

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Coverage Period: Beginning On or After 1/1/2022

Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental INF

Coverage for: Individual + Family | Plan Type: HMO




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies/M0026896_EOC.pdf or call 1-855-258-3744. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1-866-444-3272 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u>? | \$2,250 per individual / \$4,500 per family for <u>participating providers</u> . | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive care</u> and services listed in your complete terms of coverage. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits . |
| Are there other <u>deductibles</u> for specific services? | Yes. Prescription drugs -- \$300 per individual / \$600 per family. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$8,200 per individual / \$16,400 per family for <u>participating providers</u> . | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Copayments</u> for certain services, <u>premiums</u> , and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See blueshieldca.com/fad or call 1-855-258-3744 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

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 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$55/visit; <u>deductible</u> does not apply | Not Covered | -----None----- |
| | <u>Specialist</u> visit | <i>Trio+ Specialist</i> : \$90/visit; <u>deductible</u> does not apply <i>Other Specialist</i> : \$90/visit; <u>deductible</u> does not apply | Not Covered | Self-referral is available for Trio+ Specialist visits. |
| | <u>Preventive care/screening</u> /immunization | No Charge; <u>deductible</u> does not apply | Not Covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | <i>Lab & Path</i> : \$55/visit; <u>deductible</u> does not apply <i>X-Ray & Imaging</i> : \$90/visit; <u>deductible</u> does not apply <i>Other Diagnostic Examination</i> : \$90/visit; <u>deductible</u> does not apply | <i>Lab & Path</i> : Not Covered <i>X-Ray & Imaging</i> : Not Covered <i>Other Diagnostic Examination</i> : Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. The services listed are at a freestanding location. |
| | Imaging (CT/PET scans, MRIs) | <i>Outpatient Radiology Center</i> : \$300/visit <i>Outpatient Hospital</i> : \$300/visit | <i>Outpatient Radiology Center</i> : Not Covered <i>Outpatient Hospital</i> : Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at blueshieldca.com/formulary | Tier 1 | <i>Retail</i> : Level A: \$17/prescription; <u>deductible</u> does not apply Level B: \$22/prescription; <u>deductible</u> does not apply <i>Mail Service</i> : \$34/prescription; <u>deductible</u> does not apply | <i>Retail</i> : Not Covered <i>Mail Service</i> : Not Covered | <u>Preauthorization</u> is required for select drugs. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail</i> : Covers up to a 30-day supply; 90-days may be covered with a copayment for each 30-day supply; <i>Mail Service</i> : Covers up to a 90-day supply. |
| | Tier 2 | <i>Retail</i> : Level A: \$80/prescription Level B: \$105/prescription <i>Mail Service</i> : \$160/prescription | <i>Retail</i> : Not Covered <i>Mail Service</i> : Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/M0026896_EOC.pdf.

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Tier 3 | <i>Retail:</i> Level A: \$110/prescription Level B: \$150/prescription <i>Mail Service:</i> \$220/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | |
| | Tier 4 | <i>Retail and Network Specialty Pharmacies:</i> 30% <u>coinsurance</u> up to \$250/prescription <i>Mail Service:</i> 30% <u>coinsurance</u> up to \$500/prescription | <i>Retail:</i> Not Covered <i>Mail Service:</i> Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. <i>Retail and Network Specialty Pharmacies:</i> Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy. <i>Mail Service:</i> Covers up to a 90-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | <i>Ambulatory Surgery Center:</i> 30% <u>coinsurance</u> <i>Outpatient Hospital:</i> 30% <u>coinsurance</u> | <i>Ambulatory Surgery Center:</i> Not Covered <i>Outpatient Hospital:</i> Not Covered | -----None----- |
| | Physician/surgeon fees | 30% <u>coinsurance</u> ; <u>deductible</u> does not apply | Not Covered | |
| If you need immediate medical attention | <u>Emergency room care</u> | <i>Facility Fee:</i> 30% <u>coinsurance</u> <i>Physician Fee:</i> No Charge; <u>deductible</u> does not apply | <i>Facility Fee:</i> 30% <u>coinsurance</u> <i>Physician Fee:</i> No Charge; <u>deductible</u> does not apply | -----None----- |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> | This payment is for emergency or authorized transport. |
| | <u>Urgent care</u> | \$55/visit; <u>deductible</u> does not apply | <i>Within <u>Plan</u> Service Area:</i> Not Covered <i>Outside <u>Plan</u> Service Area:</i> \$55/visit; <u>deductible</u> does not apply | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Physician/surgeon fees | 30% <u>coinsurance</u> ; <u>deductible</u> does not apply | Not Covered | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: \$55/visit; <u>deductible</u> does not apply Other Outpatient Services: No Charge; <u>deductible</u> does not apply Partial Hospitalization: No Charge; <u>deductible</u> does not apply Psychological Testing: No Charge; <u>deductible</u> does not apply | Office Visit: Not Covered Other Outpatient Services: Not Covered Partial Hospitalization: Not Covered Psychological Testing: Not Covered | <u>Preauthorization</u> is required except for office visits. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | Inpatient services | Physician Inpatient Services: 30% <u>coinsurance</u> ; <u>deductible</u> does not apply Hospital Services: 30% <u>coinsurance</u> Residential Care: 30% <u>coinsurance</u> | Physician Inpatient Services: Not Covered Hospital Services: Not Covered Residential Care: Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If you are pregnant | Office visits | No Charge; <u>deductible</u> does not apply | Not Covered | -----None----- |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> ; <u>deductible</u> does not apply | Not Covered | |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | Not Covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$45/visit; <u>deductible</u> does not apply | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 visits per member per calendar year. |
| | <u>Rehabilitation services</u> | Office Visit: \$55/visit; <u>deductible</u> does not apply Outpatient Hospital: \$55/visit; <u>deductible</u> does not apply | Office Visit: Not Covered Outpatient Hospital: Not Covered | -----None----- |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|--|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | <u>Habilitation services</u> | Office Visit: \$55/visit; <u>deductible</u> does not apply Outpatient Hospital: \$55/visit; <u>deductible</u> does not apply | Office Visit: Not Covered Outpatient Hospital: Not Covered | |
| | <u>Skilled nursing care</u> | Freestanding SNF: 30% <u>coinsurance</u> Hospital-based SNF: 30% <u>coinsurance</u> | Freestanding SNF: Not Covered Hospital-based SNF: Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period. |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> ; <u>deductible</u> does not apply | Not Covered | <u>Preauthorization</u> is required. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| | <u>Hospice services</u> | No Charge; <u>deductible</u> does not apply | Not Covered | <u>Preauthorization</u> is required except for pre-hospice consultation. Failure to obtain <u>preauthorization</u> may result in non-payment of benefits. |
| If your child needs dental or eye care | Children's eye exam | No Charge; <u>deductible</u> does not apply | Not Covered | Coverage limited to one exam per member per calendar year. |
| | Children's glasses | No Charge; <u>deductible</u> does not apply | Not Covered | Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per calendar year. The cost listed is for Single Vision. |
| | Children's dental check-up | No Charge; <u>deductible</u> does not apply | Not Covered | Coverage for prophylaxis services (cleaning) is limited to once in a six month period. |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | | |
|-----------------------|--|----------------------------|------------------------|
| • Chiropractic Care | • Hearing Aids | • Private-duty nursing | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) | • Weight loss programs |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: Blue Shield Customer Service at 1-855-258-3744 or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or dol.gov/ebsa/healthreform. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit <http://www.healthhelp.ca.gov>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

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

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

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shika' at'ooowł nínízingo, kwijí' hodíílnih 1-866-346-7198.

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

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

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

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

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

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

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

Khmer (ភាសាខ្មែរ): សូមជួយភាសាខ្មែរដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

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

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

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

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

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ 1-866-346-7198.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of participating pre-natal care and a hospital delivery)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,250 |
| ■ <u>Specialist</u> copayment | \$90 |
| ■ Hospital (facility) <u>coinsurance</u> | 30% |
| ■ Other <u>copayment</u> | \$55 |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$2,300 |
| <u>Copayments</u> | \$700 |
| <u>Coinsurance</u> | \$2,600 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,660 |

Managing Joe's Type 2 Diabetes

(a year of routine participating care of a well-controlled condition)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,250 |
| ■ <u>Specialist</u> copayment | \$90 |
| ■ Hospital (facility) <u>coinsurance</u> | 30% |
| ■ Other <u>copayment</u> | \$55 |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$1,800 |
| <u>Coinsurance</u> | \$200 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,320 |

Mia's Simple Fracture

(participating emergency room visit and follow up care)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,250 |
| ■ <u>Specialist</u> copayment | \$90 |
| ■ Hospital (facility) <u>coinsurance</u> | 30% |
| ■ Other <u>copayment</u> | \$90 |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$900 |
| <u>Copayments</u> | \$400 |
| <u>Coinsurance</u> | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,400 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Evidence of Coverage

Small Group Plan
Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental
Provider Network: Trio



Blue Shield of California Endorsement to your On Exchange HMO Plans

This Endorsement should be attached to, and is made part of, your Blue Shield of California Evidence of Coverage (EOC). Please retain it for your records.

Effective **January 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revisions have been made to the **Non-Participating Providers** section:

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges as payment in full for Covered Services. Except for Emergency Services, Urgent Services, and services received at a Participating ~~Hospital-Provider facility~~ (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, this plan does not cover services from Non-Participating Providers.

Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above the Allowed Charges, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

2. The following revisions have been made to the **Continuity of care** section:

Continuity of care may be available if:

- ~~• Your provider leaves your Medical Group during your care;~~
- ~~• Your MHSA Participating Provider becomes an MHSA Non-Participating Provider during your care;~~
- Blue Shield, the Medical Group, or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving;
- You are a newly-covered Member whose coverage choices do not include out-of-network Benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

Continuity of care may also be available to you when your Employer terminates its contract with Blue Shield and contracts with a new health plan (insurer) that does not include your Blue Shield Participating Provider in its network.

If your Former Participating Provider is no longer available to you for one of the reasons noted above, Blue Shield, the Medical Group, or the MHSA will notify you of the option to continue treatment with your Former Participating Provider.

You can request to continue treatment with your ~~Former Non-Participating~~ Provider in the situations described above if you are currently receiving the following care:

- ~~Ongoing treatment for an acute or serious chronic condition;~~
- ~~Pregnancy care, including care immediately after giving birth;~~
- ~~Treatment for a maternal mental health condition;~~
- ~~Treatment for a terminal illness;~~
- ~~Other services authorized by a now terminated provider as part of a documented course of treatment; or~~
- ~~Care for a child up to 36 months old.~~

| <div>  <u>Continuity of care with a Former Participating Provider</u>  </div> | |
|---|--|
| <u>Qualifying conditions</u> | <u>Timeframe</u> |
| <u>Undergoing a course of institutional or inpatient care</u> | <u>90 days from the date of receipt of notice of the termination of the Former Participating Provider's contract, the Employer's contract, or until the treatment concludes, whichever is sooner</u> |
| <u>Acute conditions</u> | <u>As long as the condition lasts</u> |
| <u>Maternal mental health condition</u> | <u>12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later</u> |
| <u>Ongoing pregnancy care, including care immediately after giving birth</u> | <u>Up to 12 months</u> |
| <u>Recommended surgery or procedure documented to occur within 180 days</u> | <u>Within 180 days</u> |
| <u>Ongoing treatment for a child up to 36 months old</u> | <u>Up to 12 months</u> |
| <u>Serious chronic condition</u> | <u>Up to 12 months</u> |
| <u>Terminal illness</u> | <u>The duration of the terminal illness</u> |

If a condition falls within a qualifying condition under federal and state law, the more generous time frames would be followed.

To request continuity of care, visit [blueshieldca.com](https://www.blueshieldca.com) and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and may review your request for Medical Necessity.

Under Federal law, ~~t~~~~he~~ ~~Former Non-Participating~~ Provider must ~~agree to~~ accept Blue Shield's, the Medical Group's, or the MHA's Allowed Charges as payment in full for the first 90 days of your ongoing care. ~~Once~~ ~~if~~ the provider ~~agrees~~ accepts and your request is

authorized, you may continue to see the Former Non-Participating Provider at the Participating Provider Cost Share, ~~for:~~

- ~~• Up to 12 months;~~
- ~~• For a maternal mental health condition, 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later; or~~
- ~~• If you have a terminal illness, for the duration of the terminal illness.~~

3. The following revisions have been made to the **When coverage ends** section:

There is no right to receive the Benefits of this plan after coverage ends, except as described in the Extension of Benefits, Continuity of care, and Continuation of group coverage sections.

4. The following revisions have been made to the **Emergency Benefits** section:

Benefits are available for Emergency Services received in the emergency room of a Hospital or other emergency room licensed under state law. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition at any Hospital, even if it is a Non-Participating Hospital.

5. The following revisions have been made to the **Prior authorization/exception request/step therapy process** section of the **Prescription Drug Benefits** section:

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours of receipt in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care 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 on 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 your Physician or Health Care Provider believes

~~that step therapy coverage requirements are not met for a prescription need not be met and your Physician or Health Care Provider believes that the Drug is Medically Necessary, the prior authorization step therapy exception process may must~~ be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) will also apply.

6. The following revisions have been made to the **Grievance process** section:

If Blue Shield denies an exception request for coverage of a non-Formulary Drug or step therapy, you may ~~submit a grievance requesting request~~ an external exception request review. Blue Shield will ensure a decision within 72 hours. Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug or step therapy.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, or when you are experiencing severe pain, ~~or when you are being treated with a non-Formulary Drug.~~

Blue Shield will make a decision within three calendar days for expedited grievance requests related to:

- Medical Benefits;
- Mental Health and Substance Use Disorder services;
- Pediatric dental Benefits; and
- Pediatric vision Benefits.

~~Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug.~~

7. The following revisions have been made to the **Non-participating providers outside of California** section of the **BlueCard® Program** section:

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

8. The following revisions have been made to the **Allowed Charges** definition:

- For a Participating Provider: the amounts a Participating Provider agrees to accept as payment from Blue Shield.

- For a Non-Participating Provider: (1) the amounts paid by Blue Shield when services from a Non-Participating Provider are covered and are paid as a Reasonable and Customary amount, or (2) if applicable, the amount determined under state and federal law.

9. The following revisions have been made to the **Emergency Services** definition:

The following services provided for an Emergency Medical Condition:

- Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility;
- Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and
- Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and
- Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

10. The following definition has been added to the **Definitions** section:

Former Participating Provider: A Former Participating Provider is a provider of services to the Member under any of the following conditions:

- A provider who is no longer available to you as a Participating Provider or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the [Continuity of care with a Former Participating Provider table](#) in the [Continuity of care](#) section.
- A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the [Continuity of care with a Former Participating Provider table](#) in the [Continuity of care](#) section.
- A provider who is a Participating Provider with Blue Shield or the MHSA but no longer available to you as a Participating Provider or an MHSA Participating Provider because:
 - The Employer has terminated its contract with Blue Shield; and
 - The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider or the MHSA Participating Provider in its network; and

- o At the time of the Employer's contract termination you were receiving Covered Services from that provider for one of the conditions listed in the [Continuity of care with a Former Participating Provider table](#) in the [Continuity of care](#) section.

11. The following revisions have been made to the **Reasonable and Customary** definition:

In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state and federal law to be the reasonable and customary value for the services rendered by a Non-Participating Provider.

Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits or if applicable, the amount determined under state and federal law.

12. The following revisions have been made to the **Notices about your plan** section:

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as specifically provided under the *Extension of Benefits* section and, when applicable, the *Continuity of care* and *Continuation of group coverage* sections.

Effective **August 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

13. The following revisions have been made to the **Claims for Emergency or Urgent Services** section:

Claim forms are available at blueshieldca.com/covered-california-policies.

Blue Shield of California Endorsement to your On Exchange HMO Plans

This Endorsement should be attached to, and is made part of, your Blue Shield of California Evidence of Coverage (EOC). Please retain it for your records.

Effective **January 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

1. The following revisions have been made to the **Teladoc** section in the **Other ways to access care** section:

Teladoc, a Third-Party Corporate Telehealth Provider, provides primary care and behavioral health consultations by phone or online.

2. The following revisions have been made to the **Telebehavioral health services** section in the **Other ways to access care** section:

Online telebehavioral health services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers and are a Covered Service regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. If you are currently receiving telebehavioral health services for Mental Health and Substance Use Disorders, you can continue to receive those services with the MHSA Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider. Visit [blueshieldca.com](https://www.blueshieldca.com) and click on Find a Doctor to access the MHSA network.

3. The following revisions have been made to the **Diagnostic X-ray, imaging, pathology, laboratory, and other testing services** section:

Benefits include:

- Diagnostic and therapeutic imaging services, such as X-rays and ultrasounds;
- Radiological and nuclear imaging, including CT, PET, and MRI scans;
- COVID-19 diagnostic testing, screening testing, and related healthcare services. Note, Medical Necessity requirements do not apply for COVID-19 screening testing;
- Reimbursement for over-the-counter at-home COVID-19 tests. The reimbursement is allowed for up to 8 tests per Member per month. See the *Claims for Emergency or Urgent Services* section for information about how to submit a claim for repayment for this Benefit;
- Sexually transmitted disease home testing kits, including any laboratory costs of processing the kit. A Physician or other Health Care Provider's order must be provided for coverage;
- Clinical pathology services;

- Laboratory services;
- Other areas of diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

For services provided by Participating Providers, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing, screening testing, and related services. During the federal COVID-19 Public Health Emergency, Blue Shield will waive Cost Shares for COVID-19 diagnostic testing and related services from Non-Participating Providers.

Blue Shield encourages Members to seek services from Participating Providers to avoid paying extra fees. Some Non-Participating Providers may charge extra fees that are not covered by Blue Shield. Any fees not covered by Blue Shield will be the Member's responsibility. See the *How to access care* section for information about Participating and Non-Participating Providers.

4. The following revisions have been made to the **Physician and other professional services** section:

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;
- Second medical opinions;
- Administration of injectable medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. Coverage for these services will be on the same basis and to the same extent as a service conducted in person; and
- Teladoc primary care consultations.

5. The following revisions have been made to the **Preventive Health Services** section:

Benefits include:

- Adverse Childhood Experiences screenings;

6. The following revisions have been made to the **Preventive Health Services** section:

If there is a new recommendation or guideline in any of the resources described above, Blue Shield will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the plan year that

begins after that year. However, for COVID-19 Preventive Health Services and Preventive Health Services for a disease for which the Governor of the State of California has declared a public health emergency, a new recommendation will be covered within 15 business days.

7. The following revisions have been made to item 14 in the **General exclusions and limitations** section:

Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits, or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.

8. The following definition has been added to the **Definitions** section:

Adverse Childhood Experiences – An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

9. The following definition has been added to the **Definitions** section:

Third-Party Corporate Telehealth Provider – A corporation directly contracted with Blue Shield that provides health care services exclusively through a telehealth technology platform and has no physical location at which a Member can receive services.

10. The following notice has been added to the **Notices about your plan** section:

Notice about telehealth: You have the right to access your medical records. The records of any services provided to you through a Third-Party Corporate Telehealth Provider will be shared with your PCP, unless you object.

You can receive Covered Services on an in-person basis or via telehealth, if available, from your PCP, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the Timely Access to Care section.

If your plan includes Covered Services from Non-Participating Providers, you can receive the Covered Service either on an in-person basis or via telehealth.

Please see the Health care professionals and facilities section for additional information.

Effective **July 1, 2022**, your Evidence of Coverage is amended as described below. For ease of review, strikethroughs indicate deleted text and underlining indicates added text.

11. The following revision has been added to the **Pay for Covered Services** section:

Accrual balance

Blue Shield provides a summary of your accrual balances toward your Calendar Year Deductible, if any, and Out-of-Pocket Maximum for every month in which your Benefits were used until the full amount has been met. This summary will be mailed to you unless you opt to receive it electronically or have already opted out of paper mailings. You can opt back in to receive paper mailings at any time or elect to receive your balance summary electronically by logging into your member portal online and updating your communication preferences, or by calling [Customer Service/Shield Concierge] at the number on the back of your ID card. You can also check your accrual balances at any time by logging into your member portal online, which is updated daily, or calling [Customer Service/Shield Concierge]. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

12. The following notice has been added to the **Notices about your plan** section:

Notice about confidential communication requests: A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield of California at the mailing address, email address, or fax number at the bottom of this page. A confidential communication form, available by going to [blueshieldca.com/privacy](https://www.blueshieldca.com/privacy) and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

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

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

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Summary of Benefits



Group Plan
HMO Plan

Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental

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

Medical Provider Network:

Trio ACO HMO Network

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

Pharmacy Network:

Rx Spectrum

Drug Formulary:

Standard Formulary

Calendar Year Deductibles (CYD)²

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

| | | When using a Participating Provider ³ |
|--|----------------------------|--|
| Calendar Year medical Deductible | <i>Individual coverage</i> | \$2,250 |
| | <i>Family coverage</i> | \$2,250: individual \$4,500: Family |
| Calendar Year pharmacy Deductible | <i>Individual coverage</i> | \$300 |
| | <i>Family coverage</i> | \$300: individual \$600: Family |

Calendar Year Out-of-Pocket Maximum⁴

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

No Annual or Lifetime Dollar Limit

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

| | When using a Participating Provider ³ |
|----------------------------|--|
| <i>Individual coverage</i> | \$8,200 |
| <i>Family coverage</i> | \$8,200: individual \$16,400: Family |

Benefits⁵

Your payment

| | When using a Participating Provider ³ | CYD ² applies |
|---|--|--------------------------|
| Preventive Health Services⁶ | | |
| Preventive Health Services | \$0 | |
| California Prenatal Screening Program | \$0 | |
| Physician services | | |
| Primary care office visit | \$55/visit | |
| Trio+ specialist care office visit (self-referral) | \$90/visit | |
| Other specialist care office visit (referred by PCP) | \$90/visit | |
| Physician home visit | \$55/visit | |
| Physician or surgeon services in an Outpatient Facility | 30% | |
| Physician or surgeon services in an inpatient facility | 30% | |
| Other professional services | | |
| Other practitioner office visit | \$55/visit | |
| <i>Includes nurse practitioners, physician assistants, and therapists.</i> | | |
| Acupuncture services | \$55/visit | |
| Chiropractic services | Not covered | |
| Teladoc consultation | \$0 | |
| Family planning | | |
| • Counseling, consulting, and education | \$0 | |
| • Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure. | \$0 | |
| • Tubal ligation | \$0 | |
| • Vasectomy | 30% | |
| Podiatric services | \$90/visit | |
| Pregnancy and maternity care | | |
| Physician office visits: prenatal and initial postnatal | \$0 | |
| Physician services for pregnancy termination | 30% | |
| Emergency Services | | |
| Emergency room services | 30% | ✓ |
| <i>If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.</i> | | |
| Emergency room Physician services | \$0 | |

| | When using a Participating Provider ³ | CYD ² applies |
|---|--|--------------------------|
| Urgent care center services | \$55/visit | |
| Ambulance services <i>This payment is for emergency or authorized transport.</i> | 30% | ✓ |
| Outpatient Facility services Ambulatory Surgery Center Outpatient Department of a Hospital: surgery Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies | 30% 30% 30% | ✓ ✓ ✓ |
| Inpatient facility services Hospital services and stay Transplant services <i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i> <ul style="list-style-type: none"> Special transplant facility inpatient services Physician inpatient services | 30% 30% 30% | ✓ ✓ ✓ |
| Diagnostic x-ray, imaging, pathology, and laboratory services <i>This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.</i> Laboratory services <i>Includes diagnostic Papanicolaou (Pap) test.</i> <ul style="list-style-type: none"> Laboratory center Outpatient Department of a Hospital X-ray and imaging services <i>Includes diagnostic mammography.</i> <ul style="list-style-type: none"> Outpatient radiology center Outpatient Department of a Hospital Other outpatient diagnostic testing <i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i> <ul style="list-style-type: none"> Office location Outpatient Department of a Hospital Radiological and nuclear imaging services <ul style="list-style-type: none"> Outpatient radiology center Outpatient Department of a Hospital | \$55/visit \$55/visit \$90/visit \$90/visit \$90/visit \$90/visit \$300/visit \$300/visit | ✓ ✓ |

| | When using a Participating Provider ³ | CYD ² applies |
|---|--|--------------------------|
| Rehabilitative and Habilitative Services | | |
| <i>Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.</i> | | |
| Office location | \$55/visit | |
| Outpatient Department of a Hospital | \$55/visit | |
| Durable medical equipment (DME) | | |
| DME | 30% | |
| Breast pump | \$0 | |
| Orthotic equipment and devices | \$0 | |
| Prosthetic equipment and devices | \$0 | |
| Home health care services | | |
| | \$45/visit | |
| <i>Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.</i> | | |
| Home infusion and home injectable therapy services | | |
| Home infusion agency services | \$0 | |
| <i>Includes home infusion drugs and medical supplies.</i> | | |
| Home visits by an infusion nurse | \$45/visit | |
| Hemophilia home infusion services | \$0 | |
| <i>Includes blood factor products.</i> | | |
| Skilled Nursing Facility (SNF) services | | |
| <i>Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.</i> | | |
| Freestanding SNF | 30% | ✓ |
| Hospital-based SNF | 30% | ✓ |
| Hospice program services | | |
| | \$0 | |
| <i>Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i> | | |
| Other services and supplies | | |
| Diabetes care services | | |
| • Devices, equipment, and supplies | 30% | |
| • Self-management training | \$0 | |
| Dialysis services | 30% | |
| PKU product formulas and special food products | \$0 | |

Benefits⁵

Your payment

| | When using a Participating Provider ³ | CYD ² applies |
|--|--|--------------------------|
| Allergy serum billed separately from an office visit | 30% | |

Mental Health and Substance Use Disorder Benefits

Your payment

| <i>Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).</i> | When using a MHSA Participating Provider ³ | CYD ² applies |
|---|---|--------------------------|
| Outpatient services | | |
| Office visit, including Physician office visit | \$55/visit | |
| Teladoc behavioral health | \$0 | |
| Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment | \$0 | |
| Partial Hospitalization Program | \$0 | |
| Psychological Testing | \$0 | |
| Inpatient services | | |
| Physician inpatient services | 30% | |
| Hospital services | 30% | ✓ |
| Residential Care | 30% | ✓ |

Prescription Drug Benefits^{7,8}

Your payment

| <i>A separate Calendar Year pharmacy Deductible applies.</i> | When using a Participating Pharmacy ³ | | CYD ² applies |
|---|--|------------------------------|--------------------------|
| | Level A | Level B | |
| Retail pharmacy prescription Drugs | | | |
| <i>Per prescription, up to a 30-day supply.</i> | | | |
| Contraceptive Drugs and devices | \$0 | \$0 | |
| Tier 1 Drugs | \$17/prescription | \$22/prescription | |
| Tier 2 Drugs | \$80/prescription | \$105/prescription | ✓ |
| Tier 3 Drugs | \$110/prescription | \$150/prescription | ✓ |
| Tier 4 Drugs | 30% up to \$250/prescription | 30% up to \$250/prescription | ✓ |
| Retail pharmacy prescription Drugs | | | |
| <i>Per prescription, up to a 90-day supply from a 90-day retail pharmacy.</i> | | | |
| Contraceptive Drugs and devices | \$0 | \$0 | |

Prescription Drug Benefits^{7,8}

Your payment

| A separate Calendar Year pharmacy Deductible applies. | | When using a Participating Pharmacy ³ | CYD ² applies |
|---|--|--|--------------------------------|
| Tier 1 Drugs | | \$51/prescription | \$66/prescription |
| Tier 2 Drugs | | \$240/prescription | \$315/prescription ✓ |
| Tier 3 Drugs | | \$330/prescription | \$450/prescription ✓ |
| Tier 4 Drugs | | 30% up to \$750/prescription | 30% up to \$750/prescription ✓ |
| Mail service pharmacy prescription Drugs | | | |
| Per prescription, up to a 90-day supply. | | | |
| Contraceptive Drugs and devices | | \$0 | |
| Tier 1 Drugs | | \$34/prescription | |
| Tier 2 Drugs | | \$160/prescription | ✓ |
| Tier 3 Drugs | | \$220/prescription | ✓ |
| Tier 4 Drugs | | 30% up to \$500/prescription | ✓ |

Pediatric Benefits

Your payment

| <i>Pediatric Benefits are available through the end of the month in which the Member turns 19.</i> | When using a Participating Dentist³ | CYD² applies |
|--|---|--------------------------------|
| Pediatric dental⁹ | | |
| Diagnostic and preventive services | | |
| • Oral exam | \$0 | |
| • Preventive – cleaning | \$0 | |
| • Preventive – x-ray | \$0 | |
| • Sealants per tooth | \$0 | |
| • Topical fluoride application | \$0 | |
| • Space maintainers - fixed | \$0 | |
| Basic services | | |
| • Restorative procedures | See Dental Copay Schedule in Evidence of Coverage | |
| • Periodontal maintenance | | |
| • Adjunctive general services | | |
| Major services | | |
| • Oral surgery | See Dental Copay Schedule in Evidence of Coverage | |
| • Endodontics | | |
| • Periodontics (other than maintenance) | | |
| • Crowns and casts | | |
| • Prosthodontics | | |
| Orthodontics (Medically Necessary) | \$1,000 | |

Pediatric Benefits

Your payment

Pediatric Benefits are available through the end of the month in which the Member turns 19.

When using a Participating Provider³

CYD² applies

Pediatric vision¹⁰

Comprehensive eye examination

One exam per Calendar Year.

- Ophthalmologic visit \$0
- Optometric visit \$0

Contact lens fitting and evaluation

When you choose contact lenses instead of eyeglasses, one per Member every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.

There is a maximum of two follow up visits.

- Standard lenses \$0
- Non-standard lenses All charges above \$60

Eyewear/materials

One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the Benefit per Calendar Year. Any exceptions are noted below.

- Contact lenses

Non-elective (Medically Necessary) - hard or soft \$0

Up to two pairs per eye per Calendar Year.

Elective (cosmetic/convenience)

Standard and non-standard, hard \$0

Up to a 3 month supply for each eye per Calendar Year based on lenses selected.

Standard and non-standard, soft \$0

Up to a 6 month supply for each eye per Calendar Year based on lenses selected.

- Eyeglass frames

Collection frames \$0

Non-collection frames All charges above \$150

- Eyeglass lenses

Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.

Single vision \$0

Lined bifocal \$0

Lined trifocal \$0

Lenticular \$0

Optional eyeglass lenses and treatments

- Ultraviolet protective coating (standard only) \$0
- Polycarbonate lenses \$0
- Standard progressive lenses \$0
- Premium progressive lenses \$95
- Anti-reflective lens coating (standard only) \$35

Pediatric Benefits

Your payment

Pediatric Benefits are available through the end of the month in which the Member turns 19.

- Photochromic - glass lenses
- Photochromic - plastic lenses
- High index lenses
- Polarized lenses

Low vision testing and equipment

- Comprehensive low vision exam
Once every 5 Calendar Years.

- Low vision devices

One aid per Calendar Year.

Diabetes management referral

When using a Participating Provider³

CYD² applies

\$25

\$0

\$30

\$45

\$0

\$0

\$0

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

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

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

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✓) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a separate medical Deductible and pharmacy Deductible.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the individual Deductible will be applied to both the individual Deductible and the Family Deductible.

3 Using Participating Providers:

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

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

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

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

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

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

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical or pharmacy Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year. Any amount you have paid toward the individual OOPM will be applied to both the individual OOPM and the Family OOPM.

5 Separate Member Payments When Multiple Covered Services are Received:

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

6 Preventive Health Services:

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

7 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

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

8 Outpatient Prescription Drug Coverage:

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

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

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

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

Oral Anticancer Drugs. You pay up to \$250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

9 Pediatric Dental Coverage:

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

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

This plan is compliant with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

10 Pediatric Vision Coverage:

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

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

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

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

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

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

Introduction

Welcome! We are happy to have you as a Member of our Blue Shield of California (Blue Shield) health plan. This plan has been certified as a Qualified Health Plan by Covered California for Small Business (CCSB), the state's health insurance marketplace. When your Employer purchases a plan through CCSB, your Employer will send CCSB your enrollment information. Once you are enrolled, your Employer will be your primary point of contact for questions about Premiums and payment due dates. Blue Shield will be your primary point of contact for questions about Benefits, providers, and your Cost Share for Covered Services.

At Blue Shield, our mission is to ensure all Californians have access to high-quality health care at an affordable price. To achieve this mission, we pledge to:

- Provide personal service to you that is worthy of our family and friends; and
- Build deep, trusting relationships with providers to improve the quality of health care and lower the cost.

A Blue Shield health plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on your plan.

About this Evidence of Coverage

The Evidence of Coverage describes the health care coverage that is provided under the Group Health Service Contract (Contract) between Blue Shield and your Employer. The Evidence of Coverage tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your plan;
- Which services are not covered under your plan;
- When and how you must get prior authorization for certain services; and
- Important financial concepts, such as Copayment, Coinsurance, Deductible, and Out-of-Pocket Maximum.

This Evidence of Coverage includes a [Summary of Benefits](#) section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care.

Please read this Evidence of Coverage carefully. Some topics in this document are complex. For additional explanation on these topics, you may be directed to a section at the back of the Evidence of Coverage called [Other important information about your plan](#). Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Evidence of Coverage in your files for future reference.

Tables and images

In this Evidence of Coverage, you will see the following tables and images to highlight key information:

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.



This table provides easy access to information



Phone numbers and addresses

Answers to commonly-asked questions

Examples to help you better understand important concepts



This box tells you where to find additional information about a specific topic.



This box alerts you to information that may require you to take action.

“You” means the Member

In this Evidence of Coverage, “you” or “your” means any Member enrolled in the plan, including the Subscriber and all Dependents. “Your Employer” means the Subscriber’s Employer.

Capitalized words have a special meaning

Some words and phrases in this Evidence of Coverage may be new to you. Key terms with a special meaning within this Evidence of Coverage are capitalized in this document and explained in the [Definitions](#) section.

About this plan

This is a Health Maintenance Organization (HMO) plan. In an HMO plan, you have access to a network of providers who collaborate to bring you personal, efficient care. You will choose a Primary Care Physician (PCP) who is your first point of contact and manages your care. Your PCP is part of a group of Physicians called a Medical Group. Your PCP can refer you to Participating Providers in your Medical Group for specialized care and assist with other care needs. See the [How to access care](#) section for information about Participating Providers.

This plan offers a limited choice of Medical Groups and Hospitals. You should review the list of providers in the Trio HMO Physician and Hospital Directory before enrolling in this plan. In some areas, you may need to choose your PCP from within one Medical Group.



How to contact customer service



If you have questions at any time, we’re here to help. This plan has a special customer service program called Shield Concierge. A Shield Concierge representative can help

you find a doctor, pay a bill, transfer medical records, talk to a registered nurse or pharmacist, and more. Blue Shield's website and app are also useful resources. Visit blueshieldca.com or use the Blue Shield mobile app to:

- Download forms;
- View or print a temporary ID card;
- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.


Blue Shield contact information appears at the bottom of every page.



|  Contacting customer service  | |
|--|--|
| <i>If you need information about</i> | <i>You should contact</i> |
| Medical and prescription Drug Benefits | Blue Shield Shield Concierge: 1-855-258-3744 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540 |
| Acupuncture services | American Specialty Health Plans of California, Inc. (ASH Plans): (800) 678-9133 (TTY: (877) 710-2746) American Specialty Health Plans of California, Inc. P.O. Box 509002 San Diego, CA 92150-9002 |
| Mental Health and Substance Use Disorder services, including prior authorization | Mental Health Customer Service: (877) 263-9952 Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002 |

|  | Contacting customer service |  |
|---|--|---|
| <i>If you need information about</i> | <i>You should contact</i> | |
| Pediatric dental Benefits | Dental Customer Service: (800) 605-8202 Blue Shield of California Dental Plan Administrator 425 Market Street, 15th Floor San Francisco, CA 94105 | |
| Pediatric vision Benefits | Vision Customer Service: (855) 342-9105 Blue Shield of California Vision Plan Administrator Customer Service Department P. O. Box 25208 Santa Ana, CA 92799-5208 | |



If you are hearing impaired, you may contact Customer Service through Blue Shield's toll-free TTY number: 711.

Your 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 Blue Shield plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you. |
| 5 | Select a PCP and expect their team to provide or arrange for all the care you need. |
| 6 | Have reasonable access to appropriate medical and mental health services. |
| 7 | Participate actively with your PCP in decisions about your medical and mental health care. To the extent the law permits, 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 | An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your PCP, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage. |
| 10 | Receive Preventive Health Services. |
| 11 | Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living. |
| 12 | Have confidential health records, except when the law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your PCP. |
| 13 | Communicate with, and receive information from, Shield Concierge in a language you can understand. |

|  As a Blue Shield Member, you have the right to:  | |
|--|---|
| 14 | Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available. |
| 15 | Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care. |
| 16 | Voice complaints or grievances about your Blue Shield plan or the care provided to you. |
| 17 | Make recommendations on Blue Shield's Member rights and responsibilities policies. |

Your responsibilities

|  | As a Blue Shield Member, you have the responsibility to:  |
|---|--|
| 1 | <p>Carefully read all Blue Shield plan materials immediately after you are enrolled so you understand how to:</p> <ul style="list-style-type: none"> • Use your Benefits; • Minimize your out-of-pocket costs; and • Follow the provisions of your plan as explained in the Evidence of Coverage. |
| 2 | <p>Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.</p> |
| 3 | <p>Provide, to the extent possible, information needed for you to receive appropriate care.</p> |
| 4 | <p>Understand your health problems and take an active role in developing treatment goals with your PCP, whenever possible.</p> |
| 5 | <p>Follow the treatment plans and instructions you and your PCP agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.</p> |
| 6 | <p>Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.</p> |
| 7 | <p>Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.</p> |
| 8 | <p>Communicate openly with your PCP so you can develop a strong partnership based on trust and cooperation.</p> |
| 9 | <p>Offer suggestions to improve the Blue Shield plan.</p> |
| 10 | <p>Help Blue Shield maintain accurate and current records by providing timely information regarding changes in your address, family status, and other plan coverage.</p> |
| 11 | <p>Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints or grievances.</p> |
| 12 | <p>Treat all Blue Shield personnel respectfully and courteously.</p> |
| 13 | <p>Pay your Premiums, Copayments, Coinsurance, and charges for non-Covered Services in full and on time.</p> |

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

How to access care

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

Health care professionals and facilities

This plan covers care from Participating Providers within your Medical Group.

Participating Providers

Participating Providers have a contract with a Medical Group in this plan's network. With an HMO plan, there is generally no coverage for services from providers outside of your Medical Group.

If a provider leaves your Medical Group, you will not have coverage for services received from that provider. See the [Continuity of Care](#) section for more information on how to continue treatment with a Non-Participating Provider.



Visit [blueshieldca.com](https://www.blueshieldca.com) or use the Blue Shield mobile app and click on **Find a Doctor** for a list of your plan's **Participating Providers**.

Non-Participating Providers

Non-Participating Providers do not have a contract with Blue Shield to accept Blue Shield's Allowed Charges as payment in full for Covered Services. Except for Emergency Services, Urgent Services, and services received at a Participating Hospital under certain conditions, this plan does not cover services from Non-Participating Providers.

Non-Participating Providers at a Participating Provider facility

When you receive care at a Participating Provider facility, some Covered Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances.



Common types of providers



Primary Care Physicians (PCPs)

Other primary care providers, such as nurse practitioners and physician assistants

Physician Specialists, such as dermatologists and cardiologists

Physical, occupational, and speech therapists



Common types of providers



Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers

Hospitals

Freestanding labs and radiology centers

Ambulatory Surgery Centers

Benefit Administrators

Blue Shield contracts with Benefit Administrators to manage the Benefits listed in the table below through their own network of providers. Benefit Administrators authorize services, process claims, and address complaints and grievances for those Benefits on behalf of Blue Shield. If you receive a Covered Service from a Benefit Administrator, you should interact with the Benefit Administrator in the same way you would otherwise interact with your PCP.



Blue Shield's Benefit Administrators



| Benefit Administrator | Benefit |
|--|---|
| Dental Plan Administrator (DPA) | Pediatric dental Benefits |
| Vision Plan Administrator (VPA) | Pediatric vision Benefits |
| Mental Health Service Administrator (MHSA) | Mental Health and Substance Use Disorder services |
| ASH Plans | Acupuncture services |

Your Primary Care Physician

In an HMO plan, you are required to have a Primary Care Physician (PCP). Your PCP is your first point of contact for any health concern and for Preventive Health Services. Your PCP will also manage other aspects of your care, including:

- Prior authorization requests;
- Health education;
- Specialist referrals;
- Hospital admissions; and
- Hospice program admissions.

Selecting a PCP

Blue Shield will initially choose a PCP for you, but you can change this selection. You do not need to choose the same PCP for each Member in your family. To change your PCP, visit blueshieldca.com.

PCPs may be:

- General practitioners;
- Family practitioners;
- Internists;
- Obstetrician/gynecologists; or
- Pediatricians.

Your PCP must be a Participating Provider. If your PCP leaves this plan's network, Blue Shield will choose a new PCP for you and notify you.

Your relationship with your PCP

The relationship you have with your PCP is an important element of an HMO plan. Your PCP has a unique holistic view of your medical care. He or she will know your health history, which may help identify problems before they become serious. Your PCP will work with you to ensure you receive Medically Necessary professional services and accommodate your preferences to the extent possible. This relationship also allows for more open communication between you and your PCP. If you are unable to establish a satisfactory relationship with your PCP, you can choose a new one.

Your Medical Group

Some PCPs contract directly with Blue Shield, but most are part of a Medical Group. Medical Groups:

- Share administrative responsibilities with your PCP;
- Work with your PCP to authorize Covered Services;
- Ensure that a full panel of Specialists are available to you; and
- Have admission arrangements with Blue Shield's contracted Hospitals within the Medical Group Service Area.

Your PCP and Medical Group are listed on your ID card.

Changing your Medical Group

You can change your Medical Group at any time. If your PCP is not part of your new Medical Group, you will also have to select a new PCP. Visit blueshieldca.com to change your Medical Group or PCP.

Changes to your Medical Group are effective on the first day of the month after Blue Shield approves the change. At that time, authorizations for any services by your old Medical Group are no longer valid. If you still need these services, they must be reauthorized by your new Medical Group.

Blue Shield does not recommend that you change your Medical Group while you are admitted to the Hospital or in the third trimester of pregnancy. A change in Medical Group during an ongoing course of treatment may interrupt your care. Any requested changes to your Medical Group in these situations will be effective on the first day of the month after the date when it is medically appropriate to transfer your care. Exceptions must be approved by a Blue Shield Medical Director. Call Shield Concierge for more information.

Self-referral for obstetrical/gynecological (OB/GYN) services

You do not need a referral from your PCP for OB/GYN services as long as the obstetrician, gynecologist, or family practice Physician you see is in your Medical Group. Your Cost Share for OB/GYN services with that Physician will be the same as if you received those services from your PCP.

OB/GYN services are female reproductive and sexual health care services. OB/GYN services include Physician services related to:

- Family planning and contraception;
- Treatment during pregnancy;
- Diagnosis and treatment of disorders of the female reproductive system and genitalia;
- Treatment of disorders of the breast; and
- HIV testing.

Specialist referrals

You have two options if you need to see a Specialist.

PCP referrals

This option requires a referral from your PCP to see most types of Specialist. Your PCP will refer you to a Specialist or other appropriate Participating Provider in your Medical Group.

Self-referral to a Trio+ Specialist

With this option, you do not need a referral from your PCP to visit a Trio+ Specialist in your Medical Group. You can self-refer to a Trio+ Specialist for:

- An examination or other consultation; and
- In-office diagnostic procedures or treatment.

You cannot self-refer to a Trio+ Specialist for:

- Allergy testing;
- Endoscopic procedures;
- Diagnostic and nuclear imaging, including CT, MRI, or bone density measurement;
- Injectables, chemotherapy, or other infusion Drugs, other than vaccines and antibiotics;
- Infertility services;

- Inpatient services or any services that result in a facility charge, except for routine X-ray and laboratory services; or
- Services for which the Medical Group routinely allows you to self-refer without authorization from your PCP.

ID cards

Blue Shield will provide the Subscriber and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at blueshieldca.com or on the Blue Shield mobile app.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice. This fee will not be more than your Copayment or Coinsurance for the visit.

Continuity of care

Continuity of care may be available if:

- Your provider leaves your Medical Group during your care;
- Your MHPA Participating Provider becomes an MHPA Non-Participating Provider during your care;
- You are a newly-covered Member whose coverage choices do not include out-of-network Benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

You can request to continue treatment with your Non-Participating Provider in the situations described above if you are currently receiving the following care:

- Ongoing treatment for an acute or serious chronic condition;
- Pregnancy care, including care immediately after giving birth;
- Treatment for a maternal mental health condition;
- Treatment for a terminal illness;
- Other services authorized by a now-terminated provider as part of a documented course of treatment; or
- Care for a child up to 36 months old.

To request continuity of care, visit blueshieldca.com and fill out the Continuity of Care Application. Blue Shield will confirm your eligibility and review your request for Medical Necessity.

The Non-Participating Provider must agree to accept Blue Shield's Allowed Charges as payment in full for your ongoing care. If the provider agrees and your request is authorized, you may continue to see the Non-Participating Provider at the Participating Provider Cost Share for:

- Up to 12 months;

- For a maternal mental health condition, 12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later; or
- If you have a terminal illness, for the duration of the terminal illness.



See the [Your payment information](#) section for more information about the Allowed Charges.

Second medical opinion

You can ask your PCP for a referral to another provider for a second medical opinion in situations including but not limited to:

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;
- Your diagnosis is unclear;
- Your condition has not improved after completing the prescribed course of treatment;
- You need additional information before deciding on a treatment plan; or
- You have questions about your diagnosis or treatment plan.

Your Medical Group will work with you to arrange for a second medical opinion.

|  Who provides your second medical opinion  | |
|---|--|
| <i>If you want a second opinion on</i> | <i>It will come from</i> |
| A proposed treatment plan from your PCP | Another PCP in your Medical Group |
| A proposed treatment plan from a Specialist | A Participating Provider in the same or equivalent specialty |

Care outside of California

If you need urgent or emergency medical care while traveling outside of California, you're covered. Blue Shield has relationships with health plans in other states, Puerto Rico, and the U.S. Virgin Islands through the BlueCard® Program. The Blue Cross Blue Shield Association can help you access care in those geographic areas.



See the [Out-of-area services](#) section for more information about receiving care while outside of California. To find participating providers while outside of California, visit [bcbs.com](https://www.bcbs.com).

Emergency Services



If you have a medical emergency, **call 911 or seek immediate medical attention** at the nearest hospital.

The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

After you receive care, Blue Shield will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the entire cost of that non-emergency service.

If you cannot find a Participating Provider



Your PCP will refer you to other providers in your Medical Group for the care you need. If these services cannot reasonably be obtained from a Participating Provider, you can ask your Medical Group for authorization to see a Non-Participating Provider. They will review your request for Medical Necessity, and if approved, your Medical Group will pay for Covered Services from the Non-Participating Provider. You will only be responsible for the Participating Provider Cost Share. If the Medical Group cannot provide the necessary care, you can call Shield Concierge for help finding a Participating Provider who can provide the requested services.

Other ways to access care

For non-emergencies, it may be faster and easier to access care in one of the following ways. For more information, visit blueshieldca.com or use the Blue Shield mobile app.

Teladoc

Teladoc provides primary care and behavioral health consultations by phone or online. Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication. Teladoc behavioral health consultations are not available for Members under age 13. Members under age 13 may obtain telebehavioral health services for Mental Health and Substance Use Disorders from MHSA Participating Providers. Teladoc is a supplemental service that is not intended to replace care from your PCP, care from your MHSA Participating Provider, or your relationship with your PCP.

|  How to access Teladoc  | |
|--|--|
| By phone | Call 1-800-Teladoc 24 hours a day, 7 days a week |
| By secure online video | Visit teladoc.com/bsc 7 a.m. to 9 p.m. Pacific Time |

Telebehavioral health services

Online telebehavioral health services for Mental Health and Substance Use Disorders are available through MHSA Participating Providers, and are a Covered Service regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. Visit blueshieldca.com and click on Find a Doctor to access the MHSA network.

Urgent care centers

Urgent care centers are free-standing facilities that provide many of the same basic medical services as a doctor's office, often with extended hours but similar Cost Share.

If your condition is not an emergency, but you need treatment that cannot be delayed, you can visit an urgent care center to receive care that is typically faster and costs less than an emergency room visit.

If you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.

Ambulatory Surgery Centers

Many of the more common, uncomplicated, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Timely access to care

Participating Providers agree to provide timely access to care. This means that when you call for an appointment, you will see your provider within a reasonable timeframe. Blue Shield's access standards are listed below.

| When your appointment will occur | |
|--|--|
| Urgent appointments | Appointment will occur |
| Services that do not require prior authorization | Within 48 hours |
| Services that do require prior authorization | Within 96 hours |
| Urgent pediatric dental care | Within 72 hours |
| Non-urgent appointments | Appointment will occur |
| Primary Care Physician office visit | Within 10 business days |
| Specialist office visit | Within 15 business days |
| Mental or substance use disorder health provider (who is not a Physician) office visit | Within 10 business days |
| Other services to diagnose or treat a health condition | Within 15 business days |
| Non-urgent pediatric dental care | Within 30 business days |
| Preventive pediatric dental care | Within 40 business days |
| Phone inquiries | Appointment will occur |
| Access to a health care professional for phone screenings | 24 hours a day, seven days a week |
| Access to a dental care professional for phone screenings | Within 30 minutes, 24 hours a day, seven days a week |



Contact **Shield Concierge** to schedule **interpreter services** for your appointment. For more information about interpreter services, see the [Language access services](#) notice.

Health advice and education

Blue Shield provides several ways for you to get health advice and access to health education and wellness services. These resources are available to you at no extra cost.

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

NurseHelp 24/7SM

You can contact a registered nurse 24 hours a day, seven days a week through the NurseHelp 24/7SM program. Nurses are available to help you select appropriate care and answer questions about:

- Symptoms you are experiencing;
- Minor illnesses and injuries;
- Medical tests and medications;
- Chronic conditions; and
- Preventive care.

Call (877) 304-0504 or log in to your account at [blueshieldca.com](https://www.blueshieldca.com) and use the chat feature to connect with a nurse. This service is free and confidential.

NurseHelp 24/7SM is not meant to replace the advice and care you receive from your Physician or other health care professional.

LifeReferrals 24/7SM

The LifeReferrals 24/7SM program offers you access to support services 24 hours a day, seven days a week, including assessments and referrals for consultations for health and psychosocial issues. Professional counselors can provide confidential telephone or in-person support by approved appointment. You are limited to three consultations with a professional counselor every six months.

This bundle of services also includes referrals, resources, and support for additional topics such as:

- Legal services;
- Financial counseling;
- Mediation;
- Child and family care;
- Adult and elder care;
- Chronic conditions and illnesses;
- Income tax preparation; and
- Identity theft assistance.

Call (800) 985-2405 to obtain services or access online tools and resources by visiting [lifereferrals.com](https://www.lifereferrals.com) and using the code: "BSC". These services are free and confidential.

Health and wellness resources

Your Blue Shield coverage gives you access to a variety of health education and wellness services, such as:

- Prenatal and other health education programs;
- Healthy lifestyle programs to help you get more active, quit smoking, lower stress, and much more; and
- A health update newsletter.

Visit [blueshieldca.com](https://www.blueshieldca.com) to explore these resources.

Medical management

Medical management can help you coordinate your care and treatment. It includes utilization management and care management. Blue Shield uses utilization management to help you and your providers identify the most appropriate and cost-effective way to use the Benefits of this plan. Care management and palliative care can help you access the care you need to manage serious health conditions and complex treatment plans.



For written information about **Blue Shield's Utilization Management Program**, visit [blueshieldca.com](https://www.blueshieldca.com).

Prior authorization and PCP referrals

Coverage for most Benefits requires pre-approval from the Medical Group. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. Your PCP will manage your prior authorization requests.

A referral from your PCP is usually required when you want to see a Specialist or other provider, but there are some exceptions. You do not need a referral for:

- Emergency Services;
- Urgent Services;
- Trio+ Specialist visits;
- OB/GYN services by an obstetrician, gynecologist, or family practice Physician within your Medical Group; and
- Office visits with your PCP or for outpatient Mental Health and Substance Use Disorder services with an MHSA Participating Provider.

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization from your Medical Group or from Blue Shield.

The prior authorization process for self-administered prescription Drugs available at a retail, specialty, or mail order pharmacy is explained in the [Prescription Drug Benefits](#) section.



When a decision will be made about your prior authorization request



| Prior authorization or exception request | Time for decision |
|--|---------------------------|
| Routine medical, Mental Health and Substance Use Disorder, dental, and vision requests | Within five business days |
| Expedited medical, Mental Health and Substance Use Disorder, dental, and vision requests | Within 72 hours |
| Routine prescription Drug requests | Within 72 hours |
| Expedited prescription Drug requests | Within 24 hours |

Expedited requests include urgent medical and exigent pharmacy requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

While you are in the Hospital (inpatient utilization review)

When you are admitted to the Hospital, your stay will be monitored for continued Medical Necessity. If it is no longer Medically Necessary for you to receive an inpatient level of care, your Medical Group will send a written notice to you, your provider, and the Hospital. If you choose to stay in the Hospital past the date indicated in this notice, you will be financially responsible for all inpatient charges after that date. Exceptions to inpatient utilization review include maternity and mastectomy care.

For maternity, the minimum length of an inpatient stay is 48 hours for a normal, vaginal delivery and 96 hours for a C-section. The provider and mother together may decide that a shorter length of stay is adequate.

For mastectomy, you and your provider determine the Medically Necessary length of stay after the surgery.

After you leave the Hospital (discharge planning)

You may still need care at home or in another facility after you are discharged from the Hospital. Your Medical Group will work with you, your provider, and the Hospital's discharge planners to determine the most appropriate and cost-effective way to provide this care.

Using your Benefits effectively (care management)

Care management helps you coordinate your health care services and make the most efficient use of your plan Benefits. Its goal is to help you stay as healthy as possible while managing your health condition, to avoid unnecessary emergency room visits and repeated hospitalizations, and to help you with the transition from Hospital to home. A Blue Shield care management nurse may contact you to see how we might help you

manage your health condition. You may also request care management support by calling Shield Concierge. A case manager can:

- Help you identify and access appropriate services;
- Instruct you about self-management of your health care conditions; and
- Identify community resources to lend support as you learn to manage a chronic health condition.

Alternative services may be offered when they are medically appropriate and only utilized when you, your provider, and Blue Shield mutually agree. The availability of these services is specific to you for a set period of time based on your health condition. Blue Shield does not give up the right to administer your Benefits according to the terms of this Evidence of Coverage or to discontinue any alternative services when they are no longer medically appropriate. Blue Shield is not obligated to cover the same or similar alternative services for any other Member in any other instance.

Managing a serious illness (palliative care services)

Blue Shield covers palliative care services if you have a serious illness. Palliative care provides relief from the symptoms, pain, and stress of a serious illness to help improve the quality of life for you and your family.

Palliative care services include access to Physicians and case managers who are specially trained to help you:

- Manage your pain and other symptoms;
- Maximize your comfort, safety, autonomy, and well-being;
- Navigate a course of care;
- Make informed decisions about therapy;
- Develop a survivorship plan; and
- Document your quality-of-life choices.

Your payment information

Paying for coverage

Your Employer is responsible for a monthly payment to CCSB for health care coverage for the Subscriber and any enrolled Dependents. This monthly payment is a Premium. Any amount the Subscriber must contribute to the Premium is set by your Employer.

The contract states the monthly Premiums for this plan for the Subscriber and any enrolled Dependents.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Blue Shield Allowed Charges.

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.



See the [Summary of Benefits](#) section for your **Cost Share** for Covered Services.

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Services provided or arranged by Blue Shield, except as stated in the [Exception for other coverage](#) and [Reductions – third party liability](#) sections. Covered Services provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them.

If there is a payment dispute between Blue Shield and a Participating Provider over Covered Services you receive, the Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the Allowed Charges. You are only required to pay your Cost Share for those services.

When you see a Participating Provider, you are responsible for your Cost Share.

Calendar Year Deductible

The Deductible is the amount you pay each Calendar Year for Covered Services before Blue Shield begins payment. Blue Shield will pay for some Covered Services before you meet your Deductible.

Amounts you pay toward your Deductible count toward your Out-of-Pocket Maximum.

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

Some plans do not have a Deductible. For plans that do, there may be separate Deductibles for:

- an individual Member and an entire Family; and
- Medical and pharmacy Benefits.

If you have a Family plan, there is an individual Deductible within the Family Deductible. This means an individual family member can meet the individual Deductible before the entire Family meets the Family Deductible.

If you have an individual plan and you enroll a Dependent, your plan will become a Family plan. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

See the [Summary of Benefits](#) section for details on which Covered Services are subject to the Deductible and how the Deductible works for your plan.

Prior carrier Deductible credit

If you pay all or part of a Deductible for another Employer-sponsored health plan in the same Calendar Year you enroll in this plan, that amount will be applied to this plan's Deductible if:

- You were enrolled in an Employer-sponsored health plan with another carrier during the same Calendar Year this contract becomes effective and you enroll as of the original effective date of coverage under this contract;
- You were enrolled in another Blue Shield plan sponsored by the same Employer which this plan is replacing; or
- You were enrolled in another Blue Shield plan sponsored by the same Employer and you are transferring to this plan during open enrollment.

Copayment and Coinsurance

A Covered Service may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Service. A Coinsurance is a percentage of the Allowed Charges you pay for a Covered Service.

Your provider will ask you to pay your Copayment or Coinsurance at the time of service. For Covered Services that are subject to your plan's Deductible, you are also responsible for all costs up to the Allowed Charges until you reach your Deductible.

You will continue to pay the Copayment or Coinsurance for each Covered Service you receive until you reach your Out-of-Pocket Maximum.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the most you are required to pay in Cost Share for Covered Services in a Calendar Year. Your Cost Share includes Deductible, Copayment, and Coinsurance, and these amounts count toward your Out-of-Pocket Maximum, except as listed below. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services for the rest of the Calendar Year. If you want information about your Out-of-Pocket Maximum, you can call Shield Concierge.

If you have a Family plan, you will have a separate Out-of-Pocket Maximum for each individual Member and one for the entire Family.

If you have a Family plan, there is an individual Out-of-Pocket Maximum within the Family Out-of-Pocket Maximum. This means an individual family member can meet the individual Out-of-Pocket Maximum before the entire Family meets the Family Out-of-Pocket Maximum.

If you have an individual plan and you enroll a Dependent, your plan will become a Family plan. Any amount you have paid toward the Out-of-Pocket Maximum for your individual plan will be applied to both the individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum for your new plan.

The following do not count toward your Out-of-Pocket Maximum:

- Charges for services that are not covered;
- Charges over the Allowed Charges; and
- Charges for services over any Benefit maximum.

You will continue to be responsible for these costs even after you reach your Out-of-Pocket Maximum.

See the [Summary of Benefits](#) section for details on how the Out-of-Pocket Maximum works for your plan.

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Services until you reach your Deductible. Once you reach your Deductible, Blue Shield will pay the Allowed Charges for Covered Services, minus your Copayment or Coinsurance amounts, until you reach your Out-of-Pocket Maximum. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Services. Exceptions are described above.



EXAMPLE Cost to visit the doctor



Now that you know the basics, here is an example of how your Cost Share works. Please note, the DOLLAR AMOUNTS IN THE EXAMPLE ARE EXAMPLES ONLY AND DO NOT REFLECT ACTUAL DOLLAR AMOUNTS FOR YOUR PLAN.

Example: You visit the doctor for a sore throat. You have received Covered Services throughout the year and have already met your \$500 Deductible. However, you have not yet met your \$1,000 Out-of-Pocket Maximum.

*Deductible: **\$500***

*Amount paid to date toward Deductible: **\$500***

*Out-of-Pocket Maximum: **\$1,000***

*Amount paid to date toward Out-of-Pocket Maximum: **\$500***

*Participating Provider Copayment: **\$30***

*Blue Shield Allowed Charges for the doctor's visit: **\$100***

| | Participating Provider |
|-----------------------------|---|
| You pay | \$30 (\$30 Copayment) |
| Blue Shield pays | \$70 (Allowed Charges minus your Cost Share) |
| Total payment to the doctor | \$100 (Allowed Charges) |

In this example, because you have already met your Deductible, you are only responsible for the Participating Provider Copayment.

Claims for Emergency or Urgent Services

If you receive Emergency or Urgent Services from a Non-Participating Provider, you may be required to pay the charges in full and submit a claim to Blue Shield to request reimbursement. Blue Shield may send the payment to the Subscriber or directly to the Non-Participating Provider.

Claim forms are available at [blueshieldca.com](https://www.blueshieldca.com). Please submit your claim form and medical records within one year of the service date.

| How to submit a claim | | | |
|---|--|---|-------------------------------------|
| Type of claim | What to submit | Where to submit it | Due date |
| Medical services | <ul style="list-style-type: none"> Blue Shield claim form; and The itemized bill from your provider | Blue Shield of California P.O. Box 272540 Chico, CA 95927 | Within one year of the service date |
| Pharmacy services | <ul style="list-style-type: none"> Prescription Drug claim form; and Related receipts or the pharmacy's bill | Blue Shield of California P.O. Box 52136 Phoenix, AZ 85072-2136 | Within one year of the service date |
| Mental Health and Substance Use Disorder Services | <ul style="list-style-type: none"> Blue Shield claim form; and The itemized bill from your provider | Blue Shield of California P.O. Box 272540 Chico, CA 95927 | Within one year of the service date |
| Pediatric dental services | <ul style="list-style-type: none"> Dental claim form; and Related receipts or the provider's bill | Blue Shield of California Dental Plan Administrator P.O. Box 30567 Salt Lake City, UT 84130-0567 | Within one year of the service date |
| Pediatric vision services | <ul style="list-style-type: none"> Vision claim form; and Related receipts or the provider's bill | Blue Shield of California Vision Plan Administrator P.O. Box 25208 Santa Ana, CA 92799 | Within one year of the service date |

See the [Out-of-area services](#) section in the [Other important information about your plan](#) section for more information on claims for Emergency or Urgent Services outside of California.

Your coverage

This section explains eligibility and enrollment for this plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this plan

To be eligible for coverage as a Subscriber, you must meet all of your Employer's eligibility requirements and complete any waiting period established by your Employer.

Dependent eligibility

To be eligible for coverage as a Dependent, you must:

- Be listed on the enrollment form completed by the Subscriber; and
- Be the Subscriber's spouse, Domestic Partner, or be under age 26 and the child of the Subscriber, spouse, or Domestic Partner.
 - For the Subscriber's spouse to be eligible for this plan, the Subscriber and spouse must not be legally separated.
 - For the Subscriber's Domestic Partner to be eligible for this plan, the Subscriber and Domestic Partner must have a registered domestic partnership (except as otherwise permitted by your Employer).
 - "Child" includes a stepchild, newborn, child placed for adoption, child placed in foster care, and child for whom the Subscriber, spouse, or Domestic Partner is the legal guardian. It does not include a grandchild unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
 - A child age 26 or older can remain enrolled as a Dependent if the child is disabled, incapable of self-support because of a mental or physical disability, and chiefly dependent on the Subscriber for economic support.
 - The Dependent child's disability must have begun before the period he or she would become ineligible for coverage due to age.

Enrollment and effective dates of coverage

As the Subscriber, you can enroll in coverage for yourself and your Dependents during your initial enrollment period, your Employer's annual open enrollment period, or if you qualify for a special enrollment period.

You are eligible for coverage as a Subscriber on the day following the date you complete any applicable waiting period established by your Employer. Coverage starts at 12:01 a.m. Pacific Time on the effective date of coverage. The Benefits of this plan are not available before the effective date of coverage. This Contract has a 12-month term that begins on your Employer's effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. You will have an annual open enrollment period set by your

Employer. Your Employer will notify its Employees of the open enrollment period each year.

Special enrollment period

A special enrollment period is a time outside open enrollment when you can apply for coverage or change coverage. A special enrollment period begins with a Qualifying Event.

A special enrollment period gives you at least 30 days from a Qualifying Event to apply for or change coverage for yourself or your Dependents. See the [Special enrollment period](#) section for more information. You should notify your Employer as soon as possible if you experience a Qualifying Event that requires a change in your coverage.



Common Qualifying Events



Change in Dependents

Loss of coverage under another employer health plan or other health insurance

Loss of eligibility in a government program



For a complete list of Qualifying Events, see [Special enrollment period](#) on page 90 in the [Other important information about your plan](#) section.

Effective date of coverage for most special enrollment periods

If enrolled during initial enrollment or open enrollment, a Dependent will have the same effective date of coverage as the Subscriber. However, a Dependent may have a different effective date of coverage if added during a special enrollment period. Generally, if the Employee or Dependents qualify for a special enrollment period, coverage will begin no later than the 1st of the month following the date Blue Shield receives the request for special enrollment from your Employer.

Effective date of coverage for a new Dependent child

Coverage starts immediately for a:

- Newborn;
- Adopted child;
- Child placed for adoption;
- Child placed in foster care; or
- Child for whom the Subscriber, spouse, or Domestic Partner is the court-appointed legal guardian.



For coverage to continue beyond 31 days, the Subscriber must **notify CCSB and request that the child be added as a Dependent within 30 days** of birth, adoption, placement for adoption, placement in foster care, or the date of court-ordered guardianship.

If both partners in a marriage or Domestic Partnership are eligible Employees and Subscribers, they are not eligible to be Dependents of each other. You may enroll a child as a Dependent of either parent but not both.

A child will be considered adopted for the purpose of Dependent eligibility when one of the following happens:

- The child is legally adopted;
- The child is placed for adoption and there is evidence of the Subscriber, spouse, or Domestic Partner's right to control the child's health care; or
- The Subscriber, spouse, or Domestic Partner is granted legal authority to control the child's health care.

The child's eligibility as a Dependent will continue while waiting for a legal decree of adoption unless the child is removed from the Subscriber, spouse, or Domestic Partner's home before the decree is issued.

Plan changes

Blue Shield has the right to change the Benefits and terms of this plan as the law permits. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Premiums; and
- Limitations and exclusions.

Blue Shield will give your Employer written notice of Premium or coverage changes. We will send this notice at least 60 days prior to plan renewal or the effective date of the Benefit change. Your Employer is responsible for letting you know of any changes. Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

Coordination of benefits

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. Coordination of benefits determines which plan will pay first when both plans have responsibility for paying the medical claim. For more information, see the [Coordination of benefits, continued](#) section.

When coverage ends

Your coverage will end if:

- Your Employer cancels or does not renew coverage;
- The Subscriber cancels coverage; or

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

- Blue Shield or CCSB cancels or rescinds coverage.

There is no right to receive the Benefits of this plan after coverage ends, except as described in the [Continuation of group coverage](#) section.

If your Employer cancels coverage

Your Employer may cancel coverage at any time. To cancel coverage, your Employer must provide written notice to Blue Shield CCSB, and its Employees.

If the Subscriber cancels coverage

If the Subscriber decides to cancel coverage, coverage will end at 11:59 p.m. Pacific Time on a date determined by your Employer.

Reinstatement

If the Subscriber voluntarily cancels coverage, the Subscriber can contact the Employer for reinstatement options.

If Blue Shield or CCSB cancels coverage

Blue Shield or CCSB can cancel coverage if:

- You are no longer eligible for coverage in this plan;
- Your Employer fails to meet Blue Shield or CCSB's Employer eligibility, participation, and contribution requirements;
- Blue Shield terminates this plan; or
- Your Employer commit fraud or intentional misrepresentation of material fact.

Blue Shield will provide 30 days' advance written notice of cancellation of coverage to your Employer if your Employer fails to meet Blue Shield or CCSB's Employer eligibility, participation, and contribution requirements. It is your Employer's responsibility to provide a copy of the notice to its Employees.

Cancellation for Employer's nonpayment of Premiums

Blue Shield or CCSB can cancel coverage if your Employer does not pay the required Premiums in full and on time. Your Employer is responsible for all Premiums during the term of coverage, including the 30-day grace period. If Blue Shield or CCSB cancels coverage due to nonpayment of Premiums, Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the date coverage ends.

Cancellation or rescission for fraud or intentional misrepresentation of material fact

Blue Shield may cancel or rescind your coverage if you, your Dependent, or your Employer commit fraud or intentional misrepresentation of material fact. Blue Shield will send the Notice of Cancellation, Rescission or Nonrenewal to your Employer prior to any rescission. Your Employer must provide you with a copy of the Notice of Cancellation, Rescission or Nonrenewal. Rescission voids the Contract as if it never existed. Cancellation is effective on the date specified in the Notice of Cancellation, Rescission or Nonrenewal and the Notice of End of Coverage.

Extension of Benefits

If you become Totally Disabled while covered under this plan and continue to be Totally Disabled on the date the Contract terminates, Blue Shield will extend Benefits directly related to the condition, illness, or injury causing your Total Disability until one of the following occurs:

- 12 months from the effective date of termination;
- The date you are no longer Totally Disabled; or
- The date on which a replacement carrier provides coverage for your Total Disability.

Your extension of Benefits will be subject to all the limitation and restrictions of this plan.

You will not receive an extension of Benefits unless a Physician provides Blue Shield with written certification of your Total Disability within 90 days of the effective date of termination. After that, the Physician must continue to provide written certification of your Total Disability at reasonable intervals Blue Shield determines.

Continuation of group coverage

Please examine your options carefully before declining this coverage.

You can continue coverage under this group plan when your 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).

Your benefits under the group continuation of coverage provisions will be identical to the Benefits you would have received as an active Employee if the qualifying event had not occurred. Any changes in the coverage available to active Employees will also apply to group continuation coverage.

COBRA

You may elect to continue group coverage under this plan if you would otherwise lose coverage because of a COBRA qualifying event. Please contact your Employer for detailed information about COBRA continuation coverage, including eligibility, election of coverage, and Premiums.

Cal-COBRA

If you enroll in COBRA and exhaust the time limit for COBRA group continuation coverage, you may be able to continue your group coverage under Cal-COBRA for a combined total (COBRA plus Cal-COBRA) of 36 months.

You will not be eligible for benefits under Cal-COBRA if, at the time of the Cal-COBRA qualifying event, you are entitled to benefits under Medicare or are covered under another group health plan. Medicare entitlement means that you are eligible for Medicare benefits and enrolled in Part A only.

Cal-COBRA qualifying event

A Cal-COBRA qualifying event is an event that, except for the election of continuation coverage, would result in a loss of coverage for the Subscriber or eligible Dependents:

- The death of the Subscriber;
- Termination of the Subscriber's employment (except termination for gross misconduct which is not a qualifying event);
- Reduction in hours of the Subscriber's employment;
- Divorce or legal separation of the Subscriber from the covered spouse;
- Termination of the Subscriber's domestic partnership with a covered Domestic Partner;
- Loss of Dependent status by a covered Dependent;
- The Subscriber's entitlement to Medicare (This only applies to a covered Dependent); and
- With respect to any of the above, such other qualifying event as may be added to Cal-COBRA.

A child born to or placed for adoption with a covered Subscriber or Domestic Partner during the Cal-COBRA group coverage continuation period may be immediately added as a Dependent provided the Employer is properly notified of the birth or placement for adoption, and the child is enrolled within 30 days of the birth or placement for adoption.

Notification of a qualifying event

You are 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 Dependent's loss of Dependent status under this plan. This notice must be given within 60 days of the date of the qualifying event. Failure to provide such notice within 60 days will disqualify you from receiving continuation coverage under Cal-COBRA.

Your 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 you with written notice of your right to continue group coverage under this plan. You must then give Blue Shield notice in writing of your election of continuation coverage within 60 days of the date of the notice of your right to continue group coverage, or the date coverage terminates due to the qualifying event, whichever is later. The written election notice must be delivered to Blue Shield by first-class mail or other reliable means.

If you do not notify Blue Shield within 60 days, your coverage will terminate on the date you would have lost coverage because of the qualifying event.

If this plan replaces a previous group plan that was in effect with your Employer, and you had elected Cal-COBRA continuation coverage under the previous plan, you may continue coverage under this plan for the balance of your Cal-COBRA eligibility period. To begin Cal-COBRA coverage with Blue Shield, you

must notify us within 30 days of the date you were notified of the termination of your previous group plan.

Duration and extension of group continuation coverage

COBRA enrollees who reach the maximum coverage period available under COBRA may elect to continue coverage under Cal-COBRA for a combined maximum period of 36 months from the date continuation of coverage began under COBRA. You must notify Blue Shield of your Cal-COBRA election at least 30 days before COBRA termination. Your Cal-COBRA coverage will begin immediately after the COBRA coverage ends.

You must exhaust all available COBRA coverage before you can become eligible to continue coverage under Cal-COBRA.

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.

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 36 months from the date of the qualifying event that originally entitled you to continue your group coverage under this plan.

Payment of Premiums

Premiums for continuing coverage will be 110 percent of the applicable group Premium rate, except if you are eligible to continue Cal-COBRA coverage beyond 18 months because of a Social Security disability determination. In that case, the Premiums for months 19 through 36 will be 150 percent of the applicable group Premium rate.

Cal-COBRA enrollees must submit Premiums directly to Blue Shield. The initial Premiums must be paid within 45 days of the date you provided written notification to Blue Shield of your election to continue coverage and must be sent to Blue Shield by first-class mail or other reliable means. You must pay the entire amount due within the 45-day period or you will be disqualified from Cal-COBRA continuation coverage.

Effective date of the continuation of group coverage

If your initial group continuation coverage is Cal-COBRA rather than COBRA, your Cal-COBRA coverage will begin on the date your coverage under this plan would otherwise end due to a qualifying event. Your coverage will continue for up to 36 months unless terminated due to an event described in the *Termination of group continuation coverage* section.

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:

- Termination of the Contract (if your Employer continues to provide any group benefit plan for Employees, you may be able to continue coverage with another plan);
- Failure to pay Premiums in full and on time to Blue Shield. Coverage will end as of the end of the period for which Premiums were paid;
- You become covered under another group health plan;
- You become entitled to Medicare; or
- You commit fraud or deception in the use of the services of this Plan.

Continuation of group coverage while on leave

Employers are responsible to ensure compliance with state and federal laws regarding leaves of absence, including the California Family Rights Act, the Family and Medical Leave Act, the Uniformed Services Employment and Re-employment Rights Act, and Labor Code requirements for Medical Disability.

Family leave

The California Family Rights Act of 1993 and the federal Family & Medical Leave Act of 1993 allow you to continue your coverage under this plan while you are on family leave. Your Employer is solely responsible for notifying their Employee of the availability and duration of family leaves.

Military leave

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) allows you to continue your coverage under this plan while you are on military leave. If you are planning to enter the Armed Forces, you should contact your Employer for information about your rights under the (USERRA).

Your Benefits

This section describes the Benefits your plan covers. They are listed in alphabetical order so they are easy to find.

Blue Shield provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums;
- The provisions of the medical management section; and
- The terms, conditions, limitations, and exclusions of this Evidence of Coverage.

You can receive many outpatient Benefits in a variety of settings, including your home, a Physician's office, an urgent care center, an Ambulatory Surgery Center, or a Hospital. Blue Shield's medical management help your provider ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

See the [Exclusions and limitations](#) section for more information about Benefit exclusions and limitations.



See the [Summary of Benefits](#) section for your **Cost Share** for Covered Services.

Acupuncture services

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

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

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

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;
- Preparation and provision of allergy serum; and
- Allergy serum injections.

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

Benefits are available for ambulance services provided by a licensed ambulance or psychiatric transport van.

Benefits include:

- Emergency ambulance transportation (surface and air) when used to transport you from the place of illness or injury to the closest medical facility that can provide appropriate medical care; and
- Non-emergency, prior-authorized ambulance transportation (surface and air) from one medical facility to another.

Air ambulance services are covered at the Participating Provider Cost Share, even if you receive services from a Non-Participating Provider.

Chiropractic services

For all chiropractic services, Blue Shield has contracted with

Clinical trials for treatment of cancer or life-threatening diseases or conditions Benefits

Benefits are available for routine patient care when you have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition is a disease or condition that is likely to result in death unless its progression is interrupted.

The clinical trial must have therapeutic intent and the treatment must meet one of the following requirements:

- Your Participating Provider determines that your participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by you; or
- You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate.

Coverage for routine patient care received while participating in a clinical trial requires prior authorization. Routine patient care is care that would otherwise be covered by the plan if those services were not provided in connection with an approved clinical trial. The [Summary of Benefits](#) section lists your Cost Share for Covered Services. These Cost Share amounts are the same whether or not you participate in a clinical trial. Routine patient care does not include:

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;

- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 or other life-threatening diseases or conditions, and the study or investigation meets one of the following requirements:

- It is a drug trial conducted under an investigational new drug application reviewed by the FDA;
- It is a drug trial exempt under federal regulations from a new drug application; or
- It is federally funded or approved by one or more of the following:
 - One of the National Institutes of Health;
 - The Centers for Disease Control and Prevention;
 - The Agency for Health Care Research and Quality;
 - The Centers for Medicare & Medicaid Services; or
 - A designated Agency affiliate or research entity as described in the Affordable Care Act, including the Departments of Veterans Affairs, Defense, or Energy if the study has been reviewed and approved according to Health and Human Services guidelines.

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. 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 diabetes educator.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including those designed to help the visually impaired;
- Insulin pens, syringes, pumps, and all related necessary supplies;
- Blood and urine testing strips and tablets;
- Lancets and lancet puncture devices;
- Podiatric footwear and devices to prevent or treat diabetes-related complications;
- Medically Necessary foot care; and
- Visual aids, excluding eyewear and video-assisted devices, designed to help the visually impaired with proper dosing of insulin.

Your plan also covers the replacement of a covered item after the expiration of its life expectancy.

Self-management training

Benefits are available for outpatient training, education, and medical nutrition therapy when directed or prescribed by your Physician. These services can help you manage your diabetes and properly use the devices, equipment, and supplies available to you. With self-management training, you can learn to monitor your condition and avoid frequent hospitalizations and complications.

Diagnostic X-ray, imaging, pathology, laboratory, and other testing services

Benefits are available for imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury.

Benefits include:

- Diagnostic and therapeutic imaging services, such as X-rays and ultrasounds;
- Radiological and nuclear imaging, including CT, PET, and MRI scans;
- Clinical pathology services;
- Laboratory services;
- Other areas of diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, and cerebrovascular; and
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Laboratory or imaging services performed as part of a preventive health screening are covered under the Preventive Health Services Benefit.

Dialysis Benefits

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

Benefits include:

- Renal dialysis;
- Hemodialysis;
- Peritoneal dialysis; and
- Self-management training for home dialysis.

Benefits do not include:

- Comfort, convenience, or luxury equipment; or
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Durable medical equipment

Benefits are available for durable medical equipment (DME) and supplies needed to operate the equipment. DME is intended for repeated use to treat an illness or injury, to improve the function of movable body parts, or to prevent further deterioration of your medical condition. Items such as orthotics and prosthetics are only covered when necessary for Activities of Daily Living.

Benefits include:

- Mobility devices, such as wheelchairs;
- Peak flow meter for the self-management of asthma;
- Glucose monitor for the self-management of diabetes;
- Apnea monitors for the management of newborn apnea;
- Home prothrombin monitor for specific conditions;
- Oxygen and respiratory equipment;
- Disposable medical supplies used with DME and respiratory equipment;
- Required dialysis equipment and medical supplies;
- Medical supplies that support and maintain gastrointestinal, bladder, or bowel function, such as ostomy supplies;
- DME rental fees, up to the purchase price; and
- Breast pumps.

Benefits do not include:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers;
- Exercise equipment;
- Routine maintenance, repair, or replacement of DME due to loss or misuse, except when authorized;
- Self-help or educational devices;
- Speech or language assistance devices, except as specifically listed;
- Wigs;
- Adult eyewear;
- Video-assisted visual aids for diabetics;
- Generators;
- Any other equipment not primarily medical in nature; or
- Backup or alternate equipment.

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefit.

See the [Diabetes care services](#) section for more information about devices, equipment, and supplies for the management and treatment of diabetes.

Orthotic equipment and devices

Benefits are available for orthotic equipment and devices you need to perform Activities of Daily Living. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts 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;

- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities;
- Orthopedic shoes and other supportive devices for the feet, except as listed;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Prosthetic equipment and devices

Benefits are available for prosthetic appliances and devices used to replace a part of your body that is missing or does not function, and related supplies.

Benefits include:

- Tracheoesophageal voice prosthesis (e.g. Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- 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;
- Supplies necessary for the operation of prostheses;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

- Speech or language assistance devices, except as listed;
- Dental implants;
- Backup or alternate items; or
- Repair or replacement due to loss or misuse.

Emergency Benefits

Benefits are available for Emergency Services received in the emergency room of a Hospital. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition at any Hospital, even if it is a Non-Participating Hospital.



If you have a medical emergency, **call 911 or seek immediate medical attention** at the nearest hospital.

Benefits include:

- Physician services;
- Emergency room facility services; and
- Inpatient Hospital services to stabilize your Emergency Medical Condition.

After your condition stabilizes

Once your Emergency Medical Condition has stabilized, it is no longer considered an emergency. Upon stabilization, you may:

- Be released from the emergency room if you do not need further treatment;
- Receive additional inpatient treatment at the Participating Hospital; or
- Transfer to a Participating Hospital for additional inpatient treatment if you received treatment of your Emergency Medical Condition at a Non-Participating Hospital.

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. 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 delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

If you are admitted to the Hospital for Emergency Services, you should notify your PCP within 24 hours or as soon as possible after your condition has stabilized.

Family planning and Infertility Benefits

Family planning

Benefits are available for family planning services without illness or injury.

Benefits include:

- Counseling, consulting, and education;
- Office-administered contraceptives;
- Physician office visits for office-administered contraceptives;
- Tubal ligation; and
- Vasectomy.

Family planning services may also be covered under the Preventive Health Services Benefit and the Prescription Drug Benefit.

Infertility Benefits

Benefits are provided for the diagnosis and treatment of the cause of Infertility, including professional, Hospital, Ambulatory Surgery Center, and related services to diagnose and treat the cause of Infertility, with the exception of what is excluded in the [Exclusions and limitations](#) section.

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Services that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, standard fertility preservation services are a Covered Service and do not fall under the scope of Infertility Benefits described in the [Family Planning and Infertility Benefits](#) section.

Home health services

Benefits are available for home health services. These services include home health agency services, home infusion and injectable medication services, and hemophilia home infusion services.

Home health agency services

Benefits are available from a Participating home health care agency for diagnostic and treatment services received in your home under a written treatment plan approved by your Physician.

Benefits include:

- Intermittent home care for skilled services from:
 - Registered nurses;
 - Licensed vocational nurses;
 - Physical therapists;
 - Occupational therapists;
 - Speech and language pathologists;
 - Licensed clinical social workers; and
 - Home Health Aides.
- Related medical supplies.

Intermittent home care is for skilled services you receive:

- Fewer than seven days per week; or
- Daily, for fewer than eight hours per day, up to 21 days.

Benefits are limited to a visit maximum as shown in the [Summary of Benefits](#) section for home health agency visits. For this Benefit, coverage includes:

- Up to three visits per day, two hours maximum per visit, with a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, speech and language pathologist, or licensed clinical social worker. A visit of two hours or less is considered one visit. Nursing visits cannot be combined to provide Continuous Nursing Services.
- Up to four hours maximum per visit with a Home Health Aide. A visit of four hours or less is considered one visit.

Benefits do not include:

- Continuous Nursing Services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These services may also be described as "shift care" or "private duty nursing."

Home infusion and injectable medication services

Benefits are available through a Participating home infusion agency for home infusion, enteral, and injectable medication therapy.

Benefits include:

- Home infusion agency Skilled Nursing visits;
- Infusion therapy provided in an infusion suite associated with a Participating home infusion agency;
- Parenteral nutrition services and associated supplies and solutions;
- Enteral nutrition services and associated supplies and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include:

- Insulin;
- Insulin syringes; and
- Services related to hemophilia, which are described below.

Hemophilia home infusion services

Benefits are available for hemophilia home infusion products and services for the treatment of hemophilia and other bleeding disorders. Benefits must be prior authorized and provided in the home or in an infusion suite managed by a Participating Hemophilia Home Infusion Provider.

Benefits include:

- 24-hour service;
- Home delivery of hemophilia infusion products;
- Blood factor product;
- Supplies for the administration of blood factor product; and
- Nursing visits for training or administration of blood factor products.

There is no Calendar Year visit maximum for hemophilia home infusion agency services.

Benefits do not include:

- In-home services to treat complications of hemophilia replacement therapy; or
- Self-infusion training programs, other than nursing visits to assist in administration of the product.

Most Participating home health care and home infusion agencies are not Participating Hemophilia Home Infusion Providers. A list of Participating Hemophilia Home Infusion Providers is available at [blueshieldca.com](https://www.blueshieldca.com).

Hospice program services

Benefits are available through a Participating Hospice Agency for specialized care if you have been diagnosed with a terminal illness with a life expectancy of one year or less. When you enroll in a Hospice program, you agree to receive all care for your

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

terminal illness through the Hospice Agency. Hospice program enrollment is prior authorized for a specified period of care based on your Physician's certification of eligibility. The period of care begins the first day you receive Hospice services and ends when the specified timeframe is over or you choose to receive care for your terminal illness outside of the Hospice program.

The authorized period of care is for two 90-day periods followed by unlimited 60-day periods, depending on your diagnosis. Your Hospice care continues through to the next period of care when your Physician recertifies that you have a terminal illness. The Hospice Agency works with your Physician to ensure that your Hospice enrollment continues without interruption. You can change your Participating Hospice Agency only once during each period of care.

A Hospice program provides interdisciplinary care designed to ease your physical, emotional, social, and spiritual discomfort during the last phases of life, and support your primary caregiver and your family. Hospice services are available 24 hours a day through the Hospice Agency.

While enrolled in a Hospice program, you may continue to receive Covered Services that are not related to the care and management of your terminal illness from the appropriate Health Care Provider. However, all care related to your terminal illness must be provided through the Hospice Agency. You may discontinue your Hospice enrollment when an acute Hospital admission is necessary, or at any other time. You may also enroll in the Hospice program again when you are discharged from the Hospital, or at any other time, with Physician recertification.

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;
- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

- Services provided by a Non-Participating Hospice Agency, except in certain circumstances where there are no Participating Hospice Agencies in your area and services are prior authorized.

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

- Room and board, such as:
 - Semiprivate Hospital room, or private room if Medically Necessary;
 - Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care;
 - General and specialized nursing care; and
 - Meals, including special diets.
- Other inpatient Hospital services and supplies, including:
 - Operating, recovery, labor and delivery, and other specialized treatment rooms;
 - Anesthesia, oxygen, medicines, and IV solutions;
 - Clinical pathology, laboratory, radiology, and diagnostic services and supplies;
 - Dialysis services and supplies;
 - Blood and blood products;
 - Medical and surgical supplies, surgically implanted devices, prostheses, and appliances;
 - Radiation therapy, chemotherapy, and associated supplies;
 - Therapy services, including physical, occupational, respiratory, and speech therapy;
 - Acute detoxification;
 - Acute inpatient rehabilitative services; and
 - Emergency room services resulting in admission.

Medical treatment of the teeth, gums, jaw joints, and jaw bones

Benefits are available for outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues.

Benefits include:

- Treatment of gum tumors;
- Stabilization of natural teeth after traumatic injury independent of disease, illness, or any other cause;
- Surgical treatment of temporomandibular joint syndrome (TMJ);
- Non-surgical treatment of TMJ;
- Orthognathic surgery to correct a skeletal deformity;
- Dental and orthodontic services directly related to cleft palate repair;
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers; and
- General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status when:

- The Member is younger than seven years old; or
- The Member is developmentally disabled; or
- The Member's health is compromised and general anesthesia is Medically Necessary.

Benefits do not include:

- Adult routine dental or periodontal care;
- Adult orthodontia for any reason other than cleft palate repair;
- Dental implants for any reason other than cleft palate repair;
- Any procedure to prepare the mouth for dentures or for the more comfortable use of dentures;
- 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; or
- Fluoride treatments for any reason other than preparation of the oral cavity for radiation therapy.

Mental Health and Substance Use Disorder Benefits

Blue Shield's Mental Health Service Administrator (MHSA) administers Mental Health and Substance Use Disorder services from MHSA Participating Providers for Members in California. See the [Out-of-area services](#) section for an explanation of how Benefits are administered for out-of-state services.

The MHSA Participating Provider must get prior authorization from the MHSA for all non-emergency Hospital admissions for Mental Health and Substance Use Disorder services, and for certain outpatient Mental Health and Substance Use Disorder services. See the [Medical management](#) section for more information about prior authorization.

The MHSA Participating Providers network is separate from Blue Shield's Participating Provider network. Visit [blueshieldca.com](https://www.blueshieldca.com) and click on Find a Doctor to access the MHSA Participating Provider network.

Office visits

Benefits are available for professional office visits, including Physician office visits, for the diagnosis and treatment of Mental Health and Substance Use Disorders in an individual, Family, or group setting.

Benefits are also available for telebehavioral health online counseling services, psychotherapy, and medication management with a mental health or substance use disorder provider.

Other Outpatient Mental Health and Substance Use Disorder Services

In addition to office visits, Benefits are available for other outpatient services for the diagnosis and treatment of Mental Health and Substance Use Disorders. You can receive these other outpatient services in a facility, office, home, or other non-institutional setting.

Other Outpatient Mental Health and Substance Use Disorder Services include, but are not limited to:

- Behavioral Health Treatment – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, prescribed by a Physician or licensed psychologist and provided under a treatment plan approved by the MHSA to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression;
- Intensive Outpatient Program – outpatient care for mental health or substance use disorders when your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services at least five hours per day, four days per week when you are admitted directly or transferred from acute inpatient care following stabilization;
- Psychological Testing – testing to diagnose a mental health condition; and
- Transcranial magnetic stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Benefits do not include:

- Treatment for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health and Substance Use Disorders in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when you do not require acute inpatient care.

Medically Necessary inpatient substance use disorder detoxification is covered under the Hospital services Benefit.

Pediatric dental Benefits

Pediatric dental Benefits are available through the end of the month in which the covered Member turns 19 years old. A contracted Dental Plan Administrator (DPA) administers Blue Shield's pediatric dental Benefits. The DPA's network of DPA Participating Providers renders Dental Care Services to Members.

It is your responsibility to confirm that your Dental Provider is a DPA Participating Provider before you access Covered Services. The status of a DPA Participating Provider may change.

To confirm that your Dental Provider is a DPA Participating Provider, or if you have any questions about pediatric dental Benefits, visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or contact dental customer service at (800) 605-8202.

Pediatric dental Benefits covered by this plan are described in the pediatric dental Benefits table at the end of this Evidence of Coverage.

Your Dental Provider must be close enough to your home to ensure reasonable access to care.

See the [Pediatric dental exclusions](#) and [Pediatric dental limitations](#) sections for information on exclusions and limitations for your Pediatric dental Benefits.

Accessing pediatric dental Benefits

You can access pediatric dental HMO Benefits in much the same way you access your HMO medical Benefits by:

- Selecting a primary Dental Provider;
- Establishing a relationship with your primary Dental Provider;
- Changing your primary Dental Provider; and
- Obtaining a referral from your primary Dental Provider to see a Specialist.

See the [How to access care](#) section for more information on accessing Benefits of this plan.

Coordination of dental Benefits

This plan includes an embedded pediatric dental Benefit. For purposes of coordinating Benefits, if you purchase a Family dental plan that includes a supplemental pediatric dental plan, the embedded pediatric dental Benefits covered under this plan will be paid first. For the purposes of coordinating Benefits, this medical plan is your primary pediatric dental Benefit plan and the Family pediatric dental plan is the secondary pediatric dental Benefit plan.

Alternate Benefits provision

An alternate benefits provision allows a Benefit to be paid based on an alternate procedure that is professionally acceptable and more cost-effective. This plan's alternate benefits provision is as follows: 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 for Benefits based upon the less costly service. Any difference in cost between the proposed service and the less costly alternative is your financial responsibility.

Emergency dental care services

If you are within your Plan Service Area, you should contact your Dental Provider for emergency dental care services. Your Dental Provider will provide care or instructions for care. If you are unable to contact your Dental Provider prior to obtaining emergency dental care services, you must notify your Dental Provider within 24 hours of care, if possible.

If you are outside your Plan Service Area, you should contact the DPA prior to obtaining emergency dental care services. The DPA will refer you to a DPA

Participating Provider in that geographic area. If the DPA does not have a DPA Participating Provider in the area, or if you are unable to contact the DPA, you may contact a Dental Provider of your choice. If you obtain services without prior authorization from the DPA, the DPA will review the services for coverage as emergency dental care services. You will be responsible for the entire cost of the services if the DPA determines the situation did not require emergency dental care services.

Pediatric vision Benefits

Benefits are available for pediatric vision services from ophthalmologists, optometrists, and opticians.

Pediatric vision Benefits are available through the end of the month in which the covered Member turns 19 years old. A contracted Vision Plan Administrator (VPA) administers Blue Shield's pediatric vision Benefits. The VPA's network of VPA Participating Providers performs vision services for Members.

It is your responsibility to confirm that your provider is a VPA Participating Provider before you access Covered Services. The status of a VPA Participating Provider may change.

To confirm that your provider is a VPA Participating Provider, or if you have any questions about Benefits, visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or contact vision customer service at (844) 515-9068.

Benefits include:

- One comprehensive eye exam per Calendar Year. A comprehensive exam is a general evaluation of the complete visual system. It includes a history, a general medical observation, an external and ophthalmoscopic exam, an evaluation of gross visual fields, a basic sensorimotor exam, and a refractive exam. If indicated, it can include biomicroscopy, tonometry, or an exam for cycloplegia or mydriasis. The presence of trauma, severe inflammation, or other contraindication may prevent the provider from performing a complete exam. Dilation is included if professionally indicated. The comprehensive exam may occur in one session, or more than one if Medically Necessary.
 - When you choose standard or non-standard contact lenses instead of eyeglasses, you are eligible for contact lens fitting and evaluation services once in a consecutive 12-month period by a VPA Participating Provider if administered at the same time as the covered comprehensive examination up to the Benefit Allowance with a maximum of two follow up visits. For non-standard specialty contact lenses (including, but not limited to, toric, multifocal, and gas permeable lenses), you are responsible for the difference between the amount Blue Shield pays and the amount billed by the VPA Participating Provider.
- One of the following in a Calendar Year:
 - One pair of eyeglass lenses which include choice of glass, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, and

oversized and glass-grey #3 prescription sunglass lenses (Note: Polycarbonate lenses are covered in full for children, monocular patients, and patients with prescriptions $> \pm 6.00$ diopters);

- Elective contact lenses that are chosen for cosmetic or convenience purposes and are not Medically Necessary; or
- Non-elective (Medically Necessary) contact lenses prescribed 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), or hyperopia (7 or more diopters) astigmatism (over 3 diopters). Contact lenses may also be Medically Necessary in the treatment of the following conditions: pathological myopia, aphakia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism. A report from the provider and prior authorization from the VPA is required.
- One eyeglass frame in a Calendar Year.
- Low Vision testing once in a consecutive five Calendar Year period. The need for Low Vision testing is determined during a comprehensive eye exam. Low Vision testing may be obtained only from a VPA Participating Provider specializing in Low Vision care.
 - A VPA Participating Provider may prescribe optical devices, such as high-power eyeglasses, magnifiers, or telescopes, to maximize the remaining usable vision. One optical device per Calendar Year is covered. A report from the provider conducting the initial exam and prior authorization from the VPA are required for both the exam and any prescribed optical device.
- One diabetic management referral to a Blue Shield disease management program per Calendar Year. The VPA will notify Blue Shield's disease management program after the annual comprehensive eye exam when the Member is known to have or to be at risk for diabetes.

Benefits do not include:

- Any eye exam required by as a condition of employment.
- Orthoptics or vision training, subnormal vision aids, or non-prescription lenses for glasses when no Vision Prescription Change is indicated.
- Replacement or repair of lost or broken lenses or frames, except as listed in this Evidence of Coverage.
- Medical or surgical treatment of the eyes, except as covered under the Hospital services and Physician and other professional services Benefits.

Physician and other professional services

Benefits are available for services performed by a Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition.

Benefits include:

- Office visits for examination, diagnosis, counseling, education, consultation, and treatment;
- Specialist office visits;
- Urgent care center visits;

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- Second medical opinions;
- Administration of injectable medications;
- Outpatient services;
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room;
- Home visits;
- Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment; and
- Teladoc primary care consultations.

See the [Mental Health and Substance Use Disorder Benefits](#) section for information on Mental Health and Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

PKU formulas and special food products

Benefits are available for formulas and special food products if you are diagnosed with phenylketonuria (PKU). The items must be part of a diet prescribed and managed by a Physician or appropriately-licensed Health Care Provider.

Benefits include:

- Enteral formulas; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods used by the general population; or
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Podiatric services

Benefits are available for the diagnosis and treatment of conditions of the foot, ankle, and related structures. These services, including surgery, are generally provided by a licensed doctor of podiatric medicine.

Pregnancy and maternity care

Benefits are available for maternity care services.

Benefits include:

- Prenatal care;
- Postnatal care;
- Involuntary complications of pregnancy;
- Inpatient Hospital services including labor, delivery, and postpartum care;
- Elective newborn circumcision within 18 months of birth; and
- Pregnancy termination services.

See the [Diagnostic X-ray, imaging, pathology, and laboratory services](#) and [Preventive Health Services](#) sections for information about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

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. The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If your Hospital stay is shorter than the minimum stay, you can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required for this follow-up visit.

Prescription Drug Benefits

Benefits are available for outpatient prescription Drugs. Outpatient prescription Drugs are self-administered Drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies that are prescribed and are not provided for use on an inpatient basis. Drugs also include diabetic testing supplies.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. You must obtain all Drugs from a Participating Pharmacy, except as noted below. Drugs, items, and services that are not covered under this Benefit are listed in the [Exclusions and limitations](#) section.



Some Drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization to be covered. The prior authorization process is described in the [Prior authorization/exception request/step therapy process](#) section. You or your Physician may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield's Drug Formulary is a list of FDA-approved Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs. Drugs not listed on the Formulary may be covered when approved by Blue Shield through the exception request process.

Blue Shield's Formulary is established and maintained 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, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year. Your Physician or Health Care Provider might prescribe a Drug even though it is not included in the Blue Shield Formulary.

The Formulary is divided into Drug tiers. The tiers are described in the chart below. Your Copayment or Coinsurance will vary based on the Drug tier. Drugs are placed into tiers based on recommendations made by the P&T Committee.

|  | Formulary Drug tiers  |
|---|--|
| Drug Tier | Description |
| Tier 1 | <ul style="list-style-type: none"> • Most Generic Drugs and low-cost preferred Brand Drugs |
| Tier 2 | <ul style="list-style-type: none"> • Non-preferred Generic Drugs • Preferred Brand Drugs • Any other Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost |
| Tier 3 | <ul style="list-style-type: none"> • Non-preferred Brand Drugs • Drugs recommended by the P&T Committee based on drug safety, efficacy, and cost • Drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier |
| Tier 4 | <ul style="list-style-type: none"> • Drugs that are biologics, and Drugs the FDA or drug manufacturer requires to be distributed through Network Specialty Pharmacies • Drugs that require you to have special training or clinical monitoring • Drugs that cost the plan more than \$600 (net of rebates) for a one-month supply |



Visit blueshieldca.com/pharmacy, use the Blue Shield mobile app, or contact Customer Service for more information on the **Drug Formulary** or to request a printed copy of the Formulary.

Obtaining outpatient prescription Drugs at a Participating Pharmacy

You must present a Blue Shield ID card at a Participating Pharmacy to obtain prescription Drugs. You can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. See the [Obtaining Specialty Drugs from a Network Specialty Pharmacy](#) section for more information. If you obtain Drugs at a Non-Participating Pharmacy, Blue Shield will deny the claim and will not pay anything toward the cost of the Drugs, unless they are for a covered emergency.



Visit blueshieldca.com/pharmacy or use the Blue Shield mobile app to locate a **retail Participating Pharmacy**.

Blue Shield has two participation levels for retail Participating Pharmacies: Level A and Level B. If you select a Level A Participating Pharmacy, your cost share for covered Drugs will be lower than your cost share would be at a Level B Participating

Pharmacy. You may go to either Level A or Level B Participating Pharmacies to obtain covered Drugs.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than your Copayment or Coinsurance, you only pay the contracted rate. This amount will apply to any applicable Deductible and Out-of-Pocket Maximum. There is no Copayment or Coinsurance for generic, FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance only when Medically Necessary.

Drugs not listed on the Formulary may be covered if Blue Shield approves an exception request. If an exception request is approved, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment or Coinsurance. For all other Drugs that are approved as an exception, the Tier 3 Copayment or Coinsurance applies. If an exception is denied, the non-Formulary Drug is not covered and you are responsible for the entire cost of the Drug.

If you, your Physician, or your Health Care Provider selects a Brand Drug when a Generic Drug equivalent is available, you pay 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, you select 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. You would be responsible for paying the \$200 difference in cost, plus the Tier 1 Copayment or Coinsurance. This difference in cost does not apply to your Deductible or your Out-of-Pocket Maximum responsibility.

If you, your Physician, or your Health Care Provider believes the Brand Drug is Medically Necessary, you can request an exception to paying 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, you pay only the applicable tier Copayment or Coinsurance for the Brand Drug.

See the [Prior authorization/exception request/step therapy process](#) section for more information on the prior authorization process and exception requests.

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

program can file an appeal or submit a grievance to Blue Shield as described in the [Grievance Process](#) section. Members selected for participation in the PRC will receive a brochure with full program details, including participation exemptions. Any interested Member can request a PRC program brochure by calling Customer Service at the number listed on their Identification Card.

Obtaining extended day supply of outpatient prescription Drugs at a retail Participating Pharmacy

You also have an option to receive up to a 90-day supply of prescription Drugs at a pharmacy in the Rx90 Retail network when you take maintenance Drugs for an ongoing condition. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will only dispense the amount prescribed.

You must pay the applicable retail pharmacy Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com for additional information about how to get a 90-day supply of prescription Drugs from retail pharmacies.

Obtaining outpatient prescription Drugs at a Non-Participating Pharmacy in an emergency

When you receive Drugs from a Non-Participating pharmacy for a covered emergency, you must pay for the prescription in full and then submit a claim form for reimbursement. See the [Claims](#) section under [Your payment information](#) for more information.

Obtaining outpatient prescription Drugs from the mail service pharmacy

You have an option to receive prescription Drugs from the mail service pharmacy when you take maintenance Drugs for an ongoing condition. This allows you to receive up to a 90-day supply of the Drug, which may save you money. You may enroll in this program online, by phone, or by mail. Once enrolled, please allow up to 14 days to receive the Drug. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the mail service pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the mail service pharmacy.

You must pay the applicable mail service prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit blueshieldca.com or use the Blue Shield mobile app for additional information about how to get prescription Drugs from the mail service pharmacy.

Obtaining Specialty Drugs from a Network Specialty Pharmacy

Specialty Drugs are Drugs that require coordination of care, close monitoring, or extensive patient training for self-administration that cannot be met by a retail pharmacy, and that 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 generally have a higher cost.

Specialty Drugs are only available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or, at your request, will transfer the Specialty Drug to an associated retail store for pickup.

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 be covered, most Specialty Drugs require prior authorization by Blue Shield, as described in the [Prior authorization/exception request/step therapy process](#) section.

Drug manufacturers or other third parties may offer Drug discounts or copayment assistance for certain Drugs. These types of programs can lower your out-of-pocket costs. If you receive any discounts at a Network Specialty Pharmacy, only the amount you pay will be applied to any applicable Deductible and Out-of-Pocket Maximum.

Visit blueshieldca.com for a complete list of Specialty Drugs or to select a Network Specialty Pharmacy.

Prior authorization/exception request/step therapy process

Some Drugs and Drug quantities require approval based on Medical Necessity before they are eligible for coverage under this Benefit. This process is prior authorization.

The following Drugs require prior authorization:

- Some Formulary Drugs, preferred Drugs, non-preferred Drugs, compounded medications, and most Specialty Drugs;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy
- Some brand contraceptives, in order to be covered without a Copayment or Coinsurance; and
- A Brand Drug, when a Generic Drug equivalent is available, and you, your Physician, or your Health Care Provider is requesting coverage of the Brand Drug without paying the difference in cost between the Brand Drug and the Generic Drug equivalent.

You pay the Tier 3 Copayment or Coinsurance for covered compounded medications.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care 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 on 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 or Health Care Provider believes the Drug is Medically Necessary, the prior authorization process may be used and timeframes previously described will also apply.

If Blue Shield denies a request for prior authorization or an exception request, you, your representative, your Physician, or your Health Care 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

Except as otherwise stated in this section, you may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30 days, you must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

If you, your Physician, or your Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, your Copayment or Coinsurance will be pro-rated. The remaining balance of any partially filled prescription cannot be dispensed more than 30 days from the date the prescription was written.

Blue Shield has a short cycle Specialty Drug program. With your agreement, designated Specialty Drugs may be dispensed for a 15-day trial supply at a pro-rated Copayment or Coinsurance for the initial prescription. This program allows you to receive a 15-day supply of the Specialty Drug to help determine whether you will tolerate it before you obtain the full 30-day supply. This program can help you save money if you cannot tolerate the Specialty Drug. The Network Specialty Pharmacy will contact you to discuss the advantages of the program, which you can elect at that time. You, your Physician, or your Health Care Provider may choose a full 30-day supply for the first fill.

If you agree to a 15-day trial, the Network Specialty Pharmacy will contact you prior to dispensing the remaining 15-day supply to confirm that you are tolerating the Specialty Drug.



Visit blueshieldca.com/pharmacy for a list of **Specialty Drugs** in the **short cycle Specialty Drug program**.

You may receive up to a 90-day supply of Drugs at a pharmacy in the Rx90 Retail network or from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the pharmacy will dispense that

amount and you are responsible for the applicable Copayment or Coinsurance listed in the [Summary of Benefits](#) section. Refill authorizations cannot be combined to reach a 90-day supply.

Select over-the-counter 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.

You may receive up to a 12-month supply of contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

Preventive Health Services

Benefits are available for Preventive Health Services such as screenings, checkups, and counseling to prevent health problems or detect them at an early stage.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
 - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
 - Screening for HPV;
 - Screening for osteoporosis; and
 - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- California Prenatal Screening Program; and
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. See the [Family planning Benefits](#) section for more information.

If there is a new recommendation or guideline in any of the resources described above, Blue Shield will have at least one year to implement coverage. The new recommendation will be covered as a Preventive Health Service in the plan year that begins after that year.



Visit [blueshieldca.com/preventive](https://www.blueshieldca.com/preventive) for more information about **Preventive Health Services**.

Reconstructive Surgery Benefits

Benefits are available for Reconstructive Surgery services.

Benefits include:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to:
 - Improve function; or
 - Create a normal appearance to the extent possible;
- Dental and orthodontic surgery services directly related to cleft palate repair; and
- Surgery and surgically-implanted prosthetic devices in accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance;
- Reconstructive Surgery when there is a more appropriate procedure that will be approved; or
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

In accordance with the WHCRA, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered for either breast to restore and achieve symmetry following a mastectomy, and for the treatment of the physical complications of a mastectomy, including lymphedemas. For coverage of prosthetic devices following a mastectomy, see the [Durable medical equipment](#) section. Medically Necessary services will be determined by your attending Physician in consultation with you.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

Rehabilitative and habilitative services

Benefits are available for outpatient rehabilitative and habilitative services.

Rehabilitative services help to restore the skills and functional ability you need to perform Activities of Daily Living when you are disabled by injury or illness. Habilitative services are therapies that help you learn, keep, or improve the skills or functioning you need for Activities of Daily Living.

These services include physical therapy, occupational therapy, and speech therapy. Your Physician or Health Care Provider must prepare a treatment plan. Treatment must be provided by an appropriately-licensed or certified Health Care Provider. You can continue to receive rehabilitative or habilitative services as long as your treatment is Medically Necessary.

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

See the [Hospital services](#) section for information about inpatient rehabilitative Benefits.

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

See the [Home health services](#) and [Hospice program services](#) sections for information about coverage for rehabilitative and habilitative services provided in the home.

Physical therapy

Physical therapy uses physical agents and therapeutic treatment to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents and therapeutic treatments include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage as a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan.

Occupational therapy

Occupational therapy is treatment to develop, improve, and maintain the skills you need for Activities of Daily Living, such as dressing, eating, and drinking.

Speech therapy

Speech therapy is used to develop, improve, and maintain vocal or swallowing skills that have not developed according to established norms or have been impaired by a diagnosed illness or injury. Benefits are available for outpatient speech therapy for the treatment of:

- A communication impairment;
- A swallowing disorder;
- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

Benefits are available for treatment in the Skilled Nursing unit of a Hospital or in a free-standing Skilled Nursing Facility (SNF) when you are receiving Skilled Nursing or rehabilitative services. This Benefit also includes care at the Subacute Care level.

Benefits must be prior authorized and are limited to a day maximum per benefit period, as shown in the [Summary of Benefits](#) section. A benefit period begins on the date you are admitted to the facility. A benefit period ends 60 days after you are discharged from the facility or you stop receiving Skilled Nursing services. A new benefit period can only begin after an existing benefit period ends.

Transplant services

Benefits are available for tissue and kidney transplants and special transplants.

Tissue and kidney transplants

Benefits are available for facility and professional services provided in connection with human tissue and kidney transplants when you are the transplant recipient.

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

Special transplants

Benefits are available for special transplants only if:

- The procedure is performed at a special transplant facility contracting with Blue Shield, or if you access this Benefit outside of California, the procedure is performed at a transplant facility designated by Blue Shield; and
- You are the recipient of the transplant.

Special transplants are:

- Human heart transplants;
- Human lung transplants;
- Human heart and lung transplants in combination;
- Human liver transplants;
- Human kidney and pancreas transplants in combination;
- 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;
- Pediatric human small bowel transplants; and
- Pediatric and adult human small bowel and liver transplants in combination.

Donor services

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 for a Member of this plan.

Donor services include:

- Donor evaluation;
- Harvesting of the organ, tissue, or bone marrow; and
- Treatment of medical complications for 90 days after the evaluation or harvest procedure.

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center or during an after-hours office visit. You can access urgent care instead of going to the emergency room if you have a medical condition that is not life-threatening but prompt care is needed to prevent serious deterioration of your health.

If you need to visit an urgent care center and you are in your Medical Group Service Area, go to the urgent care center designated by your Medical Group or call your PCP. If you are outside of your Medical Group Service Area but within California and need urgent care, you may visit any urgent care center near you.



See the [Out-of-area services](#) section for information on urgent care services outside California.



Exclusions and limitations



This section describes the general exclusions and limitations that apply to all your plan Benefits. Prescription Drug, pediatric dental, and pediatric vision Benefits have additional exclusions and limitations.



This section has the following tables:



- General exclusions and limitations (for medical Benefits);
- Outpatient prescription Drug exclusions and limitations;
- Pediatric dental exclusions; and
- Pediatric dental limitations.



|  | General exclusions and limitations |  |
|---|---|---|
| 1 | This plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary. | |
| 2 | <p>Routine physical examinations solely for:</p> <ul style="list-style-type: none"> • Immunizations and vaccinations, by any mode of administration, for the purpose of travel; or • Licensure, employment, insurance, court order, parole, or probation. <p>This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.</p> | |
| 3 | Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation. | |
| 4 | <p>Routine foot care items and services that are not Medically Necessary, including:</p> <ul style="list-style-type: none"> • Callus treatment; • Corn paring or excision; • Toenail trimming; • Over-the-counter shoe inserts or arch supports; or • Any type of massage procedure on the foot. <p>This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.</p> | |
| 5 | <p>Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care.</p> <p>Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.</p> | |

|  | General exclusions and limitations  |
|---|---|
| | <p>Domiciliary care is a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities.</p> |
| 6 | <p>Continuous Nursing Services, private duty nursing, or nursing shift care, except as provided through a Participating Hospice Agency.</p> |
| 7 | <p>Prescription and non-prescription oral food and nutritional supplements. This exclusion does not apply to services listed in the Home infusion and injectable medication services and PKU formulas and special food products sections, or as provided through a Participating Hospice Agency. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.</p> |
| 8 | <p>Hearing aids, hearing aid examinations for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.</p> |
| 9 | <p>For Members 19 and older: eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the Prosthetic equipment and devices section.</p> <p>For all Members: video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.</p> |
| 10 | <p>Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under the Prosthetic equipment and devices section.</p> |
| 11 | <p>Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and muscles of mastication. This exclusion does not apply to items or services provided under the Medical treatment of the teeth, gums, or jaw joints and jaw bones, Pediatric dental Benefits, and Hospital services sections.</p> |
| 12 | <p>Surgery that is performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.</p> |
| 13 | <p>Unless selected as an optional Benefit by your Employer, any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian</p> |

|  | General exclusions and limitations  |
|---|---|
| | tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure. |
| 14 | Home testing devices and monitoring equipment. This exclusion does not apply to items specifically described in the Durable medical equipment or Diabetes care services sections. |
| 15 | Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program. |
| 16 | Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program. |
| 17 | Services performed by your spouse, Domestic Partner, child, brother, sister, or parent. |
| 18 | <p>Services provided by an individual or entity that:</p> <ul style="list-style-type: none"> • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. <p>This exclusion does not apply to Behavioral Health Treatment Benefits listed under the Mental Health and Substance Use Disorder Benefits section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.</p> |
| 19 | <p>Select physical and occupational therapies, such as:</p> <ul style="list-style-type: none"> • Massage therapy, unless it is a component of a multimodality rehabilitative treatment plan or physical therapy treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. <p>This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.</p> |

|  | General exclusions and limitations  |
|---|--|
| 20 | Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the Diabetes care services section, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services. |
| 21 | Services or Drugs that are Experimental or Investigational in nature. |
| 22 | <p>Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to:</p> <ul style="list-style-type: none"> • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. <p>However, drugs and medicines that 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.</p> |
| 23 | <p>The following non-prescription (over-the-counter) medical equipment or supplies:</p> <ul style="list-style-type: none"> • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs. |
| 24 | Member convenience items, such as internet, phones, televisions, guest trays, and personal hygiene items. |
| 25 | Disposable supplies for home use except as provided under the Durable medical equipment , Home health services , and Hospice program services sections, or the Prescription Drug Benefit. |
| 26 | <p>Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, we will be entitled to establish a lien up to the amount paid by Blue Shield for the treatment of such injury or disease.</p> |
| 27 | Chiropractic manipulation and adjustment. |



|  General exclusions and limitations  | |
|--|--|
| 28 | Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van). |
| 29 | Drugs dispensed by a Physician or Physician's office for outpatient use. |



|  | Outpatient prescription Drug exclusions and limitations  |
|---|--|
| 1 | 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 will not apply to items used for the administration of diabetes or asthma Drugs. |
| 2 | 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. |
| 3 | Medical devices or supplies, except as listed in the Durable medical equipment section. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices. |
| 4 | Non-Formulary Drugs, unless an exception request is approved. See the Prescription Drug Benefits section for more information. |
| 5 | Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained on an emergency basis. |
| 6 | Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy or included on a government exclusion list. |
| 7 | Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B or to female over-the-counter contraceptive Drugs and devices when prescribed by a Physician. |
| 8 | Prescription Drugs that are repackaged by an entity other than the original manufacturer. |
| 9 | Replacement of lost, stolen, or destroyed Drugs. |
| 10 | Immunizations and vaccinations solely for the purpose of travel. |
| 11 | <p>Compounded medications unless all of the following requirements are met:</p> <ul style="list-style-type: none"> • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially-available, medically-appropriate alternatives; and • The compounded medication is self-administered. |



**Outpatient prescription Drug exclusions and limitations**



12

Appetite suppressants or Drugs for body weight reduction. This exclusion does not apply to Medically Necessary Drugs for the treatment of morbid obesity, when prior authorized. This exclusion does not apply to items or services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

|  | Pediatric dental exclusions  |
|---|---|
| 1 | 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. |
| 2 | General anesthesia or intravenous/conscious sedation unless specifically listed as a Benefit in the Summary of Benefits section or on the pediatric dental Benefits table, or administered by a Dentist for a covered oral surgery. |
| 3 | Cosmetic dental care. |
| 4 | Treatment for which payment is made by any governmental agency, including any foreign government. |
| 5 | Services of Dentists or other practitioners of healing arts not associated with the plan, except upon referral arranged by a Dental Provider and authorized by the DPA, or when required in a covered emergency. |
| 6 | Hospital charges of any kind. |
| 7 | Procedures, appliances, or restorations to correct congenital or developmental malformations, unless specifically listed in the Summary of Benefits section or on the pediatric dental Benefits table. |
| 8 | Malignancies. |
| 9 | Drugs not normally supplied in a dental office. |
| 10 | Dental Care Services administered by a pediatric Dentist, except when: <ul style="list-style-type: none"> • The Member child's primary Dental Provider is a pediatric Dentist; or • The Member child is referred to a pediatric Dentist by the primary Dental Provider. |
| 11 | The cost of precious metals used in any form of dental Benefits. |
| 12 | Loss or theft of dentures or bridgework. |
| 13 | Charges for second opinions, unless previously authorized by the DPA. |

|  | Pediatric dental limitations  |
|---|--|
| Preventive (D1000- D1999) | <ul style="list-style-type: none"> • Fluoride treatment (D1206 and D1208) is only a Benefit for prescription-strength fluoride products; • Fluoride treatments do not include treatments that use fluoride with prophylaxis paste or the topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and • The application of fluoride is only a Benefit for caries control and is reimbursed when covered as a full mouth treatment regardless of the number of teeth treated. |
| Restorative (D2000- D2999) | <ul style="list-style-type: none"> • Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; • Restorations for primary teeth near exfoliation; • Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations, unless a specific allergy has been documented by a medical specialist (allergist) on his or her professional letterhead or prescription; • Prefabricated crowns for primary teeth near exfoliation; • Prefabricated crowns for abutment teeth for cast metal framework partial dentures (D5213 and D5214); • Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Prefabricated crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; • Prefabricated crowns when a tooth can be restored with an amalgam or resin-based composite restoration; • Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion, or for cosmetic purposes; • Laboratory crowns when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and • Laboratory processed crowns when the tooth can be restored with an amalgam or resin-based composite. |
| Endodontic (D3000- D3999) | <ul style="list-style-type: none"> • Endodontic procedures when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; |

|  | Pediatric dental limitations  |
|---|---|
| | <ul style="list-style-type: none"> • 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 • 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 (D4000- D4999) | <ul style="list-style-type: none"> • 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 (D5000- D5899) | <ul style="list-style-type: none"> • Prosthodontic services provided solely for cosmetic purposes; • Temporary or interim dentures to be used while a permanent denture is being constructed; • Spare or backup dentures; • Evaluation of a denture on a maintenance basis; • Preventative, endodontic, or restorative procedures for teeth to be retained for overdentures. Only extractions for the retained teeth are covered; • Partial dentures to replace missing third molars; • Laboratory relines (D5760 and D5761) for resin-based partial dentures (D5211 and D5212); • Laboratory relines (D5750, D5751, D5760, and D5761) within 12 months of chairside relines (D5730, D5731, D5740, and D5741); • Chairside relines (D5730, D5731, D5740, and D5741) within 12 months of laboratory relines (D5750, D5751, D5760, and D5761); • Tissue conditioning (D5850 and D5851) is only covered to heal unhealthy ridges prior to a definitive prosthodontic treatment; and • Tissue conditioning (D5850 and D5851) is covered the same date of service as an immediate prosthesis that required extractions. |
| Implant (D6000- D6199) | <ul style="list-style-type: none"> • Implant services are covered only when exceptional medical conditions are documented and the services are considered Medically Necessary. • Single tooth implants are not a Benefit. |
| Prosthodontic (Fixed) | <ul style="list-style-type: none"> • Fixed partial dentures (bridgework); however, the fabrication of a fixed partial denture shall be considered |

|  | Pediatric dental limitations  |
|---|---|
| (D6200-D6999) | <p>when medical conditions or employment preclude the use of a removable partial denture;</p> <ul style="list-style-type: none"> • Fixed partial dentures when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement; • Posterior fixed partial dentures when the number of missing teeth requested to be replaced in the quadrant does not significantly impact masticatory ability; • Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and • Cast resin bonded fixed partial dentures (Maryland Bridges). |
| Oral and Maxillofacial Surgery (D7000-D7999) | <ul style="list-style-type: none"> • The prophylactic extraction of third molars; • Temporomandibular joint (TMJ) dysfunction procedures are limited to differential diagnosis and symptomatic care. TMJ treatment modalities that involve prosthodontics, orthodontics, and full or partial occlusal rehabilitation are not covered; • TMJ dysfunction procedures solely for the treatment of bruxism; and • Suture procedures (D7910, D7911 and D7912) for the closure of surgical incisions. |
| Orthodontic | <p>Orthodontic procedures are covered when Medically Necessary to treat handicapping malocclusion, cleft palate, or facial growth management cases for Members under the age of 19, when prior authorization is obtained.</p> <p>Medically Necessary orthodontic treatment is limited to the following instances related to an identifiable medical condition. An initial orthodontic exam (D0140), called the Limited Oral Evaluation, must be conducted. This exam includes completion and submission of the completed Handicapping Labio-Lingual Deviation (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.</p> <p>Orthodontic procedures are covered only when the diagnostic casts verify a minimum score of 26 points on the HLD Index California Modification Score Sheet Form, DC016 (06/09), one of the six automatic qualifying conditions below exist; or when there is written documentation of a craniofacial anomaly from a credentialed specialist on his or her professional letterhead.</p> <p>The immediate qualifying conditions are:</p> <ul style="list-style-type: none"> • Cleft lip and or palate deformities; • Craniofacial Anomalies including the following: |



Pediatric dental limitations



- Crouzon's syndrome;
- Treacher-Collins syndrome;
- Pierre-Robin syndrome; and
- Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities that result in a physically handicapping malocclusion as determined by our dental consultants;
- 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.);
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present, such as stripping of the labial gingival tissue on the lower incisors. Treatment of bi-lateral posterior crossbite is not covered;
- Severe traumatic deviation must be justified by attaching a description of the condition; and
- 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 HDL Index).

- Coverage for the following conditions is excluded:
 - Crowded dentitions (crooked teeth);
 - Excessive spacing between teeth;
 - Temporomandibular joint (TMJ) conditions and/or horizontal/vertical (overjet/overbite) discrepancies;
 - Treatment in progress prior to the effective date of coverage;
 - Extractions required for orthodontic purposes;
 - Surgical orthodontics or jaw repositioning;
 - Myofunctional therapy;
 - Macroglossia;
 - Hormonal imbalances;
 - Orthodontic retreatment when initial treatment was rendered under this plan or changes in orthodontic treatment necessitated by any kind of accident;
 - Palatal expansion appliances;
 - Services performed by outside laboratories; and
 - Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Grievance process

Blue Shield has a formal grievance process to address any complaints, disputes, requests for reconsideration of health care coverage decisions made by Blue Shield, or concerns with the quality of care you received from a provider. Blue Shield will receive, review, and resolve your grievance within the required timeframes.

Submitting a grievance

If you have a question about your Benefits or any action taken by Blue Shield (or a Benefit Administrator), your first step is to make an inquiry through Shield Concierge. If Shield Concierge is not able to fully address your concerns, you can then submit a grievance or ask the Shield Concierge representative to submit one for you. If Blue Shield denies authorization or coverage for health care services, you can appeal the denial and Blue Shield will reconsider your request.

You have 180 days after a denial or other incident to submit your grievance to Blue Shield. Your provider, or someone you choose to represent you, can also submit a grievance on your behalf.

The fastest way to submit a grievance is online at blueshieldca.com. You can also submit the form by mail or begin the grievance process by calling Shield Concierge.

| Where to mail grievances | |
|---|---|
| Type of grievance | Address |
| Medical and prescription Drug Benefits | Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762 |
| Mental Health and Substance Use Disorder services from an MHSA Participating Provider | Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171 |
| Pediatric dental Benefits | Blue Shield of California Dental Plan Administrator P.O. Box 30569 Salt Lake City, UT 84130-0569 |
| Pediatric vision Benefits | Blue Shield of California Vision Plan Administrator P.O. Box 25208 Santa Ana, CA 92799-5208 |

Once Blue Shield or the Benefit Administrator receives your grievance, they will send a written acknowledgment within five calendar days.

Questions? Visit blueshieldca.com, use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

Blue Shield will resolve your grievance and provide a written response within 30 calendar days. The response will explain what action you can take if you are not satisfied with how your grievance is resolved.

If Blue Shield denies an exception request for coverage of a non-Formulary Drug, you may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours.

Expedited grievance request

You can submit an expedited grievance request to Blue Shield when the routine grievance process might seriously jeopardize your life, health, or recovery, when you are experiencing severe pain or when you are being treated with a non-Formulary Drug.

Blue Shield will make a decision within three calendar days for expedited grievance requests related to:

- Medical Benefits;
- Mental Health and Substance Use Disorder services;
- Pediatric dental Benefits; and
- Pediatric vision Benefits.

Blue Shield will make a decision within 24 hours when there are exigent circumstances related to denial of an exception request for a non-Formulary Drug.

Once a decision is made, Blue Shield will notify you and your provider as soon as possible to accommodate your condition.

California 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 (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, and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website (www.dmhca.ca.gov) has complaint forms, IMR application forms, and instructions online.

If you feel Blue Shield improperly cancels, rescinds, or does not renew coverage for you or your Dependents, you can submit a request for review to Blue Shield or to the Director of the California Department of Managed Health Care. Any request for review submitted to Blue Shield will be treated as an expedited grievance request.

Questions? Visit blueshieldca.com, use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

Independent medical review

You may be eligible for an independent medical review if your grievance involves a claim or service for which coverage was denied on the grounds that the service is:

- Not Medically Necessary; or
- Experimental or Investigational (including the external review available under the Friedman-Kowles Experimental Treatment Act of 1996).

You can apply to the Department of Managed Health Care (DMHC) for an independent medical review of the denial. For a Medical Necessity denial, you must first submit a grievance to Blue Shield and wait for at least 30 days before requesting an independent medical review. However, if the request qualifies for an expedited review as described above, or if it involves a determination that the requested service is Experimental or Investigational, you may request an independent medical review as soon as you receive a notice of denial from Blue Shield. The DMHC's application for independent medical review is included with your appeal outcome letter.

The DMHC will review your application. If the request qualifies for independent medical review, the DMHC will select an independent review organization to conduct a clinical review of your medical records. You can submit additional records for consideration as well. There is no cost to you for this independent medical review. You and your provider will receive copies of the independent medical review determination. The decision of the independent review organization is binding on Blue Shield. If the reviewer determines that the requested service is clinically appropriate, Blue Shield will arrange for the service to be provided or the disputed claim to be paid.

The independent medical review process is in addition to any other procedures or remedies available to you to resolve coverage disputes. It is completely voluntary. You are not required to participate in the independent medical review process, but if you do not, you may lose your statutory right to pursue legal action against Blue Shield regarding the disputed service.

ERISA review

If your Employer's 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 your claim have been completed and your claim has not been approved. Additionally, you and your Employer-sponsored plan may have other voluntary alternative dispute resolution options, such as mediation.

Other important information about your plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document and is part of the contractual agreement between the Subscriber and Blue Shield.

Your coverage, continued

Special enrollment period



For more information about special enrollment periods, see **Special enrollment period** on page 41 in the **Your coverage** section.

A special enrollment period is a timeframe outside of open enrollment when an Employee or Dependent can enroll in, or change enrollment in, this health plan through the Employer. The special enrollment period is 30 days following the date of a Triggering Event unless an additional 60-day period before the Triggering Event applies, as specified below. When the loss of minimum essential coverage is anticipated, a special enrollment period also precedes the Triggering Event. The following are Triggering Events:

- Loss of minimum essential coverage for a reason other than:
 - Failure to pay premiums on a timely basis (including Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or Cal-COBRA premiums);
 - A situation that would allow a rescission, such as an intentional misrepresentation of a material fact on the application for coverage; or
 - Other loss of coverage due to the fault of the enrollee. Additional 60-day period before Triggering Event applies.
- Loss or anticipated loss of coverage under an employer-sponsored health plan as a result of:
 - With respect to the Employee:
 - The termination of employment (other than through gross misconduct); or
 - The reduction of hours of employment to less than the number of hours required for eligibility.
 - With respect to the spouse, Domestic Partner and Dependent children:
 - The death of the Subscriber;
 - The termination of the Subscriber's employment (other than through the Subscriber's gross misconduct);
 - The reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility;
 - The divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership;

- The Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare");
- A Dependent child's loss of Dependent status under the generally applicable requirements of the plan; or
- The employer files for reorganization under Title XI of the United States Code, commencing on or after July 1, 1986 (COBRA only - when the Subscriber is covered as a retiree).
- Discontinuation of the employer's contribution toward Subscriber or Dependent coverage.
- Exhaustion of COBRA or Cal-COBRA continuation coverage.
- Loss of Medi-Cal coverage for pregnancy-related services or loss of access to CHIP unborn child coverage due to the birth of the child. Additional 60-day period before Triggering Event applies.
- Loss of Medicaid medically needy coverage (only once per calendar year). Additional 60-day period before Triggering Event applies.
- The Employee or Dependent was eligible for coverage under the Healthy Families Program or Medi-Cal and such coverage was terminated due to loss of such eligibility, provided that enrollment is requested no later than 60 days after the termination of coverage.
- The Employee or Dependent is eligible for coverage under the Healthy Families Program or Medi-Cal premium assistance program, provided that enrollment is within 60 days of the notice of eligibility for these premium assistance programs.
- Acquiring or becoming a Dependent through marriage, establishment of domestic partnership, birth, adoption, placement for adoption, placement in foster care or through a child support order or other court order.
 - If a parent is required to provide health insurance coverage for a child, and enrollment is requested by the Subscriber parent or upon presentation of a court order or request by the non-Subscriber parent, the local child support agency, or person having custody of the child, or the Medi-Cal program as described in Sections 3751.5 and 3766 of the Family Code.
- An Employee's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of CCSB or the Department of Health and Human Services (HHS), evaluated and determined by CCSB. In such cases the action may be taken to correct or eliminate the effects of such error, misrepresentation, or inaction.
- An Employee or Dependent demonstrates that they did not enroll in a health plan during the immediately preceding enrollment period available to the individual because they were misinformed that they were covered under minimum essential coverage.
- An Employee or Dependent demonstrates that the health plan in which they are enrolled substantially violated a material provision of its contract in relation to the Qualified Individual or Dependent.
- An Employee or Dependent gains access to a new health plans as a result of a permanent move and:
 - Had minimum essential coverage for one or more days during the 60 days preceding the date of the move; or

- Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the move.
- An Employee or Dependent has been released from incarceration.
- 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.
- An Employee or Dependent is a member of an Indian tribe which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians, as described in Title 25 of the United States Code Section 1603 (Special enrollment period is limited to once per month for this event).
- An Employee is a victim of domestic abuse or spousal abandonment, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal abandonment who is on the same application as the victim may enroll in coverage at the same time as the victim.
- An Employee or Dependent:
 - Applies for coverage from CCSB during the annual open enrollment period or due to a Triggering Event, is assessed by the exchange as potentially eligible for Medi-Cal, and is determined ineligible for Medi-Cal either after open enrollment has ended or more than 60 days after the Triggering Event; or
 - Applies for Medi-Cal during the annual open enrollment period, and is determined ineligible after open enrollment has ended.
- An Employee or Dependent was receiving services from a contracting provider under another health plan for one of the conditions eligible for completion of Covered Services and that provider is no longer participating in the other health plan.
- 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.
- An Employee or Dependent demonstrates to the exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the exchange may allow.
- The Employee or his or her Dependent, adequately demonstrates to CCSB that a material error related to plan Benefits, service area, or Premium influenced the individual's decision to purchase a QHP through Covered California.
- An Employee or Dependent qualifies for continuation coverage as a result of a qualifying event, as described in the [Continuation of group coverage](#) section of this Evidence of Coverage.
- In the case of coverage offered through an HMO, or other network arrangement, that does not provide benefits to individuals who no longer reside, live, or work in a service area.

- Individual plan: loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual).
- Group plan: loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual and no other benefit package is available to the individual).
- A situation in which a Qualified Health Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

Cancellation for Employer's nonpayment of Premiums

Premium grace period

After payment of the first Premium, your Employer has a 30-day grace period from the due date to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. Coverage will continue through the grace period. However, if your Employer does not pay all outstanding Premiums within the grace period, coverage will end the day following the 30-day grace period. Your Employer will be liable for all Premiums owed, even if coverage is canceled. This includes Premiums for coverage during the 30-day grace period. Blue Shield will send a Notice of End of Coverage to you and your Employer no later than five calendar days after the day coverage ends.

Out-of-area services

Overview

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

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

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



See the [Care outside of California](#) section for more information about receiving care while outside of California. To find participating providers while outside of California, visit bcbs.com.

Inter-Plan Arrangements

Emergency Services

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

BlueCard® Program

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

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

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

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

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to your 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 of claims as noted above. However, such adjustments will not affect the

price Blue Shield used for your claim because these adjustments will not be applied retroactively to claims already paid.

Non-participating providers outside of California

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

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

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services, as listed in the Summary of Benefits. Blue Shield pays claims for covered Emergency Services based on the Allowed Charges as defined in this Evidence of Coverage.

Blue Shield Global® Core

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

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

Submitting a Blue Shield Global® Core claim

When you pay directly for Out-of-Area Covered Health Care Services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. The claim form is available from Blue Shield Shield Concierge,

the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Limitation for duplicate coverage

Medicare

Blue Shield will provide Benefits before Medicare when:

- You are 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);
- You are 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); or
- You are eligible for Medicare solely due to end-stage renal disease during the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare.

Blue Shield will provide Benefits after Medicare when:

- You are 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);
- You are 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);
- You are eligible for Medicare solely due to end-stage renal disease after the first 30 months you are eligible to receive benefits for end-stage renal disease from Medicare; or
- You are retired and age 65 or older.

When Blue Shield provides Benefits after Medicare, your combined Benefits from Medicare and Blue Shield may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You do not have to pay any Blue Shield Deductibles, Copayments, or Coinsurance.

Medi-Cal

Medi-Cal always pays for Benefits last when you have coverage from more than one payor.

Qualified veterans

If you are a qualified veteran, Blue Shield will pay the reasonable value or the Allowed Charges for Covered Services you receive at a Veterans Administration facility for a condition that is not related to military service. If you are a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or the Allowed Charges for Benefits you receive at a Department of Defense facility. This includes Benefits for conditions related to military service.

Coverage by another government agency

If you are entitled to receive Benefits from any federal or state governmental agency, by any municipality, county, or other political subdivision, your combined Benefits from that coverage and Blue Shield will equal but not be more than what Blue Shield would pay if you were not eligible for Benefits under that coverage. Blue Shield will provide Benefits based on the reasonable value or the Allowed Charges.

Exception for other coverage

A Participating Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this plan.

If you recover from a third party the reasonable value of Covered Services received from a Participating Provider, the Participating Provider is not required to accept the fees paid by Blue Shield as payment in full. You may be liable to the Participating Provider for the difference, if any, between the fees paid by Blue Shield and the reasonable value recovered for those services.

Reductions – third-party liability

If you are injured or become ill due to the act or omission of another person (a “third party”), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the plan and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for services provided to you on a fee-for-service basis from any recovery (defined below) obtained by or on your behalf, from or on behalf of the third party responsible for the injury or illness, and you must agree to the provisions below. In addition, if you are injured and no other person is responsible but you receive (or are entitled to) a recovery from another source, and if Blue Shield paid Benefits for that injury, you must agree to the following provisions.

- All recoveries you or your 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 you or your representatives. For purposes of this provision, your representatives include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is Blue Shield's right of recovery.
- Blue Shield's right to restitution, reimbursement, or other available remedy is against any recovery you receive as a result of the injury or illness. This includes any amount awarded to you or received by way of court judgment, arbitration award, settlement, or any other arrangement, from any third party or third-party insurer, related to the illness or injury (the “Recovery”), whether or not you have been “made whole” by the Recovery. 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 will not reduce its share of any Recovery unless, in the exercise of our discretion, Blue Shield agrees in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.

- You must cooperate in doing what is reasonably necessary to assist Blue Shield with its right of recovery. You must not take any action that may prejudice Blue Shield's right of recovery.
- You must tell Blue Shield promptly if you have made a claim against another party for a condition that Blue Shield has paid or may pay Benefits for. You must seek recovery of Blue Shield's payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. Blue Shield may seek a first priority lien on the proceeds of your claim in order to be reimbursed to the full amount of Benefits Blue Shield has paid or will pay.

Blue Shield may request that you sign a reimbursement agreement consistent with this provision. Your failure to comply with the above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

Further, if you received services from a Participating Hospital for such injuries or illness, the Hospital has the right to collect from you 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 you 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"), YOU ARE ALSO REQUIRED TO DO THE FOLLOWING:

- Ensure that any recovery is kept separate from and not comingled with any other funds or your general assets;
- 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; and
- Direct any legal counsel retained by you or any other person acting on your behalf 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 Blue Shield of the monies owed.

Coordination of benefits, continued

When you are covered by more than one group health plan, payments for allowable expenses will be coordinated between the two plans. 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 determine which group health plan is primary and prevent 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:

- When a plan does not have a coordination of benefits provision, that plan will always provide its benefits first. Otherwise, the plan covering you as an Employee will provide its benefits before the plan covering you as a Dependent.
- Coverage for Dependent children:

- 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.
- 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.
- 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.
- 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:
 - The plan of the custodial parent;
 - The plan of the stepparent; then
 - The plan of the non-custodial parent.
- If the above rules do not apply, the plan which has covered you for the longer period of time is the primary plan. There may be exceptions for laid-off or retired Employees.
- 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.
- 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.

General provisions

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 providing services, including any Physician, Hospital, or other Health Care Provider or their employees.

Assignment

The Benefits of this plan may not be assigned without the written consent of Blue Shield. Participating Providers are paid directly by Blue Shield or the Medical Group. When you are authorized to receive Covered Services from a Non-Participating Provider, Blue Shield, at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider.

Plan interpretation

Blue Shield shall have the power and authority to construe and interpret the provisions of this plan, to determine the Benefits of this plan, and to determine eligibility to receive Benefits under the Contract. Blue Shield shall exercise this authority for the benefit of all Members entitled to receive Benefits under this plan.

Public policy participation procedure

Blue Shield allows Members to participate in establishing the public policy of Blue Shield. Such participation is not to be used as a substitute for the grievance process.

Recommendations, suggestions or comments should be submitted in writing to:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: (510) 607-2065

Please include your name, address, phone number, Subscriber number, and group number with each communication. Please state the public policy issue clearly. Submit all relevant information and reasons for the policy issue with your letter.

Public policy issues will be heard 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.

At least one third of the Board of Directors 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 the Sr. Manager, Regulatory Filings as listed above.

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 plan and the 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 the Member's 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 the Member's consent, except as otherwise permitted or required by law.

Right of recovery

Whenever payment on a claim is made in error, Blue Shield has the right to recover such payment from the Subscriber or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, 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 (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber's coverage, or payments made on fraudulent claims.

Definitions

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| Activities of Daily Living | Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living. |
| Allowed Charges | <ul style="list-style-type: none"> For a Participating Provider: the amounts a Participating Provider agrees to accept as payment from Blue Shield. For a Non-Participating Provider: the amounts paid by Blue Shield when services from a Non-Participating Provider are covered and are paid as a Reasonable and Customary amount. |
| Ambulatory Surgery Center | <p>An outpatient surgery facility that meets both of the following requirements:</p> <ul style="list-style-type: none"> Is a licensed facility accredited by an ambulatory surgery center accrediting body; and Provides services as a free-standing ambulatory surgery center, which is not otherwise affiliated with a Hospital. |
| Anticancer Medications | Drugs used to kill or slow the growth of cancerous cells. |
| ASH Participating Provider | A Physician or Health Care Provider under contract with ASH Plans to provide Covered Services to Members. |
| Behavioral Health Treatment (BHT) | Professional services and treatment programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. BHT includes applied behavior analysis and evidence-based intervention programs. |
| Benefits (Covered Services) | Medically Necessary services and supplies you are entitled to receive pursuant to the Contract. |
| Benefit Administrator | Administrator for specialized Benefits such as Mental Health and Substance Use Disorder Benefits. |
| Blue Shield of California | California Physicians' Service, d/b/a Blue Shield of California, is a California not-for-profit corporation, licensed as a health care service plan. It is referred to throughout this Evidence of Coverage as Blue Shield. |
| BlueCard® Service Area | The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands. |

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| Brand Drugs | Drugs that are FDA-approved after a new drug application and/or registered under a brand or trade name by its manufacturer. |
| Calendar Year | The 12-month consecutive period beginning on January 1 and ending on December 31 of the same year. |
| CCSB | Covered California for Small Business (CCSB) operated by Covered California. The state marketplace where an eligible Employer can provide its Employees and their Dependents with access to one or more health plans. |
| Coinsurance | The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible. |
| Continuous Nursing Services | Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home. |
| Copayment | The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible. |
| Cost Share | Any applicable Deductibles, Copayment, and Coinsurance. |
| Covered Services (Benefits) | Medically Necessary services and supplies you are entitled to receive pursuant to the Contract. |
| Deductible | The Calendar Year amount you must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to the Contract. |
| Dental Allowable Amount | <p>The Dental Allowable Amount is:</p> <ul style="list-style-type: none"> • The amount the DPA has determined is an appropriate payment for the service rendered in the provider's geographic area. This amount is based upon such factors as evaluation of the value of the service relative to the value of other services, market considerations, and provider charge patterns; • Such other amount as the Participating Dentist and the DPA have agreed will be accepted as payment for the service rendered; or • If an amount is not determined as described in either item above, the amount the DPA determines |

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| | is appropriate due to 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 | A Dentist or a dental practice (with one or more Dentists) that 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 Agreement. |
| Dental Plan Administrator (DPA) | Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a specialized care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the DPA to administer delivery of dental services through a network of Participating Dentists. A DPA also serves as a claims administrator for the processing of claims received from non-Participating Dentists. |
| Dental Provider | A Dentist or provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to you in accordance with the dental services contract. |
| Dentist | A duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD). |
| Dependent | <ul style="list-style-type: none"> • The spouse, Domestic Partner, or child of an eligible Employee, who is determined to be eligible and who is not independently covered as an eligible Employee or Subscriber. A spouse who is legally married to the Subscriber and who is not legally separated from the Subscriber. • A Domestic Partner to the Subscriber who meets the definition of Domestic Partner as defined in this Evidence of Coverage. • A child who is the child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age. A child does not include any children of a Dependent child (grandchildren of the Subscriber, spouse, or |

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| | Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild. |
| Domestic Partner | <p>An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements:</p> <ul style="list-style-type: none"> • Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code; • The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring; • The partners are: <ul style="list-style-type: none"> ◦ not currently married to someone else or a member of another domestic partnership, and ◦ not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited; • Both partners are capable of consenting to the domestic partnership; and • The partners have filed a Declaration of Domestic Partnership with the Secretary of State. (Note, some Employers may permit partners who meet the above criteria but have not filed a Declaration of Domestic Partnership with the Secretary of State to be eligible for coverage as a Domestic Partner under this plan. If permitted by your Employer, such individuals are included in the term "Domestic Partner" as used in this Evidence of Coverage; however the partnership may not be recognized by the State for other purposes as the partners do not meet the definition of "Domestic Partner" established under Section 297 of the California Family Code). <p>The domestic partnership is deemed created on the date when both partners meet the above requirements.</p> |
| Drugs | <p>Drugs include the following:</p> <ul style="list-style-type: none"> • FDA-approved medications that require a prescription either by California or Federal law; • Insulin; • Pen delivery systems for the administration of insulin, as Medically Necessary; • Diabetic testing supplies, including the following: <ul style="list-style-type: none"> ◦ Lancets; ◦ Lancet puncture devices; ◦ Blood and urine testing strips; and |

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| | <ul style="list-style-type: none"> ○ Test tablets; • Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B; • Contraceptive drugs and devices, including the following: <ul style="list-style-type: none"> ○ Diaphragms; ○ Cervical caps; ○ Contraceptive rings; ○ Contraceptive patches; ○ Oral contraceptives; ○ Emergency contraceptives; and ○ Female over-the-counter contraceptive products when ordered by a Physician; • Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug, such as syringes and inhaler spacers. |
| DPA Participating Provider | A provider who has an agreement in effect with the Dental Plan Administrator (DPA) for the provision of pediatric dental Benefits under this plan. |
| Emergency Dental Condition | <p>An unexpected dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following:</p> <ul style="list-style-type: none"> • Placing your health in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. |
| Emergency Medical Condition | <p>A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following:</p> <ul style="list-style-type: none"> • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder. |
| Emergency Services | The following services provided for an Emergency Medical Condition: |

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| | <ul style="list-style-type: none"> • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital. |
| 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 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 | <p>Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that 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.</p> <p>Services that 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.</p> <p>Services or supplies that 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.</p> |

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| 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 in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically. Benefits are available for Formulary Drugs. Non-Formulary Drugs are covered when Blue Shield or an external reviewer approves an exception request. |
| Generally Accepted Standards of Mental Health and Substance Use Disorder Care | <p>Standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include:</p> <ul style="list-style-type: none"> • Peer-reviewed scientific studies and medical literature; • Clinical practice guidelines and recommendations of nonprofit health care provider professional associations; • Specialty societies and federal government agencies; and • Drug labeling approved by the United States Food and Drug Administration. |
| Generic Drugs | Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs. |
| 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. |
| Health Care Provider | <p>An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to:</p> <ul style="list-style-type: none"> • Acupuncturist; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; |

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| | <ul style="list-style-type: none"> • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Massage therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law; • Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • Registered respiratory therapist; • Speech and language pathologist. |
| Hemophilia Home Infusion Provider | <p>A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.</p> <p>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.</p> |
| Home Health Aide | <p>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 home.</p> |
| Hospital | <p>An entity that meets one of the following criteria:</p> <ul style="list-style-type: none"> • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, |

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| | <p>and that provides 24-hour a day nursing service by registered nurses;</p> <ul style="list-style-type: none"> • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. <p>A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.</p> |
| Host Blue | The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area. |
| Infertility | <p>May be either of the following:</p> <ul style="list-style-type: none"> • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception. |
| Intensive Outpatient Program | An outpatient treatment program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week. |
| Inter-Plan Arrangements | Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association. |
| Late Enrollee | An eligible Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the date a written request for coverage is made or at the Employer's next open enrollment period. |
| Low Vision | 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. |
| Medical Group | An organization of Physicians who are generally located in the same facility and provide Benefits to Members, or an |

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| | independent practice association (a group of Physicians in individual offices who form an organization to contract, manage, and share financial responsibilities for providing Benefits to Members). |
| Medical Group Service Area | The geographic area served by the Medical Group. |
| Medical Necessity (Medically Necessary) | <p>Benefits are provided only for services that are Medically Necessary.</p> <p>Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are:</p> <ul style="list-style-type: none"> • Consistent with Blue Shield medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. <p>Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and 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.</p> <p>Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following:</p> <ul style="list-style-type: none"> • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. <p>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</p> |

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| | <p>committees of professional societies or Hospitals, and other consultants.</p> <p>This definition does not apply to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.</p> |
| Medically Necessary Treatment of a Mental Health or Substance Use Disorder | <p>A Covered Service or product addressing the specific needs of a Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:</p> <ul style="list-style-type: none"> • In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care; • Clinically appropriate in terms of type, frequency, extent, site, and duration; and • Not primarily for the economic benefit of the disability insurer and Members or for the convenience of the patient, treating Physician, or other Health Care Provider. |
| Member | <p>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.</p> |
| Mental Health and Substance Use Disorder(s) | <ul style="list-style-type: none"> • A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). |
| Mental Health Service Administrator (MHSA) | <p>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 administer Blue Shield's Mental Health and Substance Use Disorder services through a separate network of MHSA Participating Providers.</p> |
| MHSA Non-Participating Provider | <p>A provider who does not have an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.</p> |
| MHSA Participating Provider | <p>A provider who has an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.</p> |
| Network Specialty Pharmacy | <p>Select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.</p> |

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| Non-Participating (Non-Participating Provider) | Any provider who does not participate in this plan's network and does not contract with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services. Also referred to as an out-of-network provider. |
| Non-Participating Pharmacy | A pharmacy that does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members. |
| Other Outpatient Mental Health and Substance Use Disorder Services | <p>Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and Substance Use Disorders, including but not limited to the following:</p> <ul style="list-style-type: none"> • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Psychological Testing. <p>These services may also be provided in the office, home, or other non-institutional setting.</p> |
| Out-of-Area Covered Health Care Services | Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area. |
| Out-of-Area Follow-up Care | Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area. |
| Out-of-Pocket Maximum | The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits section. Charges for services that are not covered, charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum. |
| Outpatient Department of a Hospital | Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital. |
| Outpatient Facility | A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital. |

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| 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. You may be admitted directly to this level of care or transferred from inpatient care following stabilization. |
| Participating Dentist | A Doctor of Dental Surgery or Doctor of Dental Medicine who has contracted with the DPA to provide dental services to Members. |
| Participating Hospice or Participating Hospice Agency | An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits. |
| Participating (Participating Provider) | A provider who participates in this plan's network and has an agreement to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider. |
| Participating Pharmacy | A pharmacy that has contracted with Blue Shield to provide covered Drugs at certain rates. A Participating Pharmacy participates in the Blue Shield Pharmacy Network. |
| Physician | An individual licensed and authorized to engage in the practice of medicine. |
| Plan Service Area | A geographical area designated by the plan within which a plan shall provide health care services. |
| Premium (Dues) | The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract. |
| Preventive Health Services | Preventive medical services for early detection of disease, including related laboratory services, as specifically described in the Preventive Health Services section. |
| Primary Care Physician (PCP) | A general or family practitioner, internist, obstetrician/gynecologist, or pediatrician. Your PCP will provide your primary care and refer, authorize, supervise, and coordinate the provision of your Benefits. |
| Prosthodontics | Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth. |
| Psychological Testing | Testing to diagnose a mental health condition when referred by an MHSA Participating Provider. |

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| Qualified Health Plan (QHP) | A health plan that has been certified for sale through CCSB. |
| Reasonable and Customary | <p>In California: the lower of the provider's billed charge or the amount established by Blue Shield pursuant to applicable state law to be the reasonable and customary value for the services rendered by a Non-Participating Provider.</p> <p>Outside of California: the lower of the provider's billed charge or the Participating Provider Cost Share for Emergency Services as shown in the Summary of Benefits.</p> |
| Reconstructive Surgery | <p>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:</p> <ul style="list-style-type: none"> • Improve function; or • Create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of surgery for cleft palate procedures. |
| Schedule II Controlled Substance | Prescription Drugs or other substances that have a high potential for abuse which may lead to severe psychological or physical dependence. |
| Skilled Nursing | Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse. |
| Skilled Nursing Facility (SNF) | A health facility or a distinct part of a Hospital with a valid license issued by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis. |
| Specialist | <p>Specialists include Physicians with a specialty as follows:</p> <ul style="list-style-type: none"> • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; |

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| | <ul style="list-style-type: none"> • 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. |
| Subacute Care | Skilled Nursing or skilled rehabilitation provided in a hospital or Skilled Nursing Facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily registered nurse monitoring. A facility that 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 Contract. |
| Total Disability (Totally Disabled) | <p>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.</p> <p>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.</p> |
| Triggering Event | A change in your life that can make you eligible for a special enrollment period to enroll in health coverage. |
| Urgent Services | Those Covered Services rendered outside of the Medical Group Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Medical Group Service Area. |
| Vision Plan Administrator (VPA) | Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered |

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| | under this Benefit through a network of VPA Participating Providers. |
| Vision Prescription Change | <p>Any of the following:</p> <ul style="list-style-type: none">• Change in prescription of 0.50 diopter or more;• Shift in axis of astigmatism of 15 degrees;• Difference in vertical prism greater than 1 prism diopter; or• Change in lens type (for example, contact lenses to eyeglasses or single vision eyeglass lenses to bifocal eyeglass lenses). |
| VPA Participating Provider | A provider who has an agreement in effect with the VPA for the provision of pediatric vision Benefits under this plan. |

Notices about your plan

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 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 your Cost Share for Covered Services under this plan.

Blue Shield provides a summary of this plan at the time of enrollment. This summary allows you to compare plans available to you. The Evidence of Coverage is available for review prior to enrollment in the plan.

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this plan. You do not have the right to receive the Benefits of this plan after coverage ends, except as specifically provided under the [Extension of Benefits](#) section and, when applicable, the [Continuation of group coverage](#) section. Blue Shield may change Benefits during the term of coverage as specifically stated in this Evidence of Coverage. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary. Blue Shield reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your plan and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or contact Shield Concierge to ensure that you can obtain the health care services you need.

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

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

The Trio HMO plan offers a limited selection of 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 Medical Group Service Area, or when prior authorized, all services must be obtained through the Member's Primary Care Physician.

Notice about dental services: IMPORTANT: If you opt to receive dental services that are not Covered Services under this plan, a Dental Provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information, call dental customer service. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage.

Notice about Manifest MedEx participation: Blue Shield participates in the Manifest MedEx health information exchange (HIE). Blue Shield makes its Members' health information available to Manifest MedEx for access by their authorized Health Care Providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized Health Care Providers may securely access their patients' health information through the Manifest MedEx HIE to support the provision of care.

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

You have the right to direct Manifest MedEx not to share your health information with your Health Care Providers. Although opting out of Manifest MedEx may limit your Health Care Provider's ability to quickly access important health care information about you, your Blue Shield coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or Hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

If you do not wish to have your health care information displayed in Manifest MedEx, you should fill out the online form at manifestmedex.org/opt-out or call Manifest MedEx at (888) 510-7142.

Notice about organ and tissue donation: More than 120,000 people in the United States need an organ or tissue transplant. Each person on the transplant waiting list faces death. One person on this list dies every three hours while waiting for an available organ or tissue.

Many Californians are eligible to become organ and tissue donors. To learn more about organ and tissue donation, or to register as a donor, visit Donor Network West (donornetworkwest.org) or Donate Life California (donatelifecalifornia.org). You may also call the nearest city's regional organ procurement agency for additional information.

Notice about confidentiality of personal and health information: Blue Shield protects the privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Shield Concierge or by visiting [blueshieldca.com](https://www.blueshieldca.com).

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:

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

Pediatric dental Benefits table

The table below outlines the pediatric dental Benefits covered by this plan by dental procedure code. Pediatric Dental Benefits are subject to conditions, limitations, and exclusions. See the [Pediatric dental exclusions](#) and [Pediatric dental limitations](#) sections for more information.

| Code | Description | Limitation | Cost Share |
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| Diagnostic Procedures (D0100-D0999) | | | |
| D0120 | Periodic oral evaluation – established patient | Once every six months, per provider or after six 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: <ul style="list-style-type: none"> Up to six times in a three-month period; and Up to a maximum of 12 in a 12-month period. | No Charge |
| D0171 | Re-evaluation – post-operative office visit | | No Charge |
| D0180 | Comprehensive periodontal evaluation – new or established patient | | No Charge |
| D0190 | Screening of a patient | Not a Benefit. | Not Covered |
| D0191 | Assessment of a patient | Not a Benefit. | Not Covered |
| D0210 | Intraoral – complete series of radiographic images | Once per provider every 36 months. | No Charge |

| Code | Description | Limitation | Cost Share |
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| 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 six-month period per provider. | No Charge |
| 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 four 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 – two radiographic images | Once every six months per provider. Not a Benefit: <ul style="list-style-type: none"> • Within six months of intraoral complete series of radiographic images (D0210), same provider; and • For a totally edentulous area. | No Charge |
| D0273 | Bitewings – three radiographic images | | No Charge |
| D0274 | Bitewings – four radiographic images | Once every six months per provider. Not a Benefit: <ul style="list-style-type: none"> • Within six months of intraoral-complete series of radiographic images (D0210), same provider; • For Members under the age of 10; and • For a totally edentulous area. | No Charge |
| D0277 | Vertical bitewings – seven to eight radiographic images | | No Charge |

| Code | Description | Limitation | Cost Share |
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| D0310 | Sialography | | No Charge |
| D0320 | Temporomandibular joint arthrogram, including injection | Limited to the survey of trauma or pathology, up to a maximum of three per date of service. | No Charge |
| D0322 | Tomographic survey | Up to twice in a 12-month period per provider. | No Charge |
| D0330 | Panoramic radiographic image | Once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery). | No Charge |
| D0340 | 2D cephalometric radiographic image – acquisition, measurement and analysis | Twice in a 12 month period per provider. | No Charge |
| D0350 | 2D oral/facial photographic image obtained intra-orally or Extraorally | Up to a maximum of four per date of service. | No Charge |
| D0351 | 3D photographic image | | No Charge |
| D0419 | Assessment of salivary flow by measurement | Not a Benefit. | Not Covered |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | Not a Benefit. | Not Covered |
| D0460 | Pulp vitality tests | | No Charge |
| D0470 | Diagnostic casts | Once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment); for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly); and when provided by a certified orthodontist. | No Charge |
| D0502 | Other oral pathology procedures, by report | Must be provided by a certified oral pathologist. | No Charge |
| D0601 | Caries risk assessment and documentation, with a finding of low risk | | No Charge |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk | | No Charge |

| Code | Description | Limitation | Cost Share |
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| D0603 | Caries risk assessment and documentation, with a finding of high risk | | No Charge |
| D0701 | Panoramic radiographic image – image capture only | | \$0 |
| D0702 | 2-D cephalometric radiographic image – image capture only | | \$0 |
| D0703 | 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only | | \$0 |
| D0704 | 3-D photographic image – image capture only | | \$0 |
| D0705 | Extra-oral posterior dental radiographic image – image capture only | | \$0 |
| D0706 | Intraoral – occlusal radiographic image – image capture only | | \$0 |
| D0707 | Intraoral – periapical radiographic image – image capture only | | \$0 |
| D0708 | Intraoral – bitewing radiographic image – image capture only | | \$0 |
| D0709 | Intraoral – complete series of radiographic images – image capture only | | \$0 |
| D0999 | Unspecified diagnostic procedure, by report | | No Charge |
| Preventive Procedures (D1000-D1999) | | | |
| D1110 | Prophylaxis - adult | | No Charge |
| D1120 | Prophylaxis – child | Once in a six-month period. | No Charge |
| D1206 | Topical application of fluoride varnish | Once in a six-month period. | No Charge |
| D1208 | Topical application of fluoride – excluding varnish | Once in a six-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 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|------------|
| D1321 | Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use | | \$0 |
| 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 first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed. | No Charge |
| D1353 | Sealant repair – per tooth | | No Charge |
| D1354 | Interim caries arresting medicament application – per tooth | | No Charge |
| D1355 | Caries preventive medicament application – per tooth | | \$0 |
| D1510 | Space maintainer-fixed – unilateral – per quadrant | Once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. | No Charge |
| D1516 | Space maintainer – fixed – bilateral, maxillary | Once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant and for Members under the age of 18 Not a Benefit: <ul style="list-style-type: none"> • When the permanent tooth is near eruption or is missing; • For upper and lower anterior teeth; and • For orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. | No Charge |

| Code | Description | Limitation | Cost Share |
|-------|--|---|------------|
| D1517 | Space maintainer – fixed – bilateral, mandibular | <p>Once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant and for Members under the age of 18</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • When the permanent tooth is near eruption or is missing; • For upper and lower anterior teeth; and • For orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. | No Charge |
| D1520 | Space maintainer-removable – unilateral – per quadrant | <p>Once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • When the permanent tooth is near eruption or is missing; • For upper and lower anterior teeth; and • For orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. | No Charge |
| D1526 | Space maintainer – removable – bilateral, maxillary | <p>Once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant or for Members under the age of 18.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • When the permanent tooth is near eruption or is missing; • For upper and lower anterior teeth; and • For orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. | No Charge |
| D1527 | Space maintainer – removable – bilateral, mandibular | <p>Once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant or for Members under the age of 18.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • When the permanent tooth is near eruption or is missing; • For upper and lower anterior teeth; and • For orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. | No Charge |

| Code | Description | Limitation | Cost Share |
|--|---|--|------------|
| D1551 | Re-cement or re-bond bilateral space maintainer – maxillary | Once per provider, per applicable quadrant or arch for Members under the age of 18. | No Charge |
| D1552 | Re-cement or re-bond bilateral space maintainer – mandibular | Once per provider, per applicable quadrant or arch for Members under the age of 18. | No Charge |
| D1553 | Re-cement or re-bond unilateral space maintainer – per quadrant | Once per provider, per applicable quadrant or arch for Members under the age of 18. | No Charge |
| D1556 | Removal of fixed unilateral space maintainer – per quadrant | Not a Benefit to the original provider who placed the space maintainer. | No Charge |
| D1557 | Removal of fixed bilateral space maintainer – maxillary | Not a Benefit to the original provider who placed the space maintainer. | No Charge |
| D1558 | Removal of fixed bilateral space maintainer – mandibular | Not a Benefit to the original provider who placed the space maintainer. | No Charge |
| D1575 | Distal shoe space maintainer – fixed – unilateral – per quadrant | | No Charge |
| Restorative (Basic Services) Procedures (D2000-D2999) | | | |
| D2140 | Amalgam – one 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 – two 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 – three 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 – four 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 – one 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 – two 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 – three 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 – four 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 |

| Code | Description | Limitation | Cost Share |
|-------|--|---|-------------|
| 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 – one 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 – two 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 – three surfaces, posterior | Once in a 12-month period for primary teeth and once in a 36-month period for permanent teeth. | \$50 |
| D2394 | Resin-based composite – four or more surfaces, posterior | Once in a 12-month period for primary teeth and once in a 36-month period for permanent teeth. | \$70 |
| D2542 | Onlay - metallic – two surfaces | Not a Benefit. | Not Covered |
| D2543 | Onlay - metallic – three surfaces | Not a Benefit. | Not Covered |
| D2544 | Onlay - metallic – four or more surfaces | Not a Benefit. | Not Covered |
| D2642 | Onlay - porcelain/ceramic – two surfaces | Not a Benefit. | Not Covered |
| D2643 | Onlay - porcelain/ceramic – three surfaces | Not a Benefit. | Not Covered |
| D2644 | Onlay - porcelain/ceramic – four or more surfaces | Not a Benefit. | Not Covered |
| D2662 | Onlay - resin-based composite – two surfaces | Not a Benefit. | Not Covered |
| D2663 | Onlay - resin-based composite – three surfaces | Not a Benefit. | Not Covered |
| D2664 | Onlay - resin-based composite – four or more surfaces | Not a Benefit. | Not Covered |
| D2710 | Crown – resin-based composite (indirect) | <p>Permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>Once in a five-year period and for any resin based composite crown that is indirectly fabricated.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and For use as a temporary crown. | \$140 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|-------------|
| D2712 | Crown – 3/4 resin-based composite (indirect) | <p>Permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>Once in a five-year period and for any resin based composite crown that is indirectly fabricated.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and For use as a temporary crown. | \$190 |
| D2720 | Crown - resin with high noble metal | Not a Benefit. | Not Covered |
| D2721 | Crown – resin with predominantly base metal | <p>Permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>Once in a five-year period.</p> <p>Not a Benefit:</p> <p>For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.</p> | \$300 |
| D2722 | Crown - resin with noble metal | Not a Benefit. | Not Covered |
| D2740 | Crown – porcelain/ceramic substrate | <p>Permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>Once in a five-year period.</p> <p>Not a Benefit:</p> <p>For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.</p> | \$300 |
| D2750 | Crown - porcelain fused to high noble metal | Not a Benefit. | Not Covered |
| D2751 | Crown – porcelain fused to predominantly base metal | <p>Permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>Once in a five-year period.</p> <p>Not a Benefit:</p> <p>For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.</p> | \$300 |
| D2752 | Crown - porcelain fused to noble metal | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|---|---|-------------|
| D2753 | Crown – porcelain fused to titanium and titanium alloys | Not a Benefit. | Not Covered |
| D2780 | Crown - 3/4 cast high noble metal | Not a Benefit. | Not Covered |
| D2781 | Crown – 3/4 cast predominantly base metal | Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a five-year period. Not a Benefit: For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests. | \$300 |
| D2782 | Crown - 3/4 cast noble metal | Not a Benefit. | Not Covered |
| D2783 | Crown – 3/4 porcelain/ceramic | Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a five-year period. Not a Benefit: For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests. | \$310 |
| D2790 | Crown - full cast high noble metal | Not a Benefit. | Not Covered |
| D2791 | Crown – full cast predominantly base metal | Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a five-year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests. | \$300 |
| D2792 | Crown - full cast noble metal | Not a Benefit. | Not Covered |
| D2794 | Crown – titanium and titanium alloys | Not a Benefit. | Not Covered |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | Once in a 12-month period, per provider. | \$25 |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | | \$25 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D2920 | Re-cement or re-bond crown | The original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a Benefit within 12 months of a previous re-cementation by the same provider. | \$25 |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp | | \$45 |
| D2928 | Prefabricated porcelain/ceramic crown – permanent tooth | Once in a 12 month period. | \$120 |
| 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 third molars, unless the third molar occupies the first or second 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 third molars, unless the third molar occupies the first or second 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 third molars, unless the third molar occupies the first or second molar position. | \$80 |
| D2940 | Protective restoration | Once per tooth in a 6-month period, per provider. Not a Benefit: <ul style="list-style-type: none"> • When performed on the same date of service with a permanent restoration or crown, for same tooth; and • On root canal treated teeth. | \$25 |
| D2941 | Interim therapeutic restoration – primary dentition | | \$30 |
| D2949 | Restorative foundation for an indirect restoration | | \$45 |
| D2950 | Core buildup, including any pins when required | | \$20 |

| Code | Description | Limitation | Cost Share |
|---|---|---|------------|
| 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 three or more connected surfaces and at least one 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 |
| D2971 | Additional procedures to construct new crown under existing partial denture framework | | \$35 |
| D2980 | Crown repair, necessitated by restorative material failure | Limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider. | \$50 |
| D2999 | Unspecified restorative procedure, by report | | \$40 |
| Endodontics Procedures (D3000-D3999) | | | |
| D3110 | Pulp cap – direct (excluding final restoration) | | \$20 |
| D3120 | Pulp cap – indirect (excluding final restoration) | | \$25 |
| D3220 | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | Once per primary tooth. Not a Benefit: <ul style="list-style-type: none"> For a primary tooth near exfoliation; For a primary tooth with a necrotic pulp or a periapical lesion; For a primary tooth that is non-restorable; and d. for a permanent tooth. | \$40 |

| Code | Description | Limitation | Cost Share |
|-------|--|---|------------|
| 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: <ul style="list-style-type: none"> For primary teeth; For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and 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: <ul style="list-style-type: none"> For a primary tooth near exfoliation; With a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and 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: <ul style="list-style-type: none"> For a primary tooth near exfoliation; With a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and 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 third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. | \$300 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|-------------|
| D3331 | Treatment of root canal obstruction; non-surgical access | | \$50 |
| 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 third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. | \$365 |
| D3351 | Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) | Once per permanent tooth. Not a Benefit: <ul style="list-style-type: none"> • For primary teeth; • For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and • On the same date of service as any other endodontic procedures for the same tooth. | \$85 |
| D3352 | Apexification/recalcification – interim medication replacement | Once per permanent tooth and only following apexification/ recalcification initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a Benefit: <ul style="list-style-type: none"> • For primary teeth; • For third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and • On the same date of service as any other endodontic procedures for the same tooth. | \$45 |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|---|--|-------------|
| D3410 | Apicoectomy – anterior | For permanent anterior teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. | \$240 |
| D3421 | Apicoectomy – bicuspid (first root) | For permanent bicuspid teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented, after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. | \$250 |
| D3425 | Apicoectomy – molar (first root) | For permanent first and second 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 third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. | \$275 |
| D3426 | Apicoectomy – (each additional root) | For permanent teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. | \$110 |
| D3430 | Retrograde filling – per root | | \$90 |
| D3450 | Root amputation - per root | Not a Benefit. | Not Covered |
| D3471 | Surgical repair of root resorption – anterior | | \$160 |
| D3472 | Surgical repair of root resorption – premolar | | \$160 |
| D3473 | Surgical repair of root resorption – molar | | \$160 |

| Code | Description | Limitation | Cost Share |
|--|---|---|-------------|
| D3910 | Surgical procedure for isolation of tooth with rubber dam | | \$30 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | Not a Benefit. | Not Covered |
| D3950 | Canal preparation and fitting of preformed dowel or post | Not a Benefit. | Not Covered |
| D3999 | Unspecified endodontic procedure, by report | | \$100 |
| Periodontics Procedures (D4000-D4999) | | | |
| D4210 | Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant | Once per quadrant every 36 months and limited to Members age 13 or older. | \$150 |
| D4211 | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant | Once per quadrant every 36 months and limited to Members age 13 or older. | \$50 |
| D4240 | Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | Not a Benefit. | Not Covered |
| D4241 | Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | Not a Benefit. | Not Covered |
| D4249 | Clinical crown lengthening – hard tissue | For Members age 13 or older. | \$165 |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant | Once per quadrant every 36 months and limited to Members age 13 or older. | \$265 |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | Once per quadrant every 36 months and limited to Members age 13 or older. | \$140 |
| D4263 | Bone replacement graft – retained natural tooth – first site in quadrant | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|---|---|-------------|
| D4264 | Bone replacement graft – retained natural tooth – each additional site in quadrant | Not a Benefit. | Not Covered |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | For Members age 13 or older. | \$80 |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | Not a Benefit. | Not Covered |
| D4267 | Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) | Not a Benefit. | Not Covered |
| D4270 | Pedicle soft tissue graft procedure | Not a Benefit. | Not Covered |
| D4273 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | Not a Benefit. | Not Covered |
| D4275 | Non-autogenous connective tissue graft procedure (including recipient site and donor material) – first tooth, implant or edentulous tooth position in same graft site | Not a Benefit. | Not Covered |
| D4283 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | Not a Benefit. | Not Covered |
| D4285 | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | Not a Benefit. | Not Covered |
| D4341 | Periodontal scaling and root planing – four or more teeth per quadrant | Once per quadrant every 24 months and limited to Members age 13 or older. | \$55 |
| D4342 | Periodontal scaling and root planing – one to three teeth per quadrant | Once per quadrant every 24 months and limited to Members age 13 or older. | \$30 |

| Code | Description | Limitation | Cost Share |
|---|--|--|------------|
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation | | \$40 |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | For Members age 13 or older. | \$40 |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | For Members age 13 or older. | \$10 |
| D4910 | Periodontal maintenance | Once in a calendar quarter and only in the 24-month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning. | \$30 |
| D4920 | Unscheduled dressing change (by someone other than treating dentist or their staff) | Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261). | \$15 |
| D4999 | Unspecified periodontal procedure, by report | For Members age 13 or older. | \$350 |
| Prosthodontics, removable Procedures (D5000-D5899) | | | |
| D5110 | Complete denture – maxillary | Once in a five-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 five-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 |

| Code | Description | Limitation | Cost Share |
|-------|--|---|------------|
| D5130 | Immediate denture – maxillary | Once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a five-year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit six 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 five-year period of an immediate denture. | \$300 |
| D5211 | Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | | \$300 |
| D5212 | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | | \$300 |
| D5213 | Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | \$335 |
| D5214 | Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | \$335 |
| D5221 | Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) | <p>Once in a five-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:</p> <ul style="list-style-type: none"> • Five posterior permanent teeth are missing, (excluding third molars), or • All four first and second permanent molars are missing, or • The first and second permanent molars and second bicuspid are missing on the same side. <p>Not a Benefit for replacing missing third molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p> | \$275 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D5222 | Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) | <p>Once in a five-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:</p> <ul style="list-style-type: none"> • Five posterior permanent teeth are missing, (excluding third molars), or • All four first and second permanent molars are missing, or • The first and second permanent molars and second bicuspid are missing on the same side. <p>Not a Benefit for replacing missing third molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p> | \$275 |
| D5223 | Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | <p>Once in a five-year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> • Five posterior permanent teeth are missing, (excluding third molars), or • All four first and second permanent molars are missing, or • The first and second permanent molars and second bicuspid are missing on the same side. <p>Not a Benefit for replacing missing third molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p> | \$330 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D5224 | Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | <p>Once in a five-year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> • Five posterior permanent teeth are missing, (excluding third molars), or • All four first and second permanent molars are missing, or • The first and second permanent molars and second bicuspid are missing on the same side. <p>Not a Benefit for replacing missing third molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p> | \$330 |
| D5225 | Maxillary partial denture - flexible base (including any clasps, rests and teeth) | Not a Benefit. | Not Covered |
| D5226 | Mandibular partial denture - flexible base (including any clasps, rests and teeth) | Not a Benefit. | Not Covered |
| D5282 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary | Not a Benefit. | Not Covered |
| D5283 | Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular | Not a Benefit. | Not Covered |
| D5284 | Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant | Not a Benefit. | Not Covered |
| D5286 | Removable unilateral partial denture – one piece resin (including clasps and teeth), per quadrant | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|--------------------------------------|---|------------|
| D5410 | Adjust complete denture – maxillary | <p>Once per date of service per provider and no more than twice in a 12-month period per provider.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • Same date of service or within six months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130) or overdenture- complete (D5863 & D5865); • Same date of service or within six 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 • Same date of service or within six months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520). | \$20 |
| D5411 | Adjust complete denture – mandibular | <p>Once per date of service per provider and no more than twice in a 12-month period per provider.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • Same date of service or within six months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture- complete (D5863 & D5865); • Same date of service or within six 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 • Same date of service or within six months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520). | \$20 |

| Code | Description | Limitation | Cost Share |
|-------|------------------------------------|---|------------|
| D5421 | Adjust partial denture – maxillary | <p>Once per date of service per provider and no more than twice in a 12-month period per provider.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • Same date of service or within six 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); • Same date of service or within six 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 • Same date of service or within six months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660). | \$20 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D5422 | Adjust partial denture – mandibular | <p>Once per date of service per provider and no more than twice in a 12-month period per provider.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> • Same date of service or within six 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); • Same date of service or within six 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 • Same date of service or within six months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660). | \$20 |
| D5511 | Repair broken complete denture base, mandibular | <p>Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).</p> | \$40 |
| D5512 | Repair broken complete denture base, maxillary | <p>Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).</p> | \$40 |
| D5520 | Replace missing or broken teeth – complete denture (each tooth) | <p>Up to a maximum of four, per arch, per date of service per provider and no more than twice per arch, in a 12-month period per provider.</p> | \$40 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D5611 | Repair resin denture base, mandibular | Once per date of service per provider; no more than twice in a 12-month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761). | \$40 |
| D5612 | Repair resin denture base, maxillary | Once per date of service per provider; no more than twice in a 12-month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761). | \$40 |
| D5621 | Repair cast framework, mandibular | Once per date of service per provider and no more than twice in a 12-month period per provider. | \$40 |
| D5622 | Repair cast framework, maxillary | Once per date of service per provider and no more than twice in a 12-month period per provider. | \$40 |
| D5630 | Repair or replace broken clasp – per tooth | Up to a maximum of three, 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=four, 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 three, per date of service per provider. Not a Benefit for adding third molars. | \$35 |
| D5660 | Add clasp to existing partial denture – per tooth | Up to a maximum of three, per date of service per provider and no more than twice per arch, in a 12-month period per provider. | \$60 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | Not a Benefit. | Not Covered |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | Not a Benefit. | Not Covered |
| D5710 | Rebase complete maxillary denture | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D5711 | Rebase complete mandibular denture | Not a Benefit. | Not Covered |
| D5720 | Rebase maxillary partial denture | Not a Benefit. | Not Covered |
| D5721 | Rebase mandibular partial denture | Not a Benefit. | Not Covered |
| D5730 | Reline complete maxillary denture (chairside) | Once in a 12-month period; six months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750). | \$60 |
| D5731 | Reline complete mandibular denture (chairside) | Once in a 12-month period; six months after the date of service for an immediate denture-mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751). | \$60 |
| D5740 | Reline maxillary partial denture (chairside) | Once in a 12-month period; six 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 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D5741 | Reline mandibular partial denture (chairside) | Once in a 12-month period; six 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; six months after the date of service for an immediate denture- maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730). | \$90 |
| D5751 | Reline complete mandibular denture (laboratory) | Once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- complete (D5863 & D5865) that required extractions; or 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) complete (D5863 & D5865) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (chairside) (D5731). | \$90 |
| D5760 | Reline maxillary partial denture (laboratory) | Once in a 12-month period and six 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: <ul style="list-style-type: none"> • Within 12 months of a reline maxillary partial denture (chairside) (D5740); and • For maxillary partial denture resin base (D5211). | \$80 |

| Code | Description | Limitation | Cost Share |
|-------|--|---|------------|
| D5761 | Reline mandibular partial denture (laboratory) | Once in a 12-month period; six 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: <ul style="list-style-type: none"> • Within 12 months of a reline mandibular partial denture (chairside) (D5741); and • For a mandibular partial denture resin base (D5212). | \$80 |
| D5850 | Tissue conditioning, maxillary | Twice per prosthesis in a 36-month period. Not a Benefit: <ul style="list-style-type: none"> • 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 • 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: <ul style="list-style-type: none"> • 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 • Same date of service as a prosthesis that did not require extractions. | \$30 |
| D5862 | Precision attachment, by report | | \$90 |
| D5863 | Overdenture – complete maxillary | Once in a five-year period. | \$300 |
| D5864 | Overdenture – partial maxillary | Once in a five-year period. | \$300 |
| D5865 | Overdenture – complete mandibular | Once in a five-year period. | \$300 |
| D5866 | Overdenture – partial mandibular | Once in a five-year period. | \$300 |

| Code | Description | Limitation | Cost Share |
|---|---|---|-------------|
| D5876 | Add metal substructure to acrylic full denture (per arch) | Not a Benefit. | Not covered |
| D5899 | Unspecified removable prosthodontic procedure, by report | | \$350 |
| Maxillofacial Prosthetics Procedures (D5900-D5999) | | | |
| D5911 | Facial moulage (sectional) | | \$285 |
| D5912 | Facial moulage (complete) | | \$350 |
| 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 |

| Code | Description | Limitation | Cost Share |
|--|---|---|------------|
| D5936 | Obturator prosthesis, interim | Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932). | \$350 |
| D5937 | Trismus appliance (not for TMD treatment) | | \$85 |
| D5951 | Feeding aid | For Members under the age of 18 only. | \$135 |
| D5952 | Speech aid prosthesis, pediatric | For Members under the age of 18 only. | \$350 |
| D5953 | Speech aid prosthesis, adult | For Members under the age of 18 only. | \$350 |
| D5954 | Palatal augmentation prosthesis | | \$135 |
| D5955 | Palatal lift prosthesis, definitive | Not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958). | \$350 |
| D5958 | Palatal lift prosthesis, interim | Not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955). | \$350 |
| D5959 | Palatal lift prosthesis, modification | Twice in a 12-month period. Not a Benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958). | \$145 |
| D5960 | Speech aid prosthesis, modification | Twice in a 12-month period. Not a Benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953). | \$145 |
| D5982 | Surgical stent | | \$70 |
| D5983 | Radiation carrier | | \$55 |
| D5984 | Radiation shield | | \$85 |
| D5985 | Radiation cone locator | | \$135 |
| D5986 | Fluoride gel carrier | A Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands. | \$35 |
| D5987 | Commissure splint | | \$85 |
| D5988 | Surgical splint | | \$95 |
| D5991 | Vesiculobullous disease medicament carrier | | \$70 |
| D5999 | Unspecified maxillofacial prosthesis, by report | | \$350 |
| Implant Services Procedures (D6000-D6199) | | | |
| D6010 | Surgical placement of implant body: endosteal implant | | \$350 |
| D6011 | Surgical access to an implant body (second stage implant surgery) | | \$350 |

| Code | Description | Limitation | Cost Share |
|-------|---|------------|------------|
| D6013 | Surgical placement of mini 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 crown – porcelain fused to high noble alloys | | \$335 |
| D6067 | Implant supported crown – high noble alloys | | \$340 |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | | \$320 |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | | \$315 |

| Code | Description | Limitation | Cost Share |
|-------|--|------------|------------|
| 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 FPD – porcelain fused to high noble alloys | | \$330 |
| D6077 | Implant supported retainer for metal FPD – high noble alloys | | \$350 |
| D6080 | Implant maintenance procedures when prosthesis are removed and reinserted, including, cleansing of prosthesis and abutments | | \$30 |
| D6081 | Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure | | \$30 |
| D6082 | Implant supported crown – porcelain fused to predominantly base alloys | | \$335 |
| D6083 | Implant supported crown – porcelain fused to noble alloys | | \$335 |
| D6084 | Implant supported crown – porcelain fused to titanium and titanium alloys | | \$335 |
| D6085 | Provisional implant crown | | \$300 |
| D6086 | Implant supported crown – predominantly base alloys | | \$340 |

| Code | Description | Limitation | Cost Share |
|-------|---|--|------------|
| D6087 | Implant supported crown – noble alloys | | \$340 |
| D6088 | Implant supported crown – titanium and titanium alloys | | \$340 |
| D6090 | Repair implant supported prosthesis, by report | | \$65 |
| D6091 | Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment | | \$40 |
| D6092 | Re-cement or re-bond implant/abutment supported crown | Not a Benefit within 12 months of a previous recementation by the same provider. | \$25 |
| D6093 | Re-cement or re-bond implant/abutment supported fixed partial denture | Not a Benefit within 12 months of a previous recementation by the same provider. | \$35 |
| D6094 | Abutment supported crown – titanium and titanium alloys | | \$295 |
| D6095 | Repair implant abutment, by report | | \$65 |
| D6096 | Remove broken implant retaining screw | | \$60 |
| D6097 | Abutment supported crown – porcelain fused to titanium and titanium alloys | | \$315 |
| D6098 | Implant supported retainer – porcelain fused to predominantly base alloys | | \$330 |
| D6099 | Implant supported retainer for FPD – porcelain fused to noble alloys | | \$330 |
| D6100 | Implant removal, by report | | \$110 |
| D6110 | Implant/abutment supported removable denture for edentulous arch – maxillary | | \$350 |
| D6111 | Implant/abutment supported removable denture for edentulous arch – mandibular | | \$350 |
| D6112 | Implant/abutment supported removable denture for partially edentulous arch – maxillary | | \$350 |

| Code | Description | Limitation | Cost Share |
|---|---|----------------|-------------|
| D6113 | Implant/abutment supported removable denture for partially edentulous arch – mandibular | | \$350 |
| D6114 | Implant/abutment supported fixed denture for edentulous arch – maxillary | | \$350 |
| D6115 | Implant/abutment supported fixed denture for edentulous arch – mandibular | | \$350 |
| D6116 | Implant/abutment supported fixed denture for partially edentulous arch – maxillary | | \$350 |
| D6117 | Implant/abutment supported fixed denture for partially edentulous arch – mandibular | | \$350 |
| D6120 | Implant supported retainer – porcelain fused to titanium and titanium alloys | | \$330 |
| D6121 | Implant supported retainer for metal FPD – predominantly base alloys | | \$350 |
| D6122 | Implant supported retainer for metal FPD – noble alloys | | \$350 |
| D6123 | Implant supported retainer for metal FPD – titanium and titanium alloys | | \$350 |
| D6190 | Radiographic/surgical implant index, by report | | \$75 |
| D6191 | Semi-precision abutment – placement | | \$350 |
| D6192 | Semi-precision attachment – placement | | \$350 |
| D6194 | Abutment supported retainer crown for FPD – titanium and titanium alloys | | \$265 |
| D6195 | Abutment supported retainer – porcelain fused to titanium and titanium alloys | | \$315 |
| D6199 | Unspecified implant procedure, by report | | \$350 |
| Prosthodontics, fixed Procedures (D6200-D6999) | | | |
| D6205 | Pontic - indirect resin based composite | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D6210 | Pontic - cast high noble metal | Not a Benefit. | Not Covered |
| D6211 | Pontic – cast predominately base metal | Once in a five-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 |
| D6212 | Pontic – cast noble metal | Not a Benefit. | Not Covered |
| D6214 | Pontic – titanium and titanium alloys | Not a Benefit. | Not Covered |
| D6240 | Pontic – porcelain fused to high noble metal | Not a Benefit. | Not Covered |
| D6241 | Pontic – porcelain fused to predominantly base metal | Once in a five-year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13. | \$300 |
| D6242 | Pontic - porcelain fused to noble metal | Not a Benefit. | Not Covered |
| D6243 | Pontic – porcelain fused to titanium and titanium alloys | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|---|--|-------------|
| D6245 | Pontic – porcelain/ceramic | Once in a five-year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13. | \$300 |
| D6250 | Pontic - resin with high noble metal | Not a Benefit. | Not Covered |
| D6251 | Pontic - resin with predominantly base metal | Once in a five-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 |
| D6252 | Pontic - resin with noble metal | Not a Benefit. | Not Covered |
| D6545 | Retainer - cast metal for resin bonded fixed prosthesis | Not a Benefit. | Not Covered |
| D6548 | Retainer - porcelain/ceramic for resin bonded fixed prosthesis | Not a Benefit. | Not Covered |
| D6549 | Retainer – for resin bonded fixed prosthesis | Not a Benefit. | Not Covered |
| D6608 | Retainer only - porcelain/ceramic, two surfaces | Not a Benefit. | Not Covered |
| D6609 | Retainer only - porcelain/ceramic, three or more surfaces | Not a Benefit. | Not Covered |
| D6610 | Retainer only - cast high noble metal, two surfaces | Not a Benefit. | Not Covered |
| D6611 | Retainer only - cast high noble metal, three or more surfaces | Not a Benefit. | Not Covered |
| D6612 | Retainer only - cast predominantly base metal, two surfaces | Not a Benefit. | Not Covered |
| D6613 | Retainer only - cast predominantly base metal, three or more surfaces | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D6614 | Retainer onlay - cast noble metal, two surfaces | Not a Benefit. | Not Covered |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | Not a Benefit. | Not Covered |
| D6634 | Retainer onlay - titanium | Not a Benefit. | Not Covered |
| D6710 | Retainer crown - indirect resin based composite | Not a Benefit. | Not Covered |
| D6720 | Retainer crown - resin with high noble metal | Not a Benefit. | Not Covered |
| D6721 | Retainer crown – resin with predominantly base metal | Once in a five-year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13. | \$300 |
| D6722 | Retainer crown - resin with noble metal | Not a Benefit. | Not Covered |
| D6740 | Retainer crown – porcelain/ceramic | Once in a five-year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13. | \$300 |
| D6750 | Retainer crown – porcelain fused to high noble metal | Not a Benefit. | Not Covered |
| D6751 | Retainer crown – porcelain fused to predominantly base metal | Once in a five-year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13. | \$300 |
| D6752 | Retainer crown – porcelain fused to noble metal | Not a Benefit. | Not Covered |
| D6752 | Retainer crown – porcelain fused to titanium and titanium alloys | Not a Benefit. | Not Covered |
| D6781 | Retainer crown – 3/4 cast predominantly base metal | Once in a five-year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13. | \$300 |
| D6782 | Retainer crown - 3/4 cast noble metal | Not a Benefit. | Not Covered |

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

| Code | Description | Limitation | Cost Share |
|-------|--|--|------------|
| 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 | 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 oronasal communication, subsequent to the removal of a tooth. | \$285 |
| D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | Once per arch regardless of the number of teeth involved and for permanent anterior teeth only. | \$185 |
| D7280 | Exposure of an unerupted tooth | Not a Benefit: a. for Members age 21 or older, or b. for third molars. | \$220 |
| D7283 | Placement of device to facilitate eruption of impacted tooth | Only for Members in active orthodontic treatment. Not a Benefit: <ul style="list-style-type: none"> • For Members age 21 years or older; and • For third molars unless the third molar occupies the first or second molar position. | \$85 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D7285 | Incisional biopsy of oral tissue – hard (bone, tooth) | For the removal of the specimen only and once per arch, per date of service regardless of the areas involved. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service. | \$180 |
| D7286 | Incisional biopsy of oral tissue – soft | For the removal of the specimen only and up to a maximum of three per date of service. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous | \$110 |
| D7287 | Exfoliative cytological sample collection | Not a Benefit. | Not Covered |
| D7288 | Brush biopsy - transepithelial sample collection | Not a Benefit. | Not Covered |
| D7290 | Surgical repositioning of teeth | For permanent teeth only; once per arch; and only for Members in active orthodontic treatment. | \$185 |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | Once per arch and only for Members in active orthodontic treatment. | \$80 |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | A Benefit on the same date of service with two 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 | Alveoloplasty 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 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | \$65 |
| D7340 | Vestibuloplasty – ridge extension (secondary epithelialization) | Once in a five-year period per arch. | \$350 |

| Code | Description | Limitation | Cost Share |
|-------|---|--|------------|
| 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: <ul style="list-style-type: none"> On the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; and On the same date of service with extractions (D7111- D7250) same arch. | \$350 |
| D7410 | Excision of benign lesion up to 1.25 cm | | \$75 |
| D7411 | Excision of benign lesion greater than 1.25 cm | | \$115 |
| D7412 | Excision of benign lesion, complicated | A Benefit when there is extensive undermining with advancement or rotational flap closure. | \$175 |
| D7413 | Excision of malignant lesion up to 1.25 cm | | \$95 |
| D7414 | Excision of malignant lesion greater than 1.25 cm | | \$120 |
| D7415 | Excision of malignant lesion, complicated | A Benefit when there is extensive undermining with advancement or rotational flap closure. | \$255 |
| D7440 | Excision of malignant tumor – lesion diameter up to 1.25 cm | | \$105 |
| D7441 | Excision of malignant tumor – lesion diameter greater than 1.25 cm | | \$185 |
| D7450 | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm | | \$180 |
| D7451 | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | | \$330 |
| D7460 | Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm | | \$155 |
| D7461 | Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm | | \$250 |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | | \$40 |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | Once per quadrant and for the removal of buccal or facial exostosis only. | \$140 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D7472 | Removal of torus palatinus | Once in the Member's lifetime. | \$145 |
| D7473 | Removal of torus mandibularis | Once per quadrant. | \$140 |
| D7485 | Reduction of osseous tuberosity | Once per quadrant. | \$105 |
| D7490 | Radical resection of maxilla or mandible | | \$350 |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | Once per quadrant, same date of service. | \$70 |
| D7511 | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | Once per quadrant, same date of service. | \$70 |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | | \$70 |
| D7521 | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | | \$80 |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue | Once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250). | \$45 |
| D7540 | Removal of reaction producing foreign bodies, musculoskeletal system | Once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250). | \$75 |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone | Once per quadrant per date of service and only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a Benefit within 30 days of an associated extraction (D7111-D7250). | \$125 |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body | Not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket. | \$235 |
| D7610 | Maxilla – open reduction (teeth immobilized, if present) | | \$140 |
| D7620 | Maxilla – closed reduction (teeth immobilized, if present) | | \$250 |
| D7630 | Mandible – open reduction (teeth immobilized, if present) | | \$350 |
| D7640 | Mandible – closed reduction (teeth immobilized, if present) | | \$350 |

| Code | Description | Limitation | Cost Share |
|-------|---|---|------------|
| D7650 | Malar and/or zygomatic arch – open reduction | | \$350 |
| D7660 | Malar and/or zygomatic arch – closed reduction | | \$350 |
| D7670 | Alveolus – closed reduction, may include stabilization of teeth | | \$170 |
| D7671 | Alveolus – open reduction, may include stabilization of teeth | | \$230 |
| D7680 | Facial bones – complicated reduction with fixation and multiple surgical approaches | For the treatment of simple fractures only. | \$350 |
| D7710 | Maxilla – open reduction | | \$110 |
| D7720 | Maxilla – closed reduction | | \$180 |
| D7730 | Mandible – open reduction | | \$350 |
| D7740 | Mandible – closed reduction | | \$290 |
| D7750 | Malar and/or zygomatic arch – open reduction | | \$220 |
| D7760 | Malar and/or zygomatic arch – closed reduction | | \$350 |
| D7770 | Alveolus – open reduction stabilization of teeth | | \$135 |
| D7771 | Alveolus, closed reduction stabilization of teeth | | \$160 |
| D7780 | Facial bones – complicated reduction with fixation and multiple approaches | For the treatment of compound fractures only. | \$350 |
| D7810 | Open reduction of dislocation | | \$350 |
| D7820 | Closed reduction of dislocation | | \$80 |
| D7830 | Manipulation under anesthesia | | \$85 |
| D7840 | Condylectomy | | \$350 |
| D7850 | Surgical discectomy, with/without implant | | \$350 |
| D7852 | Disc repair | | \$350 |
| D7854 | Synovectomy | | \$350 |
| D7856 | Myotomy | | \$350 |
| D7858 | Joint reconstruction | | \$350 |
| D7860 | Arthrotomy | | \$350 |
| D7865 | Arthroplasty | | \$350 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|------------|
| D7870 | Arthrocentesis | | \$90 |
| D7871 | Non-arthroscopic lysis and lavage | | \$150 |
| D7872 | Arthroscopy – diagnosis, with or without biopsy | | \$350 |
| D7873 | Arthroscopy – lavage and lysis of adhesions | | \$350 |
| D7874 | Arthroscopy – disc repositioning and stabilization | | \$350 |
| D7875 | Arthroscopy – synovectomy | | \$350 |
| D7876 | Arthroscopy – discectomy | | \$350 |
| D7877 | Arthroscopy – debridement | | \$350 |
| D7880 | Occlusal orthotic device, by report | Not a Benefit for the treatment of bruxism. | \$120 |
| D7881 | Occlusal orthotic device adjustment | | \$30 |
| D7899 | Unspecified TMD therapy, by report | Not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis. | \$350 |
| D7910 | Suture of recent small wounds up to 5 cm | Not a Benefit for the closure of surgical incisions. | \$35 |
| D7911 | Complicated suture – up to 5 cm | Not a Benefit for the closure of surgical incisions. | \$55 |
| D7912 | Complicated suture – greater than 5 cm | Not a Benefit for the closure of surgical incisions. | \$130 |
| D7920 | Skin graft (identify defect covered, location and type of graft) | Not a Benefit for periodontal grafting. | \$120 |
| D7922 | Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site | | \$80 |
| D7940 | Osteoplasty – for orthognathic deformities | | \$160 |
| D7941 | Osteotomy – mandibular rami | | \$350 |
| D7943 | Osteotomy – mandibular rami with bone graft; includes obtaining the graft | | \$350 |
| D7944 | Osteotomy – segmented or subapical | | \$275 |
| D7945 | Osteotomy – body of mandible | | \$350 |
| D7946 | LeFort I (maxilla – total) | | \$350 |

| Code | Description | Limitation | Cost Share |
|-------|--|---|------------|
| D7947 | LeFort I (maxilla – segmented) | | \$350 |
| D7948 | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft | | \$350 |
| D7949 | LeFort II or LeFort III – with bone graft | | \$350 |
| D7950 | Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report | Not a Benefit for periodontal grafting. | \$190 |
| D7951 | Sinus augmentation with bone or bone substitutes via a lateral open approach | Only for Members with authorized implant services. | \$290 |
| D7952 | Sinus augmentation via a vertical approach | Only for Members with authorized implant services. | \$175 |
| D7955 | Repair of maxillofacial soft and/or hard tissue defect | Not a Benefit for periodontal grafting. | \$200 |
| D7961 | Buccal/labial frenectomy (frenulectomy) | Once per arch per date of service and only when the permanent incisors and cuspids have erupted. | \$120 |
| D7962 | Lingual frenectomy (frenulectomy) | Once per arch per date of service and only when the permanent incisors and cuspids have erupted. | \$120 |
| D7963 | Frenuloplasty | Once per arch per date of service and only when the permanent incisors and cuspids have erupted. Not a Benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring. | \$120 |
| D7970 | Excision of hyperplastic tissue – per arch | Once per arch per date of service. | \$175 |
| D7971 | Excision of pericoronal gingiva | | \$80 |
| D7972 | Surgical reduction of fibrous tuberosity | Once per quadrant per date of service. | \$100 |
| D7979 | Non-surgical Sialolithotomy | | \$155 |
| D7980 | Sialolithotomy | | \$155 |
| D7981 | Excision of salivary gland, by report | | \$120 |
| D7982 | Sialodochoplasty | | \$215 |
| D7983 | Closure of salivary fistula | | \$140 |
| D7990 | Emergency tracheotomy | | \$350 |

| Code | Description | Limitation | Cost Share |
|--|--|--|------------|
| D7991 | Coronoidectomy | | \$345 |
| D7995 | Synthetic graft – mandible or facial bones, by report | Not a Benefit for periodontal grafting. | \$150 |
| D7997 | Appliance removal (not by dentist who placed appliance), includes removal of archbar | Once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers. | \$60 |
| D7999 | Unspecified oral surgery procedure, by report | | \$350 |
| Orthodontics Procedures (D8000-D8999) | | | |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | Once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). | \$1,000 |
| D8210 | Removable appliance therapy | Once per Member and for Members ages six through 12. | |
| D8220 | Fixed appliance therapy | Once per Member and for Members ages six through 12. | |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | Once every three months for a maximum of six and must be done prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required. | |
| D8670 | Periodic orthodontic treatment visit – handicapping malocclusion | Once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). | |
| D8670 | Periodic orthodontic treatment visit cleft palate – primary dentition | Up to a maximum of four quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the Medical Necessity). | |
| D8670 | Periodic orthodontic treatment visit cleft palate – mixed dentition | Up to a maximum of five quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the Medical Necessity). | |
| D8670 | Periodic orthodontic treatment visit cleft palate – permanent dentition | Up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the Medical Necessity) | |

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

| Code | Description | Limitation | Cost Share |
|--|---|---|------------|
| D8704 | Replacement of lost or broken retainer – mandibular | Once per arch and only within 24 months following the date of service of orthodontic retention (D8680). | |
| D8999 | Unspecified orthodontic procedure, by report | | |
| Adjunctive General Services Procedures (D9000-D9999) | | | |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | Once per date of service per provider regardless of the number of teeth and/or areas treated. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition. | \$30 |
| D9120 | Fixed partial denture sectioning | A Benefit when at least one of the abutment teeth is to be retained. | \$95 |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | Once per date of service per provider and only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition. | \$10 |
| D9211 | Regional block anesthesia | | \$20 |
| D9212 | Trigeminal division block anesthesia | | \$60 |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | | \$15 |
| D9222 | Deep sedation/analgesia - first 15 minutes | Not a Benefit: <ul style="list-style-type: none">On the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); andWhen all associated procedures on the same date of service by the same provider are denied. | \$45 |
| D9223 | Deep sedation/general anesthesia – each 15 minute increment | | \$45 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|------------|
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | <p>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.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> On the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9243) or non-intravenous conscious sedation (D9248); and When all associated procedures on the same date of service by the same provider are denied. | \$15 |
| D9239 | Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes | <p>Not a benefit:</p> <ul style="list-style-type: none"> 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 When all associated procedures on the same date of service by the same provider are denied. | \$60 |
| D9243 | Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment | <p>Not a Benefit:</p> <ul style="list-style-type: none"> On the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); and When all associated procedures on the same date of service by the same provider are denied. | \$60 |

| Code | Description | Limitation | Cost Share |
|-------|---|--|-------------|
| D9248 | Non-intravenous conscious sedation | <p>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.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> On the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9243); and When all associated procedures on the same date of service by the same provider are denied. | \$65 |
| D9310 | Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician | | \$50 |
| D9311 | Consultation with a medical health professional | | No Charge |
| D9410 | House/extended care facility call | Once per Member per date of service and only in conjunction with procedures that are payable. | \$50 |
| D9420 | Hospital or ambulatory surgical center call | A Benefit for each hour or fraction thereof as documented on the operative report. | \$135 |
| D9430 | Office visit for observation (during regularly scheduled hours) – no other services performed | <p>Once per date of service per provider.</p> <p>Not a Benefit:</p> <ul style="list-style-type: none"> When procedures other than necessary radiographs and/or photographs are provided on the same date of service; and For visits to Members residing in a house/ extended care facility. | \$20 |
| D9440 | Office visit – after regularly scheduled hours | Once per date of service per provider and only with treatment that is a Benefit. | \$45 |
| D9450 | Case presentation, detailed and extensive treatment planning | Not a Benefit. | Not Covered |

| Code | Description | Limitation | Cost Share |
|-------|--|---|-------------|
| D9610 | Therapeutic parenteral drug, single administration | Up to a maximum of four injections per date of service. Not a Benefit: <ul style="list-style-type: none"> For the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9243) or non-intravenous conscious sedation (D9248); and When all associated procedures on the same date of service by the same provider are denied. | \$30 |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | | \$40 |
| 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: <ul style="list-style-type: none"> For the removal of bony fragments on the same date of service as an extraction; and For routine post-operative visits. | \$35 |
| D9942 | Repair and/or reline of occlusal guard | Not a Benefit. | Not Covered |
| D9943 | Occlusal guard adjustment | Not a Benefit. | Not Covered |
| D9944 | Occlusal guard – hard appliance, full arch | Not a Benefit. | Not Covered |
| D9945 | Occlusal guard – soft appliance, full arch | Not a Benefit. | Not Covered |
| D9946 | Occlusal guard – hard appliance, partial arch | Not a Benefit. | Not Covered |
| D9950 | Occlusion analysis – mounted case | Once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ dysfunction only; and for permanent dentition. Not a Benefit for bruxism only. | \$120 |

| Code | Description | Limitation | Cost Share |
|-------|--|--|-------------|
| D9951 | Occlusal adjustment – limited | Once in a 12-month period per quadrant per provider; for Members age 13 and older; and for natural teeth only. Not a Benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant. | \$45 |
| D9952 | Occlusal adjustment – complete | Once in a 12-month period following occlusion analysis-mounted case (D9950); for Members age 13 and older; for diagnosed TMJ dysfunction only; and for permanent dentition. | \$210 |
| D9995 | Teledentistry – synchronous; real-time encounter | Not a Benefit. | Not Covered |
| D9996 | Teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review | Not a Benefit. | Not Covered |
| D9997 | Dental case management – patients with special health care needs | | No Charge |
| D9999 | Unspecified adjunctive procedure, by report | | No Charge |

Trio HMO Plan Service Area

The Trio HMO Plan Service Area consists of the counties, and ZIP codes listed within those counties, on the charts below. You must reside within one of these ZIP codes to be eligible for a Trio HMO plan. The Trio HMO Plan Service Area may change. Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge for more information.

| Alameda County | | | |
|----------------|-------|-------|-------|
| 94501 | 94502 | 94505 | 94514 |
| 94536 | 94537 | 94538 | 94539 |
| 94540 | 94541 | 94542 | 94543 |
| 94544 | 94545 | 94546 | 94550 |
| 94551 | 94552 | 94555 | 94557 |
| 94560 | 94566 | 94568 | 94577 |
| 94578 | 94579 | 94580 | 94586 |
| 94587 | 94588 | 94601 | 94602 |
| 94603 | 94604 | 94605 | 94606 |
| 94607 | 94608 | 94609 | 94610 |
| 94611 | 94612 | 94613 | 94614 |
| 94615 | 94617 | 94618 | 94619 |
| 94620 | 94621 | 94622 | 94623 |
| 94624 | 94649 | 94659 | 94660 |
| 94661 | 94662 | 94666 | 94701 |
| 94702 | 94703 | 94704 | 94705 |
| 94706 | 94707 | 94708 | 94709 |
| 94710 | 94712 | 94720 | 95377 |
| 95391 | | | |

| Contra Costa County | | | |
|---------------------|-------|-------|-------|
| 94505 | 94506 | 94507 | 94509 |
| 94511 | 94513 | 94514 | 94516 |

Questions? Visit [blueshieldca.com](https://www.blueshieldca.com), use the Blue Shield mobile app, or call Shield Concierge at 1-855-258-3744.

| Contra Costa County | | | |
|---------------------|-------|-------|-------|
| 94517 | 94518 | 94519 | 94520 |
| 94521 | 94522 | 94523 | 94524 |
| 94525 | 94526 | 94527 | 94528 |
| 94529 | 94530 | 94531 | 94547 |
| 94548 | 94549 | 94551 | 94553 |
| 94556 | 94561 | 94563 | 94564 |
| 94565 | 94569 | 94570 | 94572 |
| 94575 | 94582 | 94583 | 94595 |
| 94596 | 94597 | 94598 | 94706 |
| 94707 | 94708 | 94801 | 94802 |
| 94803 | 94804 | 94805 | 94806 |
| 94807 | 94808 | 94820 | 94850 |

| El Dorado County | | | |
|------------------|-------|-------|-------|
| 95664 | 95672 | 95682 | 95762 |

| Fresno County | | | |
|---------------|-------|-------|--|
| 93245 | 93618 | 93631 | |

| Kern County | | | |
|-------------|-------|-------|-------|
| 93203 | 93205 | 93206 | 93215 |
| 93216 | 93220 | 93224 | 93225 |
| 93226 | 93240 | 93241 | 93250 |
| 93251 | 93252 | 93255 | 93263 |
| 93268 | 93276 | 93280 | 93283 |
| 93285 | 93287 | 93301 | 93302 |
| 93303 | 93304 | 93305 | 93306 |
| 93307 | 93308 | 93309 | 93311 |
| 93312 | 93313 | 93314 | 93380 |

| Kern County | | | |
|-------------|-------|-------|-------|
| 93383 | 93384 | 93385 | 93386 |
| 93387 | 93388 | 93389 | 93390 |
| 93501 | 93502 | 93504 | 93505 |
| 93516 | 93518 | 93531 | 93560 |
| 93561 | 93596 | | |

| Kings County | | | |
|--------------|-------|-------|-------|
| 93202 | 93212 | 93230 | 93245 |
| 93631 | | | |

| Los Angeles County | | | |
|--------------------|-------|-------|-------|
| 90001 | 90002 | 90003 | 90004 |
| 90005 | 90006 | 90007 | 90008 |
| 90009 | 90010 | 90011 | 90012 |
| 90013 | 90014 | 90015 | 90016 |
| 90017 | 90018 | 90019 | 90020 |
| 90021 | 90022 | 90023 | 90024 |
| 90025 | 90026 | 90027 | 90028 |
| 90029 | 90030 | 90031 | 90032 |
| 90033 | 90034 | 90035 | 90036 |
| 90037 | 90038 | 90039 | 90040 |
| 90041 | 90042 | 90043 | 90044 |
| 90045 | 90046 | 90047 | 90048 |
| 90049 | 90050 | 90051 | 90052 |
| 90053 | 90054 | 90055 | 90056 |
| 90057 | 90058 | 90059 | 90060 |
| 90061 | 90062 | 90063 | 90064 |
| 90065 | 90066 | 90067 | 90068 |
| 90069 | 90070 | 90071 | 90072 |

| Los Angeles County | | | |
|--------------------|-------|-------|-------|
| 90073 | 90074 | 90075 | 90076 |
| 90077 | 90078 | 90079 | 90080 |
| 90081 | 90082 | 90083 | 90084 |
| 90086 | 90087 | 90088 | 90089 |
| 90090 | 90091 | 90093 | 90094 |
| 90095 | 90096 | 90099 | 90189 |
| 90201 | 90202 | 90209 | 90210 |
| 90211 | 90212 | 90213 | 90220 |
| 90221 | 90222 | 90223 | 90224 |
| 90230 | 90231 | 90232 | 90233 |
| 90239 | 90240 | 90241 | 90242 |
| 90245 | 90247 | 90248 | 90249 |
| 90250 | 90251 | 90254 | 90255 |
| 90260 | 90261 | 90262 | 90263 |
| 90264 | 90265 | 90266 | 90267 |
| 90270 | 90272 | 90274 | 90275 |
| 90277 | 90278 | 90280 | 90290 |
| 90291 | 90292 | 90293 | 90294 |
| 90295 | 90296 | 90301 | 90302 |
| 90303 | 90304 | 90305 | 90306 |
| 90307 | 90308 | 90309 | 90310 |
| 90311 | 90312 | 90401 | 90402 |
| 90403 | 90404 | 90405 | 90406 |
| 90407 | 90408 | 90409 | 90410 |
| 90411 | 90501 | 90502 | 90503 |
| 90504 | 90505 | 90506 | 90507 |
| 90508 | 90509 | 90510 | 90601 |
| 90602 | 90603 | 90604 | 90605 |
| 90606 | 90607 | 90608 | 90609 |
| 90610 | 90637 | 90638 | 90639 |
| 90640 | 90650 | 90651 | 90652 |

| Los Angeles County | | | |
|--------------------|-------|-------|-------|
| 90660 | 90661 | 90662 | 90670 |
| 90671 | 90701 | 90702 | 90703 |
| 90706 | 90707 | 90710 | 90711 |
| 90712 | 90713 | 90714 | 90715 |
| 90716 | 90717 | 90723 | 90731 |
| 90732 | 90733 | 90734 | 90744 |
| 90745 | 90746 | 90747 | 90748 |
| 90749 | 90755 | 90801 | 90802 |
| 90803 | 90804 | 90805 | 90806 |
| 90807 | 90808 | 90809 | 90810 |
| 90813 | 90814 | 90815 | 90822 |
| 90831 | 90832 | 90833 | 90834 |
| 90835 | 90840 | 90842 | 90844 |
| 90846 | 90847 | 90848 | 90853 |
| 90895 | 90899 | 91001 | 91003 |
| 91006 | 91007 | 91008 | 91009 |
| 91010 | 91011 | 91012 | 91016 |
| 91017 | 91020 | 91021 | 91023 |
| 91024 | 91025 | 91030 | 91031 |
| 91040 | 91041 | 91042 | 91043 |
| 91046 | 91066 | 91077 | 91101 |
| 91102 | 91103 | 91104 | 91105 |
| 91106 | 91107 | 91108 | 91109 |
| 91110 | 91114 | 91115 | 91116 |
| 91117 | 91118 | 91121 | 91123 |
| 91124 | 91125 | 91126 | 91129 |
| 91182 | 91184 | 91185 | 91188 |
| 91189 | 91199 | 91201 | 91202 |
| 91203 | 91204 | 91205 | 91206 |
| 91207 | 91208 | 91209 | 91210 |
| 91214 | 91221 | 91222 | 91224 |

| Los Angeles County | | | |
|--------------------|-------|-------|-------|
| 91225 | 91226 | 91301 | 91302 |
| 91303 | 91304 | 91305 | 91306 |
| 91307 | 91308 | 91309 | 91310 |
| 91311 | 91313 | 91316 | 91321 |
| 91322 | 91324 | 91325 | 91326 |
| 91327 | 91328 | 91329 | 91330 |
| 91331 | 91333 | 91334 | 91335 |
| 91337 | 91340 | 91341 | 91342 |
| 91343 | 91344 | 91345 | 91346 |
| 91350 | 91351 | 91352 | 91353 |
| 91354 | 91355 | 91356 | 91357 |
| 93161 | 91364 | 91365 | 91367 |
| 91371 | 91372 | 91376 | 91380 |
| 91381 | 91382 | 91383 | 91384 |
| 91385 | 91386 | 91387 | 91390 |
| 91392 | 91393 | 91394 | 91395 |
| 91396 | 91401 | 91402 | 91403 |
| 91404 | 91405 | 91406 | 91407 |
| 91408 | 91409 | 91410 | 91411 |
| 91412 | 91413 | 91416 | 91423 |
| 91426 | 91436 | 91470 | 91482 |
| 91495 | 91496 | 91499 | 91501 |
| 91502 | 91503 | 91504 | 91505 |
| 91506 | 91507 | 91508 | 91510 |
| 91521 | 91522 | 91523 | 91526 |
| 91601 | 91602 | 91603 | 91604 |
| 91605 | 91606 | 91607 | 91608 |
| 91609 | 91610 | 91611 | 91612 |
| 91614 | 91615 | 91616 | 91617 |
| 91618 | 91702 | 91706 | 91711 |
| 91714 | 91715 | 91716 | 91722 |

| Los Angeles County | | | |
|--------------------|-------|-------|-------|
| 91723 | 91724 | 91731 | 91732 |
| 91733 | 91734 | 91735 | 91740 |
| 91741 | 91744 | 91745 | 91746 |
| 91747 | 91748 | 91749 | 91750 |
| 91754 | 91755 | 91756 | 91765 |
| 91766 | 91767 | 91768 | 91769 |
| 91770 | 91771 | 91772 | 91773 |
| 91775 | 91776 | 91778 | 91780 |
| 91788 | 91789 | 91790 | 91791 |
| 91792 | 91793 | 91801 | 91802 |
| 91803 | 91804 | 91896 | 91899 |
| 93510 | 93563 | | |

| Marin County | | | |
|--------------|-------|-------|-------|
| 94901 | 94903 | 94904 | 94912 |
| 94913 | 94914 | 94915 | 94920 |
| 94924 | 94925 | 94930 | 94933 |
| 94937 | 94938 | 94939 | 94940 |
| 94941 | 94942 | 94945 | 94946 |
| 94947 | 94948 | 94949 | 94950 |
| 94956 | 94957 | 94960 | 94963 |
| 94964 | 94965 | 94966 | 94970 |
| 94971 | 94973 | 94974 | 94976 |
| 94977 | 94978 | 94979 | 94998 |

| Monterey County | | | |
|-----------------|-------|-------|-------|
| 93933 | 93940 | 93942 | 93943 |
| 93944 | 93950 | 93953 | 93955 |

| Nevada County | | | |
|---------------|-------|-------|-------|
| 95712 | 95924 | 95945 | 95946 |
| 95949 | 95959 | 95960 | 95975 |
| 95986 | | | |

| Orange County | | | |
|---------------|-------|-------|-------|
| 90620 | 90621 | 90622 | 90623 |
| 90624 | 90630 | 90631 | 90632 |
| 90633 | 90638 | 90680 | 90720 |
| 90721 | 90740 | 90742 | 90743 |
| 92602 | 92603 | 92604 | 92605 |
| 92606 | 92607 | 92609 | 92610 |
| 92612 | 92614 | 92615 | 92616 |
| 92617 | 92618 | 92619 | 92620 |
| 92623 | 92624 | 92625 | 92626 |
| 92627 | 92628 | 92629 | 92630 |
| 92637 | 92646 | 92647 | 92648 |
| 92649 | 92650 | 92651 | 92652 |
| 92653 | 92654 | 92655 | 92656 |
| 92657 | 92658 | 92659 | 92660 |
| 92661 | 92662 | 92663 | 92672 |
| 92673 | 92674 | 92675 | 92676 |
| 92677 | 92678 | 92679 | 92683 |
| 92684 | 92685 | 92688 | 92690 |
| 92691 | 92692 | 92693 | 92694 |
| 92697 | 92698 | 92701 | 92702 |
| 92703 | 92704 | 92705 | 92706 |
| 92707 | 92708 | 92711 | 92712 |
| 92728 | 92735 | 92780 | 92781 |
| 92782 | 92799 | 92801 | 92802 |

| Orange County | | | |
|---------------|-------|-------|-------|
| 92803 | 92804 | 92805 | 92806 |
| 92807 | 92808 | 92809 | 92811 |
| 92812 | 92814 | 92815 | 92816 |
| 92817 | 92821 | 92822 | 92823 |
| 92825 | 92831 | 92832 | 92833 |
| 92834 | 92835 | 92836 | 92837 |
| 92838 | 92840 | 92841 | 92842 |
| 92843 | 92844 | 92845 | 92846 |
| 92850 | 92856 | 92857 | 92859 |
| 92861 | 92862 | 92863 | 92864 |
| 92865 | 92866 | 92867 | 92868 |
| 92869 | 92870 | 92871 | 92885 |
| 92886 | 92887 | 92899 | |

| Placer County | | | |
|---------------|-------|-------|-------|
| 95602 | 95603 | 95604 | 95648 |
| 95650 | 95658 | 95661 | 95663 |
| 95677 | 95678 | 95713 | 95746 |
| 95747 | 95765 | | |

| Riverside County | | | |
|------------------|-------|-------|-------|
| 91752 | 92220 | 92201 | 92202 |
| 92203 | 92210 | 92211 | 92223 |
| 92230 | 92234 | 92235 | 92236 |
| 92240 | 92241 | 92247 | 92248 |
| 92253 | 92255 | 92258 | 92260 |
| 92261 | 92262 | 92263 | 92264 |
| 92270 | 92276 | 92282 | 92320 |

| Riverside County | | | |
|------------------|-------|-------|-------|
| 92501 | 92502 | 92503 | 92504 |
| 92505 | 92506 | 92507 | 92508 |
| 92509 | 92513 | 92514 | 92516 |
| 92517 | 92518 | 92519 | 92521 |
| 92522 | 92530 | 92531 | 92532 |
| 92543 | 92544 | 92545 | 92546 |
| 92548 | 92549 | 92551 | 92552 |
| 92553 | 92554 | 92555 | 92556 |
| 92557 | 92562 | 92563 | 92564 |
| 92567 | 92570 | 92571 | 92572 |
| 92581 | 92582 | 92583 | 92584 |
| 92585 | 92586 | 92587 | 92589 |
| 92590 | 92591 | 92592 | 92593 |
| 92595 | 92596 | 92599 | 92860 |
| 92877 | 92878 | 92879 | 92880 |
| 92881 | 92882 | 92883 | |

| Sacramento County | | | |
|-------------------|-------|-------|-------|
| 94203 | 94204 | 94205 | 94206 |
| 94207 | 94208 | 94209 | 94211 |
| 94229 | 94230 | 94232 | 94234 |
| 94235 | 94236 | 94237 | 94239 |
| 94240 | 94244 | 94245 | 94247 |
| 94248 | 94249 | 94250 | 94252 |
| 94254 | 94256 | 94257 | 94258 |
| 94259 | 94261 | 94262 | 94263 |
| 94267 | 94268 | 94269 | 94271 |
| 94273 | 94274 | 94277 | 94278 |
| 94279 | 94280 | 94282 | 94283 |

| Sacramento County | | | |
|-------------------|-------|-------|-------|
| 94284 | 94285 | 94287 | 94288 |
| 94289 | 94290 | 94291 | 94293 |
| 94294 | 94295 | 94296 | 94297 |
| 94298 | 94299 | 95608 | 95609 |
| 95610 | 95611 | 95615 | 95621 |
| 95624 | 95626 | 95628 | 95630 |
| 95632 | 95638 | 95639 | 95652 |
| 95655 | 95660 | 95662 | 95670 |
| 95671 | 95673 | 95683 | 95693 |
| 95741 | 95742 | 95757 | 95758 |
| 95759 | 95763 | 95811 | 95812 |
| 95813 | 95814 | 95815 | 95816 |
| 95817 | 95818 | 95819 | 95820 |
| 95821 | 95822 | 95823 | 95824 |
| 95825 | 95826 | 95827 | 95828 |
| 95829 | 95830 | 95831 | 95832 |
| 95833 | 95834 | 95835 | 95836 |
| 95837 | 95838 | 95840 | 95841 |
| 95842 | 95843 | 95851 | 95852 |
| 95853 | 95860 | 95864 | 95865 |
| 95866 | 95867 | 95894 | 95899 |

| San Bernardino County | | | |
|-----------------------|-------|-------|-------|
| 91701 | 91708 | 91709 | 91710 |
| 91729 | 91730 | 91737 | 91739 |
| 91743 | 91758 | 91759 | 91761 |
| 91762 | 91763 | 91764 | 91784 |
| 91785 | 91786 | 92256 | 92268 |
| 92284 | 92286 | 92301 | 92305 |
| 92307 | 92308 | 92313 | 92314 |

| San Bernardino County | | | |
|-----------------------|-------|-------|-------|
| 92315 | 92316 | 92317 | 92318 |
| 92321 | 92322 | 92324 | 92325 |
| 92329 | 92331 | 92333 | 92334 |
| 92335 | 92336 | 92337 | 92339 |
| 92340 | 92341 | 92342 | 92344 |
| 92345 | 92346 | 92350 | 92352 |
| 92354 | 92356 | 92357 | 92358 |
| 92359 | 92368 | 92369 | 92371 |
| 92372 | 92373 | 92374 | 92375 |
| 92376 | 92377 | 92378 | 92382 |
| 92385 | 92386 | 92391 | 92392 |
| 92393 | 92394 | 92395 | 92397 |
| 92399 | 92401 | 92402 | 92403 |
| 92404 | 92405 | 92406 | 92407 |
| 92408 | 92410 | 92411 | 92413 |
| 92415 | 92418 | 92423 | 92427 |

| San Diego County | | | |
|------------------|-------|-------|-------|
| 91901 | 91902 | 91903 | 91905 |
| 91906 | 91908 | 91909 | 91910 |
| 91911 | 91912 | 91913 | 91914 |
| 91915 | 91916 | 91917 | 91921 |
| 91931 | 91932 | 91933 | 91935 |
| 91941 | 91942 | 91943 | 91944 |
| 91945 | 91946 | 91948 | 91950 |
| 91951 | 91962 | 91963 | 91976 |
| 91977 | 91978 | 91979 | 91980 |
| 91987 | 92003 | 92007 | 92008 |
| 92009 | 92010 | 92011 | 92013 |
| 92014 | 92018 | 92019 | 92020 |

| San Diego County | | | |
|------------------|-------|-------|-------|
| 92021 | 92022 | 92023 | 92024 |
| 92025 | 92026 | 92027 | 92028 |
| 92029 | 92030 | 92033 | 92036 |
| 92037 | 92038 | 92039 | 92040 |
| 92046 | 92049 | 92051 | 92052 |
| 92054 | 92055 | 92056 | 92057 |
| 92058 | 92059 | 92060 | 92061 |
| 92064 | 92065 | 92067 | 92068 |
| 92069 | 92071 | 92072 | 92074 |
| 92075 | 92078 | 92079 | 92081 |
| 92082 | 92083 | 92084 | 92085 |
| 92088 | 92091 | 92092 | 92093 |
| 92096 | 92101 | 92102 | 92103 |
| 92104 | 92105 | 92106 | 92107 |
| 92108 | 92109 | 92110 | 92111 |
| 92112 | 92113 | 92114 | 92115 |
| 92116 | 92117 | 92118 | 92119 |
| 92120 | 92121 | 92122 | 92123 |
| 92124 | 92126 | 92127 | 92128 |
| 92129 | 92130 | 92131 | 92132 |
| 92134 | 92135 | 92136 | 92137 |
| 92138 | 92139 | 92140 | 92142 |
| 92143 | 92145 | 92147 | 92149 |
| 92150 | 92152 | 92153 | 92154 |
| 92155 | 92158 | 92159 | 92160 |
| 92161 | 92163 | 92165 | 92166 |
| 92167 | 92168 | 92169 | 92170 |
| 92171 | 92172 | 92173 | 92174 |
| 92175 | 92176 | 92177 | 92178 |
| 92179 | 92182 | 92186 | 92187 |
| 92190 | 92191 | 92192 | 92193 |

| San Diego County | | | |
|------------------|-------|-------|-------|
| 92195 | 92196 | 92197 | 92198 |
| 92199 | | | |

| San Francisco County | | | |
|----------------------|-------|-------|-------|
| 94102 | 94103 | 94104 | 94105 |
| 94107 | 94108 | 94109 | 94110 |
| 94111 | 94112 | 94114 | 94115 |
| 94116 | 94117 | 94118 | 94119 |
| 94120 | 94121 | 94122 | 94123 |
| 94124 | 94125 | 94126 | 94127 |
| 94128 | 94129 | 94130 | 94131 |
| 94132 | 94133 | 94134 | 94137 |
| 94139 | 94140 | 94141 | 94142 |
| 94143 | 94144 | 94145 | 94146 |
| 94147 | 94151 | 94158 | 94159 |
| 94160 | 94161 | 94163 | 94164 |
| 94172 | 94177 | 94188 | |

| San Joaquin County | | | |
|--------------------|-------|-------|-------|
| 94514 | 95201 | 95202 | 95203 |
| 95204 | 95205 | 95206 | 95207 |
| 95208 | 95209 | 95210 | 95211 |
| 95212 | 95213 | 95214 | 95215 |
| 95219 | 95220 | 95227 | 95230 |
| 95231 | 95234 | 95236 | 95237 |
| 95240 | 95241 | 95242 | 95253 |
| 95258 | 95267 | 95269 | 95296 |
| 95297 | 95304 | 95320 | 95330 |

| San Joaquin County | | | |
|--------------------|-------|-------|-------|
| 95336 | 95337 | 95361 | 95366 |
| 95376 | 95377 | 95378 | 95385 |
| 95391 | 95632 | 95686 | 95690 |

| San Luis Obispo County | | | |
|------------------------|-------|-------|-------|
| 93401 | 93402 | 93403 | 93405 |
| 93406 | 93407 | 93408 | 93409 |
| 93410 | 93412 | 93420 | 93421 |
| 93422 | 93423 | 93424 | 93426 |
| 93428 | 93430 | 93432 | 93433 |
| 93435 | 93442 | 93443 | 93444 |
| 93445 | 93446 | 93447 | 93448 |
| 93449 | 93451 | 93453 | 93461 |
| 93465 | 93475 | 93483 | |

| San Mateo County | | | |
|------------------|-------|-------|-------|
| 94002 | 94005 | 94010 | 94011 |
| 94014 | 94015 | 94016 | 94017 |
| 94018 | 94019 | 94020 | 94021 |
| 94025 | 94026 | 94027 | 94028 |
| 94030 | 94037 | 94038 | 94044 |
| 94060 | 94061 | 94062 | 94063 |
| 94064 | 94065 | 94066 | 94070 |
| 94074 | 94080 | 94083 | 94128 |
| 94303 | 94401 | 94402 | 94403 |
| 94404 | 94497 | | |

| Santa Barbara County | | | |
|----------------------|-------|-------|-------|
| 93013 | 93014 | 93067 | 93101 |
| 93102 | 93103 | 93105 | 93106 |
| 93107 | 93108 | 93109 | 93110 |
| 93111 | 93116 | 93117 | 93118 |
| 93120 | 93121 | 93130 | 93140 |
| 93150 | 93160 | 93190 | 93199 |
| 93460 | 93463 | 93464 | |

| Santa Clara County | | | |
|--------------------|-------|-------|-------|
| 94022 | 94023 | 94024 | 94035 |
| 94039 | 94040 | 94041 | 94042 |
| 94043 | 94085 | 94086 | 94087 |
| 94088 | 94089 | 94301 | 94302 |
| 94303 | 94304 | 94305 | 94306 |
| 94309 | 94550 | 95002 | 95008 |
| 95009 | 95011 | 95013 | 95014 |
| 95015 | 95020 | 95021 | 95023 |
| 95026 | 95030 | 95031 | 95032 |
| 95033 | 95035 | 95036 | 95037 |
| 95038 | 95042 | 95044 | 95046 |
| 95050 | 95051 | 95052 | 95053 |
| 95054 | 95055 | 95056 | 95070 |
| 95071 | 95076 | 95101 | 95103 |
| 95106 | 95108 | 95109 | 95110 |
| 95111 | 95112 | 95113 | 95115 |
| 95116 | 95117 | 95118 | 95119 |
| 95120 | 95121 | 95122 | 95123 |
| 95124 | 95125 | 95126 | 95127 |
| 95128 | 95129 | 95130 | 95131 |

| Santa Clara County | | | |
|--------------------|-------|-------|-------|
| 95132 | 95133 | 95134 | 95135 |
| 95136 | 95138 | 95139 | 95140 |
| 95141 | 95148 | 95150 | 95151 |
| 95152 | 95153 | 95154 | 95155 |
| 95156 | 95157 | 95158 | 95159 |
| 95160 | 95161 | 95164 | 95170 |
| 95172 | 95173 | 95190 | 95191 |
| 95192 | 95193 | 95194 | 95196 |

| Santa Cruz County | | | |
|-------------------|-------|-------|-------|
| 95001 | 95003 | 95005 | 95006 |
| 95007 | 95010 | 95017 | 95018 |
| 95019 | 95033 | 95041 | 95060 |
| 95061 | 95062 | 95063 | 95064 |
| 95065 | 95066 | 95067 | 95073 |
| 95076 | 95077 | | |

| Solano County | | | |
|---------------|-------|-------|-------|
| 94503 | 94510 | 94589 | 94592 |
| 95620 | | | |

| Stanislaus County | | | |
|-------------------|-------|-------|-------|
| 95307 | 95313 | 95316 | 95319 |
| 95323 | 95326 | 95328 | 95329 |
| 95350 | 95351 | 95352 | 95353 |
| 95354 | 95355 | 95356 | 95357 |
| 95358 | 95361 | 95363 | 95367 |
| 95368 | 95380 | 95381 | 95382 |

| Stanislaus County | | | |
|-------------------|-------|-------|--|
| 95386 | 95387 | 95397 | |

| Tulare County | | | |
|---------------|-------|-------|-------|
| 93212 | 93218 | 93219 | 93221 |
| 93223 | 93227 | 93235 | 93237 |
| 93244 | 93247 | 93256 | 93257 |
| 93260 | 93267 | 93270 | 93271 |
| 93272 | 93274 | 93277 | 93282 |
| 93286 | 93291 | 93292 | 93603 |
| 93615 | 93618 | 93631 | 93647 |
| 93670 | 93673 | | |

| Ventura County | | | |
|----------------|-------|-------|-------|
| 91319 | 91320 | 91358 | 91359 |
| 91360 | 91361 | 91362 | 91377 |
| 93001 | 93002 | 93003 | 93004 |
| 93005 | 93006 | 93007 | 93009 |
| 93010 | 93011 | 93012 | 93015 |
| 93016 | 93020 | 93021 | 93022 |
| 93023 | 93024 | 93030 | 93031 |
| 93032 | 93033 | 93034 | 93035 |
| 93036 | 93040 | 93041 | 93042 |
| 93043 | 93044 | 93060 | 93061 |
| 93062 | 93063 | 93064 | 93065 |
| 93066 | 93094 | 93099 | |

| Yolo County | | | |
|-------------|-------|-------|-------|
| 95605 | 95606 | 95607 | 95612 |
| 95616 | 95617 | 95618 | 95627 |
| 95637 | 95645 | 95653 | 95691 |
| 95694 | 95695 | 95697 | 95698 |
| 95776 | 95798 | 95799 | 95937 |

Infertility Services Rider

Group Rider
HMO

Additional Blue Shield Infertility Benefits
Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this Infertility services Benefit.

| Benefits | Your Payment | |
|--|-------------------------------------|---|
| | When using a Participating Provider | When using a Non-Participating Provider |
| Infertility Services | 50% of the Allowed Charges | Not covered |
| <i>Services are not subject to any applicable Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.</i> | | |

Assisted Reproductive Technology (ART)
Procedures and Associated Services

| Lifetime Benefit Maximums | |
|---|-------------|
| Natural artificial inseminations | 6/lifetime |
| <i>Without ovum [oocyte or ovarian tissue (egg)] stimulation</i> | |
| Stimulated artificial inseminations | 3/lifetime |
| <i>With ovum [oocyte or ovarian tissue] stimulation</i> | |
| Gamete intrafallopian transfer (GIFT) | 1 /lifetime |
| Cryopreservation of embryos, oocytes, ovarian tissue, sperm | 1 /lifetime |
| <i>Retrieved from a Member. Includes one retrieval and one year of storage per person</i> | |

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

Introduction

The Member is entitled to Benefits under this Infertility Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician to a Member for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Benefits

Benefits are provided for a Member who has a current diagnosis of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Member is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered by the provider to induce fertilization. Self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance under the *Prescription Drug Benefits* section of the Evidence of Coverage. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

Benefits are only provided for services received from Participating Providers.

The Calendar Year Medical Deductible does not apply to these Covered Services, and Cost Share for these Covered Services does not apply towards the Out-of-Pocket Maximum responsibility.

Exclusions

No Benefits are provided for:

- ART and associated services related to intracytoplasmic sperm injection (ICSI);
- ART and associated services related to zygote intrafallopian transfer (ZIFT);
- ART and associated services related to in vitro fertilization (IVF);
- Services received from Non-Participating Providers;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this Infertility Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this Infertility Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Member had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; or
- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Member who has diagnosed Infertility as defined at the time services are provided.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
 - Qualified sign language interpreters
 - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)

Fax: (844) 696-6070

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Notice of the Availability of Language Assistance Services

Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知： 您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa librang tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosish yíiniłta'go bííniłhah? Doo bííniłhahgóó éí, naaltsoos nich'í' yíidóoltałhígíí ła' nihee hółó. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoolníł nínízingo bííghah. Doo ɓaah ilínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiłnih dóó námboo éí díí Blue Shield bee néiho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jì' hodiłnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要： お客様は、この手紙を読むことができますか？もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیاران قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتري تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866). (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้
คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย
โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร
(866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मੈबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້.
ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ,
ຫຼືໂທໂປຫາເບີ(866) 346-7198. (Laotian)