	91118	91313
91001	91121	91316
91003	91123	91321
91006	91124	91322
91007	91125	91324
91008	91126	91325
91009	91129	91326
91010	91182	91327
91011	91184	91328
91012	91185	91329
91016	91188	91330
91017	91189	91331
91020	91199	91333
91021	91201	91334
91023	91202	91335
91024	91203	91337
91025	91204	91340
91030	91205	91341
91031	91206	91342
91040	91207	91343
91041	91208	91344
91042	91209	91345
91043	91210	91346
91046	91214	91350
91066	91221	91351
91077	91222	91352
91101	91224	91353
91102	91225	91354
91103	91226	91355
91104	91301	91356
91105	91302	91357
91106	91303	91364
91107	91304	91365
91108	91305	91367
91109	91306	91371

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 ACO 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*
91372	91504	91740
91376	91505	91741
91380	91506	91744
91381	91507	91745
91382	91508	91746
91383	91510	91747
91384	91521	91748
91385	91522	91749
91386	91523	91750
91387	91526	91754
91390	91601	91755
91392	91602	91756
91393	91603	91765
91394	91604	91766
91395	91605	91767
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	-----
91503	91735	-----

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 ACO HMO SERVICE AREA CHART

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Orange County (only those Zip Codes shown here)	**Orange County (only those Zip Codes shown here)** *continued*	**Orange County (only those Zip Codes shown here)** *continued*
90620	92647	92706
90621	92648	92707
90622	92649	92708
90623	92650	92711
90624	92651	92712
90630	92652	92728
90631	92653	92735
90632	92654	92780
90633	92655	92781
90680	92656	92782
90720	92657	92799
90721	92658	92801
90740	92659	92802
90742	92660	92803
90743	92661	92804
92602	92662	92805
92603	92663	92806
92604	92672	92807
92605	92673	92808
92606	92674	92809
92607	92675	92811
92609	92676	92812
92610	92677	92814
92612	92678	92815
92614	92679	92816
92615	92683	92817
92616	92684	92821
92617	92685	92822
92618	92688	92823
92619	92690	92825
92620	92691	92831
92623	92692	92832
92624	92693	92833
92625	92694	92834
92626	92697	92835
92627	92698	92836
92628	92701	92837
92629	92702	92838
92630	92703	92840
92637	92704	92841
92646	92705	92842

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TRIO ACO HMO SERVICE AREA CHART

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Orange County (only those Zip Codes shown here) *continued*	**Riverside County (only those Zip Codes shown here)**	**Riverside County (only those Zip Codes shown here)** *continued*
92843	91752	92563
92844	92220	92564
92845	92223	92567
92846	92230	92570
92850	92320	92571
92856	92501	92572
92857	92502	92581
92859	92503	92582
92861	92504	92583
92862	92505	92584
92863	92506	92585
92864	92507	92586
92865	92508	92587
92866	92509	92589
92867	92513	92590
92868	92514	92591
92869	92515	92592
92870	92516	92593
92871	92517	92595
92885	92518	92596
92886	92519	92599
92887	92521	92860
92899	92522	92877
Placer County (only those Zip Codes shown here)	92530	92878
95602	92531	92879
95603	92532	92880
95604	92543	92881
95648	92544	92882
95650	92545	**Sacramento County (only those Zip Codes shown here)**
95658	92546	94203
95661	92548	94204
95663	92551	94205
95677	92552	94206
95678	92553	94207
95713	92554	94208
95746	92555	94209
95747	92556	94211
95765	92557	94229
-----	92562	94230

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TRIO ACO 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*	**Sacramento County (only those Zip Codes shown here)** *continued*
94232	94290	95814
94234	94291	95815
94235	94293	95816
94236	94294	95817
94237	94295	95818
94239	94296	95819
94240	94297	95820
94244	94298	95821
94245	94299	95822
94247	95608	95823
94248	95609	95824
94249	95610	95825
94250	95611	95826
94252	95615	95827
94254	95621	95828
94256	95624	95829
94257	95626	95830
94258	95628	95831
94259	95630	95832
94261	95632	95833
94262	95638	95834
94263	95639	95835
94267	95652	95836
94268	95655	95837
94269	95660	95838
94271	95662	95840
94273	95670	95841
94274	95671	95842
94277	95673	95843
94278	95683	95851
94279	95693	95852
94280	95741	95853
94282	95742	95860
94283	95757	95864
94284	95758	95865
94285	95759	95866
94286	95763	95867
94287	95811	95894
94288	95812	95899
94289	95813	-----

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TRIO ACO HMO SERVICE AREA CHART

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San Bernardino County (only those Zip Codes shown here)	**San Bernardino County (only those Zip Codes shown here)** *continued*	**San Bernardino County (only those Zip Codes shown here)** *continued*
91701	92340	92408
91708	92341	92410
91709	92342	92411
91710	92344	92413
91729	92345	92415
91730	92346	92418
91737	92350	92423
91739	92352	92427
91743	92354	**San Diego County (only those Zip Codes shown here)**
91758	92356	91901
91759	92357	91902
91761	92358	91903
91762	92359	91905
91763	92368	91906
91764	92369	91908
91784	92371	91909
91785	92372	91910
91786	92373	91911
92301	92374	91912
92305	92375	91913
92307	92376	91914
92308	92377	91915
92313	92378	91916
92314	92382	91917
92315	92385	91921
92316	92386	91931
92317	92391	91932
92318	92392	91933
92321	92393	91935
92322	92394	91941
92324	92395	91942
92325	92397	91943
92329	92399	91944
92331	92401	91945
92333	92402	91946
92334	92403	91948
92335	92404	91950
92336	92405	91951
92337	92406	91962
92339	92407	91963

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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*
91976	92058	92117
91977	92060	92118
91978	92061	92119
91979	92064	92120
91980	92065	92121
91987	92067	92122
92003	92068	92123
92007	92069	92124
92008	92071	92126
92009	92072	92127
92010	92074	92128
92011	92075	92129
92013	92078	92130
92014	92079	92131
92018	92081	92132
92019	92082	92134
92020	92083	92135
92021	92084	92136
92022	92085	92137
92023	92088	92138
92024	92091	92139
92025	92092	92140
92026	92093	92142
92027	92096	92143
92029	92101	92145
92030	92102	92147
92033	92103	92149
92036	92104	92150
92037	92105	92152
92038	92106	92153
92039	92107	92154
92040	92108	92155
92046	92109	92158
92049	92110	92159
92051	92111	92160
92052	92112	92161
92054	92113	92163
92055	92114	92165
92056	92115	92166
92057	92116	92167

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San Diego County (only those Zip Codes shown here) *continued*	**San Francisco County (only those Zip Codes shown here)** *continued*	**San Joaquin County (only those Zip Codes shown here)** *continued*
92168	94119	95205
92169	94120	95206
92170	94121	95207
92171	94122	95208
92172	94123	95209
92173	94124	95210
92174	94125	95211
92175	94126	95212
92176	94127	95213
92177	94129	95215
92178	94130	95219
92179	94131	95220
92182	94132	95227
92186	94133	95230
92187	94134	95231
92190	94137	95234
92191	94139	95236
92192	94140	95237
92193	94141	95240
92195	94142	95241
92196	94143	95242
92197	94144	95253
92198	94145	95258
92199	94146	95267
San Francisco County (only those Zip Codes shown here)	94147	95269
94102	94151	95296
94103	94158	95297
94104	94159	95304
94105	94160	95320
94107	94161	95330
94108	94163	95336
94109	94164	95337
94110	94172	95366
94111	94177	95376
94112	94188	95377
94114	**San Joaquin County (only those Zip Codes shown here)**	95378
94115	95201	95385
94116	95202	95391
94117	95203	95686
94118	95204	-----

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San Mateo County (only those Zip Codes shown here)	**Santa Clara County (only those Zip Codes shown here)** *continued*	**Santa Clara County (only those Zip Codes shown here)** *continued*
94002	94042	95056
94005	94043	95070
94010	94085	95071
94011	94086	95101
94014	94087	95103
94015	94088	95106
94016	94089	95108
94017	94301	95109
94018	94302	95110
94019	94303	95111
94025	94304	95112
94026	94305	95113
94027	94306	95115
94030	94309	95116
94037	95002	95117
94038	95008	95118
94044	95009	95119
94061	95011	95120
94062	95013	95121
94063	95014	95122
94064	95015	95123
94065	95020	95124
94066	95021	95125
94070	95026	95126
94080	95030	95127
94083	95031	95128
94128	95032	95129
94401	95035	95130
94402	95036	95131
94403	95037	95132
94404	95038	95133
94497	95042	95134
Santa Clara County (only those Zip Codes shown here	95044	95135
94022	95046	95136
94023	95050	95138
94024	95051	95139
94035	95052	95140
94039	95053	95141
94040	95054	95148
94041	95055	95150

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Santa Clara County (only those Zip Codes shown here) *Continued*	**Santa Cruz County (only those Zip Codes shown here)** *continued*	**Stanislaus County (only those Zip Codes shown here)** *continued*
95151	95064	95382
95152	95065	95386
95153	95066	95387
95154	95067	95397
95155	95073	**Tulare County (only those Zip Codes shown here)**
95156	95076	93219
95157	95077	93256
95158	**Solano County (only those Zip Codes shown here)**	93260
95159	94503	**Ventura County (only those Zip Codes shown here)**
95160	94510	91319
95161	94589	91320
95164	94592	91358
95170	95620	91359
95172	**Stanislaus County (only those Zip Codes shown here)**	91360
95173	95307	91361
95190	95313	91362
95191	95316	91377
95192	95319	93010
95193	95323	93011
95194	95326	93012
95196	95328	93015
Santa Cruz County (only those Zip Codes shown here)	95329	93016
95001	95350	93020
95003	95351	93021
95005	95352	93040
95006	95353	93062
95007	95354	93063
95010	95355	93064
95017	95356	93065
95018	95357	93066
95019	95358	93094
95033	95361	93099
95041	95363	-----
95060	95367	-----
95061	95368	-----
95062	95380	-----
95063	95381	-----

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Yolo County (only those Zip Codes shown here)	**Yolo County (only those Zip Codes shown here** *continued*	**Yolo County (only those Zip Codes shown here** *continued*
95605	95627	95697
95606	95637	95698
95607	95645	95776
95612	95653	95798
95616	95691	95799
95617	95694	95937
95618	95695	-----

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