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Blue Shield Trio Platinum 90 HMO 0/25 PCP + Child Dental INF

Período de cobertura: del 1/1/2027 en adelante

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

El Resumen de Beneficios y Cobertura (SBC, por sus siglas en inglés) lo ayudará a escoger un plan de salud. El SBC le muestra cómo usted y el plan compartirían el costo de los servicios de atención de la salud cubiertos. NOTA: Se entregará por separado información sobre el costo de este plan (llamado "prima"). Este documento es solo un resumen. Para obtener más información sobre su cobertura o conseguir una copia de los términos de cobertura completos, visite bsca.com/policies/M0046314_EOC.pdf o llame al **1-855-258-3744**. Para ver una definición general de las palabras usadas con frecuencia, como cantidad permitida, facturación del saldo, coseguro, copago, deducible, proveedor u otras palabras subrayadas, consulte el Glosario. Puede ver el Glosario en healthcare.gov/sbc-glossary o llamar al **1-866-444-3272** para pedir una copia.

Preguntas importantes	Respuestas	Conceptos importantes:
¿Cuál es el deducible general?	**$0.**	Vea el cuadro de situaciones médicas comunes que está a continuación para conocer los costos de los servicios que cubre este plan.
¿Hay servicios que están cubiertos antes de que alcance su deducible?	Sí. La atención preventiva y los servicios que están incluidos en los términos de cobertura completos.	Este plan cubre algunos productos y servicios aunque todavía no haya alcanzado la cantidad del deducible. Sin embargo, es posible que tenga que pagar un copago o coseguro. Por ejemplo, este plan cubre ciertos servicios preventivos sin costo compartido y antes de que alcance su deducible. Vea la lista de servicios preventivos cubiertos en healthcare.gov/coverage/preventive-care-benefits.
¿Hay otros deducibles para servicios específicos?	No.	No tiene que alcanzar deducibles para servicios específicos.
¿Cuál es el límite de gastos de bolsillo para este plan?	**$5,000** por persona/**$10,000** por familia para proveedores participantes.	El límite de gastos de bolsillo es la cantidad máxima que podría pagar en un año por los servicios cubiertos. Si tiene otros familiares incluidos en este plan, tienen que alcanzar sus propios límites de gastos de bolsillo hasta que se haya alcanzado el límite de gastos de bolsillo familiar total.
¿Qué no se incluye en el límite de gastos de bolsillo?	Los copagos para ciertos servicios, las primas y la atención de la salud que no cubra este plan.	Aunque usted pague estos gastos, no cuentan para el límite de gastos de bolsillo.
¿Pagará menos si usa un proveedor de la red?	Sí. Para ver una lista de proveedores de la red, visite blueshieldca.com/fad o llame al **1-855-258-3744**.	Este plan usa una red de proveedores. Pagará menos si usa un proveedor de la red del plan. Sin embargo, pagará la cantidad máxima si usa un proveedor fuera de la red; además, un proveedor podría enviarle una factura por la diferencia entre lo que cobra el proveedor y lo que paga su plan (facturación del saldo). Tenga en cuenta que su proveedor de la red podría usar un proveedor fuera de la red para algunos servicios (como los análisis de laboratorio). Pregúntele a su proveedor antes de recibir los servicios.
¿Necesita una referencia para ver a un especialista?	Sí.	Este plan pagará una parte o la totalidad de los costos de los servicios cubiertos en la consulta con un especialista, pero solo si usted tiene una referencia antes de la consulta con el especialista.

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

Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si visita el consultorio o la clínica de un proveedor de atención de la salud	Visita de atención primaria para tratar una lesión o enfermedad	$25/visita	Sin cobertura	----------Ninguna----------
	Visita a un especialista	*Especialista de Trio+ Specialist*: $40/visita *Otro especialista*: $40/visita	Sin cobertura	La autorreferencia está disponible para las visitas a especialistas de Trio+ Specialist.
	Atención preventiva/pruebas de detección/inmunizaciones	Sin cargo	Sin cobertura	Es posible que tenga que pagar por los servicios que no sean preventivos. Pregúntele a su proveedor si los servicios que necesita son preventivos. Después averigüe qué pagará su plan.
Si se hace una prueba	Prueba de diagnóstico (radiografías, análisis de sangre)	*Análisis de laboratorio y patología*: $20/visita *Radiografías y diagnóstico por imágenes:* $35/visita *Otros exámenes de diagnóstico:* $35/visita	*Análisis de laboratorio y patología*: Sin cobertura *Radiografías y diagnóstico por imágenes:* Sin cobertura *Otros exámenes de diagnóstico:* Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. Los servicios mencionados se brindan en un centro independiente.
	Diagnóstico por imágenes (tomografía computarizada, tomografía por emisión de positrones e imágenes por resonancia magnética)	*Centro de radiología para pacientes ambulatorios*: $150/visita *Hospital para pacientes ambulatorios*: $150/visita	*Centro de radiología para pacientes ambulatorios*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.

*** Para tener más información sobre las limitaciones y las excepciones, lea el documento del plan o la póliza en bsca.com/policies/M0046314_EOC.pdf.**

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Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si necesita medicamentos para tratar su enfermedad o problema de salud Hay más información disponible sobre la **cobertura de medicamentos recetados** en blueshieldca.com/formulary	Nivel 1	*Al por menor*: Nivel A: $10/receta Nivel B: $15/receta *Entrega en el hogar*: $20/receta	*Al por menor*: Sin cobertura *Entrega en el hogar*: Sin cobertura	Se necesita autorización previa para ciertos medicamentos. Si no consigue una autorización previa, es posible que no se paguen los beneficios. *Al por menor*: Cubre un suministro de hasta 30 días; pueden cubrirse 90 días con un copago por cada suministro de 30 días. *Entrega en el hogar*: Cubre un suministro de hasta 90 días.
	Nivel 2	*Al por menor*: Nivel A: $25/receta Nivel B: $40/receta *Entrega en el hogar*: $50/receta	*Al por menor*: Sin cobertura *Entrega en el hogar*: Sin cobertura	
	Nivel 3	*Al por menor*: Nivel A: $40/receta Nivel B: $60/receta *Entrega en el hogar*: $80/receta	*Al por menor*: Sin cobertura *Entrega en el hogar*: Sin cobertura	
	Nivel 4	*Farmacias especializadas de la red y al por menor*: 10 % de coseguro hasta un máximo de $250/receta *Entrega en el hogar*: 10 % de coseguro hasta un máximo de $500/receta	*Al por menor*: Sin cobertura *Entrega en el hogar*: Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. *Farmacias especializadas de la red y al por menor*: Cubre un suministro de hasta 30 días. Los medicamentos especializados deben comprarse en una farmacia especializada de la red. *Entrega en el hogar*: Cubre un suministro de hasta 90 días.

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		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si le tienen que hacer una cirugía ambulatoria	Tarifa del centro de atención (p. ej., centro quirúrgico ambulatorio)	*Centro quirúrgico ambulatorio*: $100/cirugía *Hospital para pacientes ambulatorios*: $100/cirugía	*Centro quirúrgico ambulatorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	----------Ninguna----------
	Tarifas del médico/cirujano	$35/visita	Sin cobertura	
Si necesita atención médica inmediata	Atención en la sala de emergencias	*Tarifa del centro de atención*: $250/visita *Tarifa del médico*: Sin cargo	*Tarifa del centro de atención*: $250/visita *Tarifa del médico*: Sin cargo	----------Ninguna----------
	Transporte médico de emergencia	$150/transporte	$150/transporte	Este pago es para transporte autorizado o de emergencia.
	Atención urgente	$25/visita	*Dentro del área de servicio del plan*: Sin cobertura *Fuera del área de servicio del plan*: $25/visita	----------Ninguna----------

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Situación médica común	Servicios que puede necesitar	Lo que pagará usted		Limitaciones, excepciones y otra información importante
		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
En caso de hospitalización	Tarifa del centro de atención (p. ej., la habitación del hospital)	$300/día hasta un máximo de 5 días/admisión	Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
	Tarifas del médico/cirujano	Sin cargo	Sin cobertura	----------Ninguna----------
Si necesita servicios de salud mental, conductual o por abuso de sustancias adictivas	Servicios para pacientes ambulatorios	*Visita al consultorio*: $25/visita *Otros servicios para pacientes ambulatorios*: $25/visita *Hospitalización parcial*: $25/visita *Pruebas psicológicas y neuropsicológicas*: $25/visita	*Visita al consultorio*: Sin cobertura *Otros servicios para pacientes ambulatorios:* Sin cobertura *Hospitalización parcial*: Sin cobertura *Pruebas psicológicas y neuropsicológicas*: Sin cobertura	Se necesita autorización previa, menos para las visitas al consultorio y el tratamiento en el consultorio por dependencia de opioides. Si no consigue una autorización previa, es posible que no se paguen los beneficios.
	Servicios para pacientes internados	*Servicios para pacientes internados brindados por un médico*: Sin cargo *Servicios hospitalarios*: $300/día hasta un máximo de 5 días/admisión *Atención en una residencia:* $300/día hasta un máximo de 5 días/admisión	*Servicios para pacientes internados brindados por un médico:* Sin cobertura *Servicios hospitalarios:* Sin cobertura *Atención en una residencia*: Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios.

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		Proveedor participante (pagará lo mínimo)	Proveedor no participante (pagará lo máximo)	
Si está embarazada	Visitas al consultorio	Sin cargo	Sin cobertura	----------Ninguna----------
	Servicios profesionales para el nacimiento/parto	Sin cargo	Sin cobertura	
	Servicios de un centro de atención para el nacimiento/parto	$300/día hasta un máximo de 5 días/admisión	Sin cobertura	
Si necesita ayuda para su recuperación u otros cuidados de salud especiales	Atención de la salud en el hogar	$20/visita	Sin cobertura	Se necesita autorización previa. Si no consigue una autorización previa, es posible que no se paguen los beneficios. Cobertura limitada a 100 visitas por miembro por año calendario.
	Servicios de rehabilitación	*Visita al consultorio*: $25/visita *Hospital para pacientes ambulatorios*: $25/visita	*Visita al consultorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	----------Ninguna----------
	Servicios de habilitación	*Visita al consultorio*: $25/visita *Hospital para pacientes ambulatorios*: $25/visita	*Visita al consultorio*: Sin cobertura *Hospital para pacientes ambulatorios:* Sin cobertura	

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

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Servicios excluidos y otros servicios cubiertos:

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

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

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

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

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

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

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

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

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Servicios de acceso a idiomas:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Declaración de divulgación de la PRA

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

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Sobre estos ejemplos de cobertura:

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

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

- **Deducible general del plan** **$0**
- **Copago de especialista** **$40**
- **Copago de hospital (centro)** **$300**
- **Otro copago** **$20**

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

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

En este ejemplo, Peg pagaría:

Costo compartido	
Deducibles	$0
Copagos	$1,000
Coseguro	$0
Lo que no está cubierto	
Límites o exclusiones	$60
Total que pagaría Peg	**$1,060**

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

- **Deducible general del plan** **$0**
- **Copago de especialista** **$40**
- **Copago de hospital (centro)** **$300**
- **Otro copago** **$20**

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

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

En este ejemplo, Joe pagaría:

Costo compartido	
Deducibles	$0
Copagos	$800
Coseguro	$80
Lo que no está cubierto	
Límites o exclusiones	$20
Total que pagaría Joe	**$900**

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

- **Deducible general del plan** **$0**
- **Copago de especialista** **$40**
- **Copago de hospital (centro)** **$300**
- **Otro copago** **$35**

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

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

En este ejemplo, Mía pagaría:

Costo compartido	
Deducibles	$0
Copagos	$600
Coseguro	$30
Lo que no está cubierto	
Límites o exclusiones	$0
Total que pagaría Mía	**$630**

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

Evidence of Coverage

Small Group Plan

Blue Shield Trio Platinum 90 HMO 0/25 PCP + Child Dental

Provider Network: Trio

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Summary of Benefits

Group Plan
HMO Plan

Blue Shield Trio Platinum 90 HMO 0/25 PCP + Child Dental

This Summary of Benefits shows the amount you will pay for Covered Benefits 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 Benefits under the Plan.

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

Calendar Year Out-of-Pocket Maximum[4]

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

	When using a Participating Provider[3]
Individual coverage	$5,000
Family coverage	$5,000: individual
	$10,000: Family

No Annual or Lifetime Dollar Limit

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

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Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$25/visit	
Trio+ specialist care office visit (self-referral)	$40/visit	
Other specialist care office visit (referred by PCP)	$40/visit	
Physician home visit	$25/visit	
Physician or surgeon services in an Outpatient Facility	$35/visit	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$25/visit	
Acupuncture services	$25/visit	
Chiropractic services	Not covered	
Teladoc Health 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	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and initial postnatal	$0	
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$250/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Urgent care center services	$25/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$150/transport	
Outpatient Facility services		
Ambulatory Surgery Center	$100/surgery	
Outpatient Department of a Hospital: surgery	$100/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	
Inpatient facility services		
Hospital services and stay	$300/day up to 5 days/admission	
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*		
• Special transplant facility inpatient services	$300/day up to 5 days/admission	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Benefits that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Benefits that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$20/visit	
• Outpatient Department of a Hospital	$20/visit	
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$35/visit	
• Outpatient Department of a Hospital	$35/visit	
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*		
• Office location	$35/visit	
• Outpatient Department of a Hospital	$35/visit	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*		
• Outpatient radiology center	$150/visit	

Benefits[5]	Your payment When using a Participating Provider[3]	CYD[2] applies
• Outpatient Department of a Hospital	$150/visit	
Rehabilitative and Habilitative Services *Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services. There is no visit limit for Rehabilitative or Habilitative Services.*		
Office location	$25/visit	
Outpatient Department of a Hospital	$25/visit	
Durable medical equipment (DME)		
DME	10%	
Breast pump	$0	
Orthotic equipment and devices	10%	
Prosthetic equipment and devices	10%	
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	$20/visit	
Home infusion and home injectable therapy services		
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$0	
Hemophilia home infusion services *Includes blood factor products.*	$0	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*		
Freestanding SNF	$150/day up to 5 days/admission	
Hospital-based SNF	$150/day up to 5 days/admission	
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	10%	
• Self-management training	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
• Medical nutrition therapy	$0	
Dialysis services	10%	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	10%	

Mental Health or Substance Use Disorder Benefits	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$25/visit	
Teladoc Health mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism		
• Office location, clinic, home, or other non-institutional facility setting	$25/visit	
• Outpatient Department of a Hospital	$25/visit	
Office-based opioid treatment	$25/visit	
Partial Hospitalization Program	$25/visit	
Neuropsychological and Psychological Testing	$25/visit	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$300/day up to 5 days/admission	
Residential Care	$300/day up to 5 days/admission	

Prescription Drug Benefits[7,8]	Your payment		
	When using a Participating Pharmacy[3]		CYD[2] applies
	Level A	Level B	
Retail pharmacy prescription Drugs			
Per prescription, up to a 30-day supply.			
Contraceptive Drugs and devices	$0	$0	
Tier 1 Drugs	$10/prescription	$15/prescription	
Tier 2 Drugs	$25/prescription	$40/prescription	
Tier 3 Drugs	$40/prescription	$60/prescription	

Prescription Drug Benefits[7,8]	Your payment		
	When using a Participating Pharmacy[3]		CYD[2] applies
Tier 4 Drugs	10% up to $250/prescription	10% up to $250/prescription	
Retail pharmacy prescription Drugs			
Per prescription, for a 90-day supply.			
Contraceptive Drugs and devices	$0	$0	
Tier 1 Drugs	$30/prescription	$45/prescription	
Tier 2 Drugs	$75/prescription	$120/prescription	
Tier 3 Drugs	$120/prescription	$180/prescription	
Tier 4 Drugs	10% up to $750/prescription	10% up to $750/prescription	
Home delivery pharmacy prescription Drugs			
Per prescription, for a 31-90-day supply.			
Contraceptive Drugs and devices	$0		
Tier 1 Drugs	$20/prescription		
Tier 2 Drugs	$50/prescription		
Tier 3 Drugs	$80/prescription		
Tier 4 Drugs	10% up to $500/prescription		

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	When using a Participating Dentist[3]	CYD[2] applies
Pediatric dental[9]		
Diagnostic and preventive services		
• Oral exam	$0	
• Preventive – cleaning	$0	
• Preventive – x-ray	$0	
• Sealants per tooth	$0	
• Topical fluoride application	$0	
• Space maintainers - fixed	$0	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**
Basic services • Restorative procedures • Periodontal maintenance • Adjunctive general services	See Dental Copay Schedule in Evidence of Coverage	
Major services • Oral surgery • Endodontics • Periodontics (other than maintenance) • Crowns and casts • Prosthodontics	See Dental Copay Schedule in Evidence of Coverage	
Orthodontics (Medically Necessary)	$1,000	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**
Pediatric vision[10]		
Comprehensive eye examination *One exam per Calendar Year.*		
• Ophthalmologic visit	$0	
• Optometric visit	$0	
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	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Provider[3]**	**CYD[2] applies**
Non-collection frames	All charges above $150	
• Eyeglass lenses		
Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.		
Single vision	$0	
Lined bifocal	$0	
Lined trifocal	$0	
Lenticular	$0	
Optional eyeglass lenses and treatments		
• Ultraviolet protective coating (standard only)	$0	
• Polycarbonate lenses	$0	
• Standard progressive lenses	$0	
• Premium progressive lenses	$95	
• Anti-reflective lens coating (standard only)	$35	
• Photochromic - glass lenses	$25	
• Photochromic - plastic lenses	$0	
• High index lenses	$30	
• Polarized lenses	$45	
Low vision testing and equipment		
• Comprehensive low vision exam	$0	
Once every 5 Calendar Years.		
• Low vision devices	$0	
One aid per Calendar Year.		

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 Benefits under the Plan.

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

Notes

3 Using Participating Providers:

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

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 Benefits in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowed Charges for Covered Benefits for the rest of the Calendar Year.

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

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

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

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section of the EOC for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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.

Notes

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.

Retail pharmacy. You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

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.

Home delivery. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the home delivery pharmacy.

Insulin. You will not pay more than $35 for a 30-day supply of Formulary insulin Prescription Drugs from a Participating Pharmacy.

9 Pediatric Dental Coverage:

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

Orthodontic Covered Benefits. The Copayment or Coinsurance for Medically Necessary orthodontic Covered Benefits 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.

Teledentistry. To the extent this Plan offers teledentistry, it is offered at no charge.

Administration of these plan designs must comply 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.

These endnotes do not limit an issuer's obligations to comply with applicable federal, state, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these endnotes.

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 $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 Benefits.

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 Benefits. 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:

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

If you need information about	*You should contact*
Accolade Care virtual primary care, mental health care, and Specialist care, including scheduling an appointment	Accolade Care Customer Service: (844) 560-6649
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 or Substance Use Disorder services, including prior authorization	Mental Health Customer Service: (877) 263-9952 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540

Contacting customer service	
If you need information about	***You should contact***
Pediatric dental Benefits	Dental Customer Service: (800) 605-8202 Blue Shield of California Dental Plan Administrator P.O. Box 272540 Chico, CA 95927-2540
Pediatric vision Benefits	Vision Customer Service: (877) 601-9083

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 information about your rights and responsibilities.
2	Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
3	Make recommendations regarding the Plan's member rights and responsibilities policy.
4	Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
5	Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
6	Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
7	Receive timely and geographically accessible health care.
8	Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
9	Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
10	Certain accommodations for your disability, including: • Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility. • Full and equal access, as other members of the public, to medical facilities. • Extra time for visits if you need it. • Taking your service animal into exam rooms with you.
11	Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
12	Receive considerate and courteous care and be treated with respect and dignity.

	As a Blue Shield Member, you have the right to:
13	Receive culturally competent care, including but not limited to: • Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions. • To be addressed by your preferred name and pronoun.
14	Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
15	Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
16	A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
17	Receive health care coverage even if you have a pre-existing condition.
18	Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
19	Receive certain Preventive Health Services, including many without a co-pay, Coinsurance, or Deductible.
20	Have no annual or lifetime dollar limits on basic health care services.
21	Keep eligible Dependent(s) on your Plan.
22	Be notified of an unreasonable rate increase or change, as applicable.
23	Protection from illegal balance billing by a Health Care Provider.
24	Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
25	Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
26	Ask most Health Care Providers for information regarding who has received your personal health information.
27	Ask your Plan or your doctor to contact you only in certain ways or at certain locations.

	As a Blue Shield Member, you have the right to:
28	Have your medical information related to sensitive services protected.
29	Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
30	Have an interpreter who speaks your language at all points of contact when you receive health care services.
31	Have an interpreter provided at no cost to you.
32	Receive written materials in your preferred language where required by law.
33	Have health information provided in a usable format if you are blind, deaf, or have low vision.
34	Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
35	Have an Advanced Health Care Directive.
36	Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
37	File a complaint, grievance, or appeal in your preferred language about: • Your Plan or Health Care Provider. • Any care you receive, or access to care you seek. • Any covered service or benefit decision that your Plan makes. • Any improper charges or bills for care. • Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions. • Not meeting your language needs.
38	Know why your Plan denies a service or treatment.
39	Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
40	Ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

Your responsibilities

	As a Blue Shield Member, you have the responsibility to:
1	Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
2	Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
3	Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
4	To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
5	Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
6	Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
7	Timely pay any premiums, copayments, and charges for non-covered services.
8	Notify your Plan as soon as reasonably possible if you are billed inappropriately.

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.

If you are assigned to the Accolade Care virtual Medical Group, some services may be provided outside of your Medical Group. Not all medical conditions can be appropriately treated through virtual services. Your Participating Provider will identify any condition that requires treatment by an in-person provider and will refer you to in-person care as appropriate. Your Cost Share for the in-person care will be the same as the amount due to a virtual Participating Provider.

Please note, services provided in a Hospital by house officers, residents, interns, or other professionals in training must be performed under the supervision of an attending Physician in association with an accredited clinical education program.

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*** 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 Benefits. Except for Emergency Services, Urgent Services, services received at a Participating Provider facility (Hospital, Ambulatory Surgery Center, laboratory, radiology center, imaging center, or certain other outpatient settings) under certain conditions, and services provided by a 988 center, Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, 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 Benefits 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.

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
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 Benefit 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
	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 virtual or in-person:

- 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 new PCP will either be virtual or in-person based on your prior PCP. You will be assigned to an Accolade Care virtual PCP if your prior PCP was a virtual Participating Provider or you will be assigned to an in-person PCP if your prior PCP was an in-person Participating Provider.

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 Benefits;
- 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.

If you are assigned to an Accolade Care virtual PCP, your integrated care team will assist your PCP with administrative responsibilities and coordination of care.

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

Changing your Medical Group

You can change your Medical Group by visiting blueshieldca.com. If your PCP is not part of your new Medical Group, you will also have to select a new PCP.

Changes to your Medical Group are effective on the first day of the month after Blue Shield approves the change, including changes to the Accolade Care virtual Medical Group through your member portal online. If you are assigned to the Accolade Care virtual Medical Group and you would like to make an immediate change, call Shield Concierge to request the change. Once the change is effective, 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.

You may not change Medical Groups while you are admitted to the Hospital or in the third trimester of pregnancy. Any requested changes to your Medical Group in these situations will not be effective until the first day of the month after the date of your discharge from the Hospital or completion of postpartum care.

A change in Medical Group during an ongoing course of treatment may interrupt your care. Any requested changes to your Medical Group during an ongoing course of treatment requires an exception. Exceptions must be approved by a Blue Shield Medical Director and will be effective when medically appropriate to transfer care. 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. If you are assigned to the Accolade Care virtual Medical Group, Specialist services will be provided outside of your Medical Group. Your PCP will refer you to a virtual or in-person Participating Provider as needed. Not all medical conditions can be appropriately treated through virtual services. Your Accolade Care virtual PCP will identify any condition that requires treatment by an in-person provider and will refer you to in-person care as appropriate. Your Cost Share for the in-person care will be the same as the amount due to a virtual Participating Provider.

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;
- Advanced 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.

If you are assigned to the Accolade Care virtual Medical Group, Specialist services will be provided outside of your Medical Group. You will need a referral from your PCP to see a Specialist.

Accolade

Blue Shield has contracted with Accolade, a Third Party Corporate Telehealth Provider, to provide telehealth (virtual) services and a telehealth technology platform. These virtual services are available to you if you select or if you are assigned to a virtual PCP in the Accolade Care Medical Group.

Benefits are available for ongoing primary care, mental health care, and Specialist care visits by phone or secure online video. Specialist care visits require a referral from your PCP. Some age restrictions apply. See the table below for age restrictions by service.

Integrated virtual care team

Benefits are provided through an integrated virtual care team that collaborates to manage and deliver health care, assist with some administrative tasks, and answer medical questions. The team includes your Primary Care Physician, mental health care provider, and a health coach.

Primary care

- On-going, routine care.
- Diagnosis and treatment of urgent concerns.
- PCPs can prescribe certain medications.
- Help with referrals to a virtual Specialist or in-person care as appropriate.
- Documentation of all care in the electronic medical record.
- Available to all Members, but a parent or guardian must be present for Members under age 18.

Mental health care

- Mental health visits with a marriage and family therapist (MFT) or a licensed clinical social worker (LCSW).
- Help directing you to a virtual Specialist or in-person care as appropriate in coordination with your PCP.
- Documentation of all care in the electronic medical record.
- Available to Members age 12 and older.

Health coach

- Assistance with scheduling.
- Assistance locating virtual Specialists or in-person care as appropriate in coordination with your PCP.
- Documentation of all care in the electronic medical record.
- Follow up to resolve questions.
- Available to all Members age 12 and older.

Specialist care

- Requires referral from your PCP.
- Diagnosis, treatment, and management of conditions by Specialists with the following specialties: allergy and immunology, cardiology, dermatology, dietary nutrition, endocrinology, gastroenterology, general surgery, HIV medicine, hepatology, infectious disease, nephrology, neurology, orthopedics, otolaryngology, physical medicine and rehabilitation, pulmonology, rheumatology, and urology.
- Specialists can prescribe certain medications.
- Help directing you to another virtual care provider or in-person care as appropriate in coordination with your PCP.
- Available for Members age 18 and older, except dermatologists, allergists, immunologists, and dietary nutritionists are available for Members age 12 and older.
- Documentation of all care in the electronic medical record.
- Members under age 18 require a parent or guardian be present.

Other program services

- Nurse triage with a registered nurse 24 hours a day, seven days a week to help you select appropriate care and to answer general health questions.

- Online tools such as appointment booking, flexible scheduling, prescription renewals, and messaging with your care team.
- Documentation of all care in the electronic medical record.

Not all medical conditions can be appropriately treated through virtual services. Your virtual PCP or Specialist will identify any condition that requires treatment by an in-person provider and will refer you to an in-person network provider as appropriate. Your Cost Share for the in-person care from a network provider will be the same as the amount due to a virtual network provider for the same service.

Call Shield Concierge for questions about virtual services or Participating Providers. You can also visit blueshieldca.com and click on Find a Doctor to access virtual Participating Providers.

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.

Continuity of care

Continuity of care may be available if:

- Blue Shield or the Medical Group 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 or the Medical Group will notify you of the option to continue treatment with your Former Participating Provider.

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

Continuity of care with a Former Participating Provider	
Qualifying conditions	***Timeframe***
Undergoing a course of institutional or inpatient care	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
Acute conditions	As long as the condition lasts
Maternal mental health condition	12 months after the condition's diagnosis or 12 months after the end of the pregnancy, whichever is later
Ongoing pregnancy care, including care immediately after giving birth	Up to 12 months
Recommended surgery or procedure documented to occur within 180 days	Within 180 days
Ongoing treatment for a child up to 36 months old	Up to 12 months
Serious chronic condition	Up to 12 months
Terminal illness	The duration of the terminal illness

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 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, the Former Participating Provider must accept Blue Shield's or the Medical Group's Allowed Charges as payment in full for the first 90 days of your ongoing care. Once the provider accepts and your request is authorized, you may continue to see the Former Participating Provider at the Participating Provider Cost Share.

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. If you are assigned to the Accolade Care virtual Medical Group, your PCP and the integrated care team will work with you to arrange for a second medical opinion from another virtual Participating Provider or from an in-person Participating Provider as necessary.

Who provides your second medical opinion

If you want a second opinion on	*It will come from*
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 Inter-Plan Program. The Blue Cross Blue Shield Association can help you access care in those geographic areas.

For Members assigned to the Accolade Care virtual Medical Group, you can also access routine care or Urgent Services from your Medical Group while traveling outside of California. The Accolade Care Participating Provider must be licensed in the state you are visiting.

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***.

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 or a Psychiatric 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 or a Psychiatric 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 Benefits from the Non-Participating Provider. If you are assigned to the Accolade Care virtual Medical Group, you can ask your Accolade Care PCP for approval to see a Non-Participating Provider when services cannot reasonably be obtained from a Participating Provider. The Accolade Care PCP will coordinate with Blue Shield to review your request for Medical Necessity, and if approved, Blue Shield will pay for Covered Benefits 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 Health

Teladoc Health, a Third-Party Corporate Telehealth Provider, provides health consultations by phone or secure online video. Teladoc Health general medical Physicians can diagnose and treat basic non-emergency medical conditions, and can also prescribe certain medication. Teladoc Health mental health consultations are available for Members age 13 and older. Members under age 13 may obtain telebehavioral health services for Mental Health or Substance Use Disorders from a Participating Provider. Teladoc Health is a supplemental service that is not intended to replace care from your PCP, or other Participating Provider, or your relationship with your PCP.

How to access Teladoc Health		
Teladoc Health service	***Ways to access***	***Availability***
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	24 hours a day, 7 days a week by phone or secure online video Consultations can be requested on-demand or by scheduled appointment
Mental health	Phone: 1-800-835-2362 Online: blueshieldca.com/teladochealth	7 a.m. to 9 p.m., 7 days a week by scheduled appointment only Consultations must be scheduled online and cannot be requested by phone

Telebehavioral health services

Online telebehavioral health services for Mental Health or Substance Use Disorders available through Participating Providers are a Covered Benefit regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. If you are currently receiving telebehavorial health services for Mental Health or Substance Use Disorders, you can continue to receive those services with a Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider. Visit blueshieldca.com and click on Find a Doctor to find a Participating Provider.

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.

Evaluations and services under the CARE Act

Blue Shield covers the cost of developing an evaluation and the provision of all health care services for an enrollee when required or recommended pursuant to a CARE (Community Assistance, Recovery, and Empowerment) agreement or CARE plan approved by a court in accordance with the CARE Act. The evaluation and services, other than prescription Drugs, are covered at no charge whether they are provided by a Participating or Non-Participating Provider.

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

When your appointment will occur	
Follow-up appointments with a mental or substance use disorder health provider (who is not a Physician)	Within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing Mental Health or Substance Use Disorder condition
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 triage or screening services by calling Shield Concierge	24 hours a day, seven days a week

Call Shield Concierge if you need help finding a Participating Provider or if a Participating Provider is not available. Please see the *If you cannot find a Participating Provider* section for more information.

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.

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 and use the chat feature to connect with a nurse. This service is free and confidential.

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

LifeReferrals 24/7SM

The LifeReferrals 24/7 SM 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. 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 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.

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 determined by Blue Shield. The requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. Your PCP will manage your prior authorization requests. If you are assigned to the Accolade Care virtual Medical Group, pre-approval will come from Blue Shield. Your Accolade Care PCP will coordinate with Blue Shield to review 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 or Substance Use Disorder services with a 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. Prescription Drugs intended for outpatient use must be obtained from a Participating Pharmacy as described in the *Prescription Drug Benefits* section.

The prior authorization process for self-administered prescription Drugs available at a retail, specialty, or home delivery pharmacy is explained in the *Prescription Drug Benefits* section.

Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Participating Provider.

For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for that disease will be covered without a Cost Share.

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical, Mental Health or Substance Use Disorder, dental, and vision requests	Within five business days, but not to exceed seven calendar days
Expedited medical, Mental Health or Substance Use Disorder, dental, and vision requests	Within 72 hours
Routine prescription Drug requests	Within 72 hours
Expedited prescription Drug requests	Within 24 hours

Once a decision is made for routine Mental Health or Substance Use Disorder requests, a written notice will be sent to you and your provider within five calendar days. For urgent Mental Health or Substance Use Disorder requests, a written notice will be sent to you and your provider within 72 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 or Blue Shield 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 Benefits

Your Cost Share is the amount you pay for Covered Benefits. 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 Benefits.

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Benefits provided or arranged by Blue Shield, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections. Covered Benefits 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 you are assigned to the Accolade Care virtual Medical Group and you are referred to an in-person Participating Provider, Blue Shield will pay the provider directly.

If there is a payment dispute between Blue Shield and a Participating Provider over Covered Benefits 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 Benefits before Blue Shield begins payment. Blue Shield will pay for some Covered Benefits before you meet your Deductible.

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

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

Your provider will ask you to pay your Copayment or Coinsurance at the time of service. For Covered Benefits 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 Benefit 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 Benefits 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 Benefits 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.

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 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 Shield Concierge. Your accrual balance information is updated once a claim is received and processed and may not reflect recent services.

Cost Share concepts in action

To recap, you are responsible for all costs for Covered Benefits until you reach your Deductible. Once you reach your Deductible, Blue Shield will pay the Allowed Charges for Covered Benefits, 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 Benefits. 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 Benefits 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 Copyament.

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 will process your claim within 30 calendar days of receipt if it

is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. Blue Shield cannot process your claim until we receive the missing information. Once the missing information is received, Blue Shield will have 30 calendar days to process your claim. Blue Shield may send the payment to the Subscriber or directly to the Non-Participating Provider.

Claim forms are available at blueshieldca.com/covered-california-policies . 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	• 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	• Prescription Drug claim form; and • Related receipts or the pharmacy's bill	Blue Shield of California 1606 Ave. Ponce de Leon San Juan, PR 00909-4830	Within one year of the service date
Mental Health or Substance Use Disorder Services	• 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	• 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	• Vision claim form; and • Related receipts or the provider's bill	Blue Shield of California Vision Plan Administrator Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	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 101 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

- 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 *Extension of Benefits*, *Continuity of care* and *Continuation of group coverage* sections.

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 1991 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 Benefits.

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.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services and Emergency Medical Services programs

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.

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

Benefits are also available for Covered Benefits provided by community paramedicine programs, triage to alternate destination programs, and mobile integrated health programs developed by local Emergency Medical Services (EMS) agencies. Covered Benefits provided by these EMS programs are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

Examples of transportation that is not provided by a licensed ambulance or psychiatric transport van include transportation by car, taxi, bus, gurney van, or wheelchair van.

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 Benefits. 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.

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 continuous blood glucose monitors and those designed to help the visually impaired, and all related necessary supplies;
- 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.

Examples of routine foot care items and services that are personal or comfort items and not Medically Necessary, include:

- 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.

Self-management training and medical nutrition therapy

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:

- Basic diagnostic imaging services, such as plain film X-rays, ultrasounds, and mammography;
- Advanced diagnostic radiological and nuclear imaging, including CT, PET, MRI, and MRA scans;
- COVID-19 diagnostic testing, screening testing, and related healthcare services. 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, subject to a maximum reimbursement of $12 per test. See the *Claims for Emergency or Urgent Services* section for information about how to submit a claim for repayment for this Benefit;
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of your disease or condition to guide treatment decisions. Benefits must be prior authorized;
- Clinical pathology services;
- Laboratory services;
- Other areas of non-invasive diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, cardiovascular, 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.

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.

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 including continuous blood glucose monitor, and all related necessary supplies 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;
- Over-the-counter at-home COVID-19 tests and sexually transmitted disease home testing kits;
- DME rental fees, up to the purchase price;
- Pasteurized donor human milk; 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 postoperative 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 or other emergency room licensed under state law. The Emergency Benefit also includes Hospital admission when inpatient treatment of your Emergency Medical Condition or a Psychiatric Emergency Medical Condition is Medically Necessary. You can access Emergency Services for an Emergency Medical Condition or a Psychiatric 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 or a Psychiatric Emergency Medical Condition.

Emergency Services and follow-up health care treatment are provided without a Cost Share for Members treated following a rape or sexual assault for the first nine months after the Member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

The Cost Share waiver is applicable to follow-up health care treatment provided by a Participating Provider, any provider of Emergency Services, or a Non-Participating Provider when Blue Shield has approved your request to receive services from the Non-Participating Provider at the Participating Provider Cost Share. For more information, please reference *If you cannot find a Participating Provider* section. The Cost Share waiver will only apply to services the treating provider has identified in their claim submission using accurate diagnosis codes specific to rape or sexual assault.

After your condition stabilizes

Once your Emergency Medical Condition or a Psychiatric 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 or a Psychiatric 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 or a Psychiatric 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;
- Clinical services related to the provision or use of contraceptives, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling;
- Follow-up services related to contraceptive Drugs, devices, products, and procedures, including but not limited to management of side effects, counseling for continued adherence, and device removal;
- Voluntary tubal ligation and other similar sterilization procedures; and
- Vasectomy services and procedures.

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.

Unless selected as an optional Benefit by your Employer, Benefits do not include any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to:

- Harvesting or stimulation of the human ovum;
- In vitro fertilization;
- Gamete intrafallopian Transfer (GIFT) procedure;
- Zygote intrafallopian Transfer (ZIFT);
- Intracytoplasmic sperm injections (ICSI);
- Preimplantation genetic screening;
- Donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm;
- Any type of artificial insemination;
- Services or medications to treat low sperm count;

- Services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
- Services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Benefits that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, Standard Fertility Preservation Services, including retrieval and cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos, are a Covered Benefit and do not fall under the scope of Infertility Benefits described in the *Family Planning and Infertility Benefits* section.

Blue Shield will provide written notice explaining the covered storage period within 30 business days after receipt of a claim for cryopreservation services.

Blue Shield will provide written notice 90 calendar days prior to the expiration of the storage periods.

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;
- Administration of parenteral nutrition formulations and solutions;
- Administration of enteral nutrition formulas and solutions;
- Medical supplies used during a covered visit; and
- Medications injected or administered intravenously.

See the *PKU formulas and special food products* section for more information.

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.

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 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 Benefits 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.
- Domiciliary care, which 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.
- Custodial care, which is assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as part of a Hospice program.

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:
  - Inpatient care in a Hospital that is not solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation;
  - 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.

Benefits do not include:

- Domiciliary care, which 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.
- Custodial care, which is assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Inpatient Hospital care.

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 odontogenic and non-odontogenic oral tumors (benign or malignant);
- 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:

- Diagnostic dental services such as oral examinations, oral pathology, oral medicine, X-rays, and models of the teeth, except when related to surgical and non-surgical treatment of TMJ;
- Preventive dental services such as cleanings, space maintainers, and habit control devices except as covered under the Preventive Health Services Benefit;

- Periodontal care such as hard and soft tissue biopsies and routine oral surgery including removal of teeth;
- Reconstructive or restorative dental services such as crowns, fillings, and root canals;
- 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 or for Benefits covered under Preventive Health Services.

Mental Health or Substance Use Disorder Benefits

Blue Shield administers Mental Health or Substance Use Disorder services for Members in California. See the *Out-of-area services* section for an explanation of how Benefits are administered for out-of-state services.

Mental Health or Substance Use Disorder Benefits include Medically Necessary basic health care services and intermediate services, at the full range of levels of care, including but not limited to residential treatment, Partial Hospitalization Program, and Intensive Outpatient Program, and prescription Drugs.

A Participating Provider must get prior authorization from Blue Shield for all non-emergency Hospital admissions for Mental Health or Substance Use Disorder services, and for certain outpatient Mental Health or Substance Use Disorder services. See the *Medical management* section for more information about prior authorization.

To find a Participating Provider, visit blueshieldca.com and click on Find a Doctor.

If you are unable to schedule an appointment with a Participating Provider for Mental Health or Substance Use Disorder services, contact Mental Health Customer Service. We will help you schedule an appointment with a Participating Provider and, within five calendar days of your initial request, provide written notice that if we are unable to find a Participating Provider, we will help you schedule an appointment with a Non-Participating Provider. . If there is no available Participating Provider for any Covered Benefits, you will only be responsible for paying the Participating Provider Cost Share for these services. Mental Health Customer Service may work with you to transition to a Participating Provider when one becomes available.

Upon request to Mental Health Customer Service, and at no cost to you, Mental Health Customer Service will provide the clinical review criteria and any training material or resources used to conduct utilization reviews for Mental Health or Substance Use Disorder benefits and services.

Office visits

Benefits are available for professional services for the diagnosis and treatment of Mental Health or Substance Use Disorders. You can receive these services at an office visit, including Physician office visit, or in an individual, Family, or group professional outpatient setting, or as a telebehavioral health service.

Benefits include therapy, counseling, and medication management.

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 or Substance Use Disorders. You can receive these other outpatient services in a facility, office, clinic, home, or other non-institutional setting.

For Behavioral Health Crisis Services rendered by a Non-Participating Provider, you will pay the same Cost Share for Covered Benefits received from a Participating Provider. Prior authorization is not required for the Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by a 988 center, Mobile Crisis Team, or other Behavioral Health Crisis Services.

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 Blue Shield to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism;
- Behavioral Health Crisis Services and other services provided by a 988 center, a Mobile Crisis Team, or other provider of Behavioral Health Crisis Services, regardless of whether the service is rendered by a Participating or Non-Participating Provider;
- Electroconvulsive therapy – the passing of a small electric current through the brain to induce an anesthesia-controlled seizure, used in the treatment of severe psychiatric conditions;
- Intensive Outpatient Program – outpatient care for Mental Health or Substance Use Disorders when your condition requires structure, monitoring, and medical/psychological intervention for nine to nineteen hours a 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 that are at a minimum 20 hours per week;
- Neuropsychological and Psychological Testing – testing to diagnose a mental health condition and/or to assess the health of certain brain functions; and
- Transcranial magnetic stimulation – a non-invasive method of delivering magnetic stimulation to the brain for the treatment of severe depression.

Benefits do not include treatment not supported by current Generally Accepted Standards of Mental Health and Substance Use Disorder Care, including:

- Outdoor, youth, or wilderness programs and accommodations;
- Equine assisted therapy;
- Treatment for the purpose of providing respite or day care;
- Educational services; or
- Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.

In addition, Benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs.

Inpatient Services

Benefits are available for inpatient facility and professional services for the treatment of Mental Health or 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 withdrawal management (detoxification) is covered under the Hospital services Benefit.

This Plan does not cover domiciliary care, which 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. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Mental Health or Substance Use Disorder services.

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 Benefits. 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, 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 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 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 Vison 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 Benefits. 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, use the Blue Shield mobile app, or contact vision customer service at (877) 601-9083.

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 > +/- 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.

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;
- Second medical opinions;
- Administration of injectable medications that must be administered by a Health Care Provider;
- Administration of radiopharmaceutical 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 Health general medical consultations.

See the *Mental Health or Substance Use Disorder Benefits* section for information on Mental Health or Substance Use Disorder office visits and Other Outpatient Mental Health and Substance Use Disorder services.

Medical nutrition therapy

You can continue to receive medical nutrition therapy 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 *Diabetes care services* section for information about medical nutrition therapy for diabetes.

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;
- Parenteral nutrition formulations; and
- Special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods including shakes, snack bars, used by the general population;
- Additives such as thickeners, enzyme products; 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
- Abortion and abortion-related services, including preabortion and followup 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, self-applied continuous blood glucose monitors, and all related necessary supplies. Please note, Drugs used for hemophilia, blood or blood products are examples of Drugs that are not considered to be safe for self-administration. These products and Drugs may be covered under the Home health services, Home infusion and injectable medication services, Hospice program services, or Family Planning sections.

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.

Prescription Drug information is available by logging into your member portal at blueshieldca.com and selecting "Price Check My Rx." This tool can show you:

- Your eligibility for a prescription Drug;
- The current cost of the prescription Drug;
- Any available lower cost alternative(s) to the prescription Drug based on your plan Formulary and the pharmacy that fills your prescription;
- Any limits, restrictions, or requirements for each Drug, if applicable; and
- Your current plan Formulary.

"Price Check My Rx" prices are based on your Deductible and Out-of-Pocket Maximum accruals (if applicable) at the time you view the prescription Drug price. Costs may be different at the time you fill your prescription due to claims processing. You or your Physician or Health Care Provider can also request this Prescription Drug information by calling Customer Service.

Benefits are provided for COVID-19 therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a Health Care Provider acting within their scope of practice and the standard of care. Coverage is provided without a Cost Share for services provided by a Participating Provider.

For a disease for which the Governor of the State of California has declared a public health emergency, therapeutics approved or granted emergency use authorization by the U.S. Food and Drug Administration for that disease will be covered without a Cost Share.

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	• Most Generic Drugs and low-cost preferred Brand Drugs
Tier 2	• 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	• 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	• Drugs that 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. Contraceptive Drugs and devices obtained from a Participating Pharmacy are covered without a Copayment or Coinsurance, except for brands that have a generic equivalent. If your Physician or Health Care Provider determines that the covered Generic Drug is not appropriate for you, the brand name equivalent contraceptive will be covered without a Copayment or Coinsurance upon submission of an exception request.

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 or Biosimilar Drug is available, you pay the difference in cost, plus the applicable tier Copayment or Coinsurance of the Brand Drug. This is calculated by taking the difference between the Participating Pharmacy's contracted rate for the Brand Drug and the Generic Drug equivalent or Biosimilar Drug, plus the applicable tier Copayment or Coinsurance of the Brand Drug. For example, you select Brand Drug A when there is an equivalent Generic Drug A or Biosimilar Drug A available. The Participating Pharmacy's contracted rate for Brand Drug A is $300 and the contracted rate for Generic Drug A or Biosimilar Drug A is $100. You would be responsible for paying the $200 difference in cost, plus the applicable Copayment or Coinsurance of the Brand Drug. 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 or Biosimilar Drug 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 Participating Pharmacy when you take maintenance Drugs on a regular basis to treat an ongoing chronic 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 home delivery Participating Pharmacy

You have an option to receive prescription Drugs from the home delivery pharmacy when you take maintenance Drugs on a regular basis to treat an ongoing chronic condition. This allows you to receive up to a 90-day supply of the Drug. You may enroll in this program online or by phone. If your Physician or Health Care Provider submits a prescription for less than a 90-day supply, the home delivery pharmacy will only dispense the amount prescribed. Specialty Drugs are not available from the home delivery pharmacy.

You must pay the applicable Copayment or Coinsurance listed in the *Summary of Benefits* 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 home delivery 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. If you obtain a Specialty Drug anywhere other than at a Network Specialty Pharmacy, you may be responsible for the entire cost of the Drug. 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 for the Medically Necessary treatment of Class III obesity when prior authorized. You are required to enroll in a comprehensive weight loss program that includes a reduced calorie diet, physical activity, and behavior therapy. You will need to be in this type of program for a reasonable period of time, prior to and while on the weight loss Drug;
- Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy; and
- A Brand Drug, when a Generic Drug equivalent or Biosimilar Drug 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 or Biosimilar Drug. See the *Obtaining Outpatient Prescription Drugs at a Participating Pharmacy* section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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. 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. Approvals for prior authorizations can be granted for up to one year, however, the timeframe may be greater or less, depending on the medication.

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. You can submit an exception request by calling Shield Concierge. 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. See the *Obtaining Outpatient Prescription Drugs at a Participating Pharmacy* section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

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 for a prescription need not be met and that the Drug is Medically

Necessary, the step therapy exception process must be used and timeframes previously described (within 72 hours in routine circumstances or within 24 hours in exigent circumstances) 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 Participating Pharmacy or from the home delivery 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 hormonal contraceptive Drugs.

You may refill covered prescriptions at a Medically Necessary frequency.

Special programs

Blue Shield may offer programs to support the use of more cost-effective and clinically appropriate prescription Drugs. Such programs may lower your out-of-pocket cost for a limited time if you participate.

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 had in effect on January 1, 2025 a rating of A or B in the recommendations of the United States Preventive Services Task Force (USPSTF), which the California Department of Public Health can modify or supplement. Examples of recommendations are:
  - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
  - Screening for HPV;
  - Screening for osteoporosis; and
  - Health education;
- Immunizations that had in effect on January 1, 2025 a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or 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, as of January 1, 2025, which the California Department of Public Health can modify or supplement;
- 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;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines, as periodically updated, supported by the Health Resources and Services Administration as of January 1, 2025, which the California Department of Public Health can modify or supplement. This includes screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- Adverse Childhood Experiences screenings;
- 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 as of January 1, 2025, which the California Department of Public Health can modify or supplement. 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. 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.

Visit ***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.

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

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage when performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider.

Occupational therapy

Occupational therapy uses physical agents, therapeutic treatment, and modalities to develop, improve, and maintain the skills you need for activities of daily living, such as dressing, eating, and drinking. Physical agents, therapeutic treatments, and modalities include but are not limited to:

- Ultrasound;
- Heat;
- Range of motion testing;
- Targeted exercise; and
- Massage when performed as part of a rehabilitative or habilitative occupational therapy treatment plan by a licensed or certified Health Care Provider.

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.

This Plan does not cover domiciliary care, which 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. In addition, this Plan does not cover custodial care, which is assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

However, the Plan does cover assistance with activities of daily living (activities related to independence in normal everyday living, recreational, leisure, or sports activities are not considered activities of daily living) that are incidental to Covered Benefits provided as Skilled Nursing services.

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, during an after-hours office visit or through Accolade if you are assigned to the Accolade Care virtual Medical Group. 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

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

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	Acupuncture Services. This Plan does not cover acupuncture services, except as described in this EOC in the *Acupuncture services* section or as required by law.
2	Chiropractic Services. This Plan does not cover chiropractic services, except as required by law.
3	Clinical Trials. This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in the *Clinical trials for treatment of cancer or Life-Threatening diseases or conditions Benefits* section or as required by law. Coverage of Approved Clinical Trials does not include the following: • The investigational drug, item, or service itself. • Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member. • Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law. • Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor. This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental or Investigational services independent review process as described in this EOC in the *Independent Medical Review* section, or to the Independent Medical Review (IMR) from the Department of Managed Health

General exclusions and limitations	
	Care (DMHC) as described in this EOC in the *California Department of Managed Health Care review* section.
4	Cosmetic Services, Supplies, or Surgeries. This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in the *Reconstructive Surgery Benefits* section, or as required by law. This exclusion does not apply to the following: • Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages. • Reconstructive surgery as described in this EOC in the *Reconstructive Surgery Benefits* section. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the *Reconstructive Surgery Benefits* section.
5	Custodial or Domiciliary Care. This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered or domiciliary care, which involves 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 except as described in this EOC or as required by law. This exclusion does not apply to the following: • Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals. • Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, inpatient hospital care, or services provided in a healthcare facility, including Mental Health or Substance Use Disorder services.
6	Dietary or Nutritional Supplements. This Plan does not cover dietary or nutritional supplements, except as described in this EOC in the *PKU formulas and special food products* section or as required by law.

	General exclusions and limitations
7	Disposable Supplies for Home Use. This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in the *Durable medical equipment*, *Home health services*, *Hospice program services*, and *Prescription Drug Benefits* sections, or as required by law.
8	Experimental or Investigational services. This Plan does not cover Experimental Services or Investigational Services, except as required by law. Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation. Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but: o Testing is not complete; and o The efficacy and safety of such services in human subjects are not yet established; and o The service is not in wide usage. The determination that a service is an Experimental Service or Investigational Service is based on: • Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration); • Consultation with provider organizations, academic and professional specialists pertinent to the specific service; • Reference to current medical literature. However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an opportunity for you to request an external, independent review. Qualifications 1. You must have a Life-Threatening or Seriously Debilitating condition. 2. Your Health Care Provider must certify to the Plan that you have a Life Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan. 3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care

	General exclusions and limitations
	Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy. 4. You have been denied coverage by the Plan for the recommended or requested service. 5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered. External, Independent Review Process If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. DMHC's Independent Medical Review (IMR) This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in the *Independent Medical Review* section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the *California Department of Managed Health Care review* section.
9	Hearing Aids. This Plan does not cover hearing aids, except as required by law. The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.
10	Immunizations. This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.
11	Non-licensed or Non-certified Providers. This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in the *Mental Health or Substance Use Disorder Benefits* section or as required by law. This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the

General exclusions and limitations	
	direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
12	Personal or Comfort Items. This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
13	Private Duty Nursing. This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this EOC in the *Hospice program services* section or as required by law.
14	Reversal of Voluntary Sterilization. This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
15	Routine Physical Examination. The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.
16	Surrogate Pregnancy. This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.
17	Therapies. This Plan does not cover the following physical and occupational therapies, except as described in this EOC in the *Rehabilitative and habilitative services* section or as required by law: • Massage therapy, unless it is a component of a treatment plan; • Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; and • Vocational, educational, recreational, art, dance, music, or reading therapy.
18	Travel and Lodging. This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in the *Ambulance services* section, as otherwise described in this EOC in the *Bariatric surgery Benefits* and *Transplant services* sections, or as required by law.
19	Weight Control Programs and Exercise Programs. This Plan does not cover weight control programs and exercise programs, except as described in this EOC in the *Diabetes care services* section or as required by law.
20	Adult Vision Services. This Plan does not cover Vision Services for Members age 19 and older, except as described in this EOC in the *Prosthetic equipment and devices* section or as required by law.

	General exclusions and limitations
21	Pediatric Vision Services. This Plan does not cover the following vision services for Members up to age 19 except as described in this EOC in *Pediatric vision Benefits* section or as required by law. The exclusions and limitations for covered pediatric vision services are provided in the Pediatric vision Benefits section.
22	Adult Dental Services. This Plan does not cover dental services or supplies for Members age 19 and older, except as described in this EOC in the *Medical treatment of the teeth, gums, or jaw joints and jaw bones* and *Hospital services* sections or as required by law.
23	Pediatric Dental Services. This Plan does not cover dental services or supplies for Members up to age 19, except as described in this EOC in *Pediatric dental Benefits* section or as required by law. The exclusions and limitations for covered pediatric dental services are provided below in the *Pediatric dental exclusion and limitations tables*.

	Outpatient Prescription Drug exclusions and limitations
1	When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
2	When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
3	When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
4	When prescribed solely for the purpose of shortening the duration of the common cold.

	General exclusions and limitations
5	Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to: • Insulin, • Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs), • Over-the-counter drugs for reversal of an opioid overdose, or • An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
6	Replacement of lost or stolen drugs.
7	Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
8	Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

	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.

	General exclusions and limitations
8	Malignancies.
9	Drugs not normally supplied in a dental office.
10	Dental Care Services administered by a pediatric Dentist, except when: • 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)	• 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)	• 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)	• Endodontic procedures when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;

Pediatric dental limitations	
	• 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)	• 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)	• 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 (D5211and 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)	• 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)	• Fixed partial dentures (bridgework); however, the fabrication of a fixed partial denture shall be considered

Pediatric dental limitations	
(D6200-D6999)	when medical conditions or employment preclude the use of a removable partial denture; • 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)**	• 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	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. 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. 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. The immediate qualifying conditions are: • 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 Benefits, Mental Health or Substance Use Disorder services, and prescription Drug Benefits	Blue Shield of California Customer Service Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762
Pediatric dental Benefits	Blue Shield of California Dental Plan Administrator Attn: Dental Appeals/Grievances P.O. Box 30545 Salt Lake City, UT 84130-0545
Pediatric vision Benefits	Blue Shield of California Vision Plan Administrator Attn: Quality Assurance 4000 Luxottica Place Cincinnati, OH 45040

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

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 or step therapy, you may 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.

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

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

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 in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

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.

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-Knowles 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 47 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 plan as a result of a permanent 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 Benefits 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 Licensees Inter-Plan Programs. These Inter-Plan Programs 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 those services may be processed through one of these Inter-Plan Programs.

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 Program unless the services and out of state provider are 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 Programs

Emergency Services

Members who experience an Emergency Medical Condition or a Psychiatric 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 or a Psychiatric Emergency Medical Condition.

Inter-Plan Programs

Under the Inter-Plan Programs, 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 Inter-Plan 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 Inter-Plan 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 considers 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 considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also consider 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 Domestic 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.

If you do not see a participating provider through the Inter-Plan 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 Benefits, 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 (Domestic 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 Domestic 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 Domestic 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 Benefits 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 Benefits 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. Notwithstanding the foregoing, no coverage is provided under the Plan for 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.

- 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.

Services not charged

Blue Shield will not cover services that you are not legally obligated to pay, or for which you are not charged.

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 Benefits 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

Advanced Health Care Directive	Means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.
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.
Allowed Charges	• 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.
Ambulatory Surgery Center	An outpatient surgery facility that meets both of the following requirements: • 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.
Appropriately Qualified Health Care Provider	Means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

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 another Life Threatening disease or condition that meets at least one of the following:
	• The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
	  ○ The National Institutes of Health.
	  ○ The federal Centers for Disease Control and Prevention.

	○ The Agency for Healthcare Research and Quality. ○ The federal Centers for Medicare and Medicaid Services. ○ A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs. ○ A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. ○ One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review: ▪ The United States Department of Veteran Affairs. ▪ The United States Department of Defense. ▪ The United States Department of Energy. • The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration. • The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.
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 Benefits to Members.
Behavioral Health Crisis Services	The continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, Mobile Crisis Teams, and crisis receiving and stabilization services.

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 Benefits)	Means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.
Benefit Administrator	Administrator for specialized Benefits such as acupuncture services.
Biosimilar Drugs	Drugs that are FDA-approved that are highly similar to an FDA-approved biologic (reference product) with no clinically meaningful differences in terms of safety, purity, strength and effectiveness.
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.
Domestic Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
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 Benefits 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 Benefits after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Benefits (Benefits)	Means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.
Deductible	The Calendar Year amount you must pay for specific Covered Benefits before Blue Shield pays for Covered Benefits pursuant to the Contract.
Dental Allowable Amount	The Dental Allowable Amount is: • 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 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	• 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 Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

Domestic Partner	An individual who is personally related to the Subscriber by a domestic partnership that meets all the following requirements:
	• 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:
	  ○ 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). The domestic partnership is deemed created on the date when both partners meet the above requirements.
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	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: • Placing your health in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.
Emergency Medical Condition	Means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: • Placing the patient's health in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.
Emergency Services and Care (Emergency Services)	Means: • medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel 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, within the scope of that person's license, if necessary to relieve or

	eliminate the Emergency Medical Condition, within the capability of the facility; and/or • an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.
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.
Evidence of Coverage	Means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.
Experimental Services (Experimental)	Means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.
Family	The Subscriber and all enrolled Dependents.
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, but at the time of the provider's contract termination with Blue Shield, you were receiving Covered Benefits 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 Benefits 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 but no longer available to you as a Participating Provider because:
	  o The Employer has terminated its contract with Blue Shield; and
	  o The Employer currently contracts with a new health plan (insurer) that does not include the Blue Shield Participating Provider in its network; and
	  o At the time of the Employer's contract termination you were receiving Covered Benefits 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.

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	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 and Mental Health or Substance Use Disorder care include: • 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 U.S. 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	Means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish Covered Benefits.
Hemophilia Home Infusion Provider	A provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia. A Participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Hospital	An entity that meets one of the following criteria: • 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, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the Domestic Service Area.
Independent Medical Review (IMR)	Means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Infertility	• A licensed Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility in paragraph (3); • A person's inability to reproduce either as an individual or with their partner without medical intervention; or • The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.
Intensive Outpatient Program	An outpatient treatment program for Mental Health or Substance Use Disorders that provides structure, monitoring, and medical/psychological intervention for nine to nineteen hours a week.
Inter-Plan Programs	Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Investigational Services (Investigational)	Means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but: o Testing is not complete; and o The efficacy and safety of such services in human subjects are not yet established; and o The service is not in wide usage.
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.
Life-Threatening	Means either or both of the following: • Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

	• Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
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 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.
Medically Necessary (Medical Necessity)	Means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following: • In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care. • Clinically appropriate in terms of type, frequency, extent, site, and duration. • Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.
Member	Means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.
Mental Health or Substance Use Disorder(s)	Means 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 that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
Mobile Crisis Team	A multidisciplinary team of trained behavioral health professionals who provide Behavioral Health Crisis Services in

	the least restrictive setting 24 hours a day, 7 days a week, 365 days per year.
Network Specialty Pharmacy	Select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.
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 Benefits. 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	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health or Substance Use Disorders, including but not limited to the following: • Partial Hospitalization; • Intensive Outpatient Program; • Electroconvulsive therapy; • Office-based opioid treatment; • Transcranial magnetic stimulation; • Behavioral Health Treatment; and • Neuropsychological and Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the 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 Service Area.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Benefits 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.
Outpatient Prescription Drug	Means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services that are at a minimum 20 hours per week.
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 Benefits. 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. Retail pharmacy participation may be at either Level A or Level B.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under the Contract.
Prescription Drug (Drug)	Means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes: • disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; • syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes;

	• drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and • at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.
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. If your PCP is an Accolade Care virtual PCP, your PCP will coordinate with Blue Shield to review prior authorization requests.
Prosthodontics	Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.
Psychiatric Emergency Medical Condition	Means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
Neuropsychological and Psychological Testing	Testing to diagnose a mental health condition and/or to assess the health of certain brain functions when referred by a Participating Provider providing Mental Health or Substance Use Disorder Benefits.
Qualified Health Plan (QHP)	A health plan that has been certified for sale through CCSB.
Reasonable and Customary	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.

Reconstructive Surgery	Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: • 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.
Seriously Debilitating	Means diseases or conditions that cause major irreversible morbidity.
Service Area	Means the geographic area designated by the plan within which a plan shall provide health care services.
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	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and • Other designated as appropriate.
Specialty Drugs	Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot

	be met by a retail pharmacy and are available exclusively through a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high-cost.

Standard Fertility Preservation Services	Any of the following services consistent with the current established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine:
	• Retrieval of gametes as follows:
	  o A lifetime limit of up to two cycles for oocyte retrieval for enrollees with ovaries.
	  o A lifetime limit of up to two attempts to collect sperm for enrollees with testicles.
	• A lifetime limit of up to two attempts of embryo creation. Blue Shield will not cover any costs associated with the retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility.
	• A lifetime limit of up to two attempts to retrieve gonadal tissue.
	• The lifetime limits of this section shall apply to Members regardless of the number of health care service plans the Member enrolls in during their lifetime.
	• Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos as follows:
	  o Until the enrollee reaches age 26 for an enrollee who is under the age 18 on the date the enrollee's genetic material is first cryopreserved.
	  o Until the enrollee reaches age 26 or for three years, whichever period is longer, for an enrollee who is 18 years or older but not yet 26 years old on the date the enrollee's genetic material is first cryopreserved.
	  o For a period of three years for an enrollee who is 26 years or older at the time the enrollee's genetic material is first cryopreserved.
	• With respect to cryopreservation of genetic material, a health care service plan shall have the right to select a storage vendor of its choosing.
	• Gonadal shielding or transposition during a procedure or treatment, if not already included in

	the usual coverage for that procedure or treatment. • Any other standard fertility preservation services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
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.
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.
Total Disability (Totally Disabled)	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. 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.
Trans-Inclusive Health Care	Means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.
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 Benefits 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 under this Benefit through a network of VPA Participating Providers.
Vision Prescription Change	Any of the following: • 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).
Vision Services	Services or materials related to orthoptics, vision training, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses. Video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.
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 Benefits 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 *Continuity of care* and *Continuation of group coverage* sections. 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 fertility preservation services: You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network costsharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary, as determined by Blue Shield and consistent with federal and state laws, and Blue Shield medical policies, medication policies, and other guidelines and criteria adopted by Blue Shield. 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. If two or more services or sequence of services are 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, coverage is provided for the least costly service or sequence of services.

Notice about Mental Health or Substance Use Disorder services: You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Blue Shield fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

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.

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 Benefits 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 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 Benefits 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 existing timeliness and geographic access standards. See the Timely Access to Care section for more information.

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

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

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: Thousands of people in the United States need an organ or tissue transplant. Each person on the transplant waiting list faces death 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 state or federal 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.

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

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 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

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
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: • 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 – comprehensive series of radiographic images	Once per provider every 36 months.	No Charge

Code	Description	Limitation	Cost Share
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: • 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: • 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
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
D0396	3D printing of a 3D dental surface scan		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
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
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 – comprehensive series of radiographic images – image capture only		$0
D0801	3D intraoral surface scan – direct		No Charge
D0802	3D dental surface scan – indirect		No Charge
D0803	3D facial surface scan – direct		No Charge
D0804	3D facial surface scan – indirect		No Charge
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

Code	Description	Limitation	Cost Share
D1320	Tobacco counseling for the control and prevention of oral disease		No Charge
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
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: • 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	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: • 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	Once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth. Not a Benefit: • 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	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. Not a Benefit: • 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	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. Not a Benefit: • 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 (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)	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a five-year period and for any resin based composite crown that is indirectly fabricated. 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; and • For use as a temporary crown.	$140

Code	Description	Limitation	Cost Share
D2712	Crown – 3/4 resin-based composite (indirect)	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a five-year period and for any resin based composite crown that is indirectly fabricated. 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; 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	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
D2722	Crown - resin with noble metal	Not a Benefit.	Not Covered
D2740	Crown – 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.	$300
D2750	Crown - porcelain fused to high noble metal	Not a Benefit.	Not Covered
D2751	Crown – porcelain fused to predominantly base metal	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 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
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	Placement of interim direct restoration	Once per tooth in a 6-month period, per provider. Not a Benefit: • When performed on the same date of service with a permanent restoration or crown, for same tooth; and • On root canal treated teeth.	$25
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 customize a crown to fit under an existing partial denture framework		$35
D2976	Band stabilization – per tooth		$40
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
D2989	Excavation of a tooth resulting in the determination of non-restorability		$50
D2991	Application of hydroxyapatite regeneration medicament – per tooth		No Charge
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

Code	Description	Limitation	Cost Share
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: • 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
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: • 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: • 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: • 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

Code	Description	Limitation	Cost Share
D3320	Endodontic therapy, premolar 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
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 – premolar	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.	$350
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Once per permanent tooth. Not a Benefit: • 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

Code	Description	Limitation	Cost Share
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: • 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
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 – premolar (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

Code	Description	Limitation	Cost Share
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
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site		$350
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site		$350
D3430	Retrograde filling – per root		$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery		$80
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not a Benefit.	Not Covered
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
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

Code	Description	Limitation	Cost Share
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
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, per site	For Members age 13 or older.	$80
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not a Benefit.	Not Covered
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	Not a Benefit.	Not Covered
D4270	Pedicle soft tissue graft procedure	Not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
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
D4286	Removal of non-resorbable barrier	Not a Benefit.	Not Covered
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Once per quadrant every 24 months and limited to Members age 13 or older.	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	Once per quadrant every 24 months and limited to Members age 13 or older.	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation		$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	For Members age 13 or older.	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	For Members age 13 or older.	$10

Code	Description	Limitation	Cost Share
D4910	Periodontal maintenance	Once in a calendar quarter and only in the 24-month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning.	$30
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	For Members age 13 or older.	$350
Prosthodontics, removable Procedures (D5000-D5899)			
D5110	Complete denture – maxillary	Once in a 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
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

Code	Description	Limitation	Cost Share
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)	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: • 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. Not a Benefit for replacing missing third molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	Once in a 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: • 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. Not a Benefit for replacing missing third molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$275

Code	Description	Limitation	Cost Share
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	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: • 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. Not a Benefit for replacing missing third molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	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: • 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. Not a Benefit for replacing missing third molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).	$330
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit.	Not Covered
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials , rests, and teeth)	Not a Benefit.	Not Covered
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit.	Not Covered
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit.	Not Covered
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit.	Not Covered
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	Not a Benefit.	Not Covered
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests,and teeth), per quadrant	Not a Benefit.	Not Covered
D5410	Adjust complete denture – maxillary	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit: • 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

Code	Description	Limitation	Cost Share
D5411	Adjust complete denture – mandibular	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit: • 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
D5421	Adjust partial denture – maxillary	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit: • 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 & D 5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).	$20

Code	Description	Limitation	Cost Share
D5422	Adjust partial denture – mandibular	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit: • 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	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).	$40
D5512	Repair broken complete denture base, maxillary	Once per date of service per provider and no more than twice in a 12-month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).	$40
D5520	Replace missing or broken teeth – complete denture – per tooth	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.	$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 missing or broken teeth – partial denture – per tooth	Up to a maximum of 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 – per tooth	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: • 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: • 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: • 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: • 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 – natural tooth borne	Once in a five-year period.	$300
D5864	Overdenture – partial maxillary – natural tooth borne	Once in a five-year period.	$300
D5865	Overdenture – complete mandibular – natural tooth borne	Once in a five-year period.	$300

Code	Description	Limitation	Cost Share
D5866	Overdenture – partial mandibular – natural tooth borne	Once in a five-year period.	$300
D5876	Add metal substructure to acrylic complete denture – per arch	Not a Benefit.	Not covered
D5899	Unspecified removable prosthodontic procedure, by report		$350
Maxillofacial Prosthetics Procedures (D5900-D5999)			
D5909	Maxillary guidance prosthesis with guide flange		$350
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
D5930	Maxillary guidance prosthesis without guide flange		$350
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

Code	Description	Limitation	Cost Share
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 guidance prosthesis with guide flange		$350
D5935	Mandibular guidance prosthesis without guide flange		$350
D5936	Obturator prosthesis, interim	Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).	$350
D5937	Trismus appliance (not for TMD treatment)		$85
D5938	Resection prosthesis, maxillary complete removable		$350
D5939	Resection prosthesis, mandibular complete removable		$350
D5940	Resection prosthesis, maxillary partial removable		$350
D5941	Resection prosthesis, mandibular partial removable		$350
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch		$350
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for endentulous arch		$350
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial endentulous arch		$350
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch		$350
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch		$350

Code	Description	Limitation	Cost Share
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch		$350
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch		$350
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch		$350
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 for soft tissue healing		$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

Code	Description	Limitation	Cost Share
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
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant		$350
D6013	Surgical placement of mini implant		$350
D6040	Surgical placement: eposteal implant		$350
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure		$35
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

Code	Description	Limitation	Cost Share
D6062	Abutment supported cast metal crown (high noble metal)		$315
D6063	Abutment supported cast metal crown (predominantly base metal)		$300
D6064	Abutment supported cast metal crown (noble metal)		$315
D6065	Implant supported porcelain/ceramic crown		$340
D6066	Implant supported crown – porcelain fused to high noble alloys		$335
D6067	Implant supported crown – high noble alloys		$340
D6068	Abutment supported retainer for porcelain/ceramic FPD		$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		$290
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

Code	Description	Limitation	Cost Share
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments		$30
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes 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	Interim implant crown		$300
D6086	Implant supported crown – predominantly base alloys		$340
D6087	Implant supported crown – noble alloys		$340
D6088	Implant supported crown – titanium and titanium alloys		$340
D6089	Accessing and retorquing loose implant screw – per screw		$60
D6090	Repair of implant/abutment supported prosthesis		$65
D6091	Replacement of replaceable part of semi-precision or precision attachment 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

Code	Description	Limitation	Cost Share
D6094	Abutment supported crown – titanium and titanium alloys		$295
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	Surgicalremoval of implant body		$110
D6105	Removal of implant body not requiring bone removal or flap elevation		$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary		$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular		$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary		$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular		$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary		$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular		$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary		$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular		$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular		$350

Code	Description	Limitation	Cost Share
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary		$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
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments		$30
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
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		$95
D6198	Remove interim implant component		$110
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
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch		$20
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not a Benefit.	Not Covered
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not a Benefit.	Not Covered
D6549	Retainer – for resin bonded fixed prosthesis	Not a Benefit.	Not Covered
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Not a Benefit.	Not Covered
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Not a Benefit.	Not Covered
D6610	Retainer onlay - cast high noble metal, two surfaces	Not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Not a Benefit.	Not Covered
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Not a Benefit.	Not Covered
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Not a Benefit.	Not Covered
D6614	Retainer onlay - cast noble metal, two surfaces	Not a Benefit.	Not Covered
D6615	Retainer onlay - cast noble metal, three or more surfaces	Not a Benefit.	Not Covered
D6634	Retainer onlay - titanium	Not a Benefit.	Not Covered
D6710	Retainer crown - indirect resin based composite	Not a Benefit.	Not Covered
D6720	Retainer crown - resin with high noble metal	Not a Benefit.	Not Covered
D6721	Retainer crown – resin with predominantly base metal	Once in a 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
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	Not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
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
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 – primary tooth	Not a Benefit for asymptomatic teeth.	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Not a Benefit when removed by the same provider who performed the initial tooth extraction.	$65

Code	Description	Limitation	Cost Share
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	A Benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.	$120
D7220	Removal of impacted tooth – soft tissue	A Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.	$95
D7230	Removal of impacted tooth – partially bony	A Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.	$145
D7240	Removal of impacted tooth – completely bony	A Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.	$160
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
D7252	Partial extraction for immediate implant placement		$80
D7259	Nerve dissection		$280
D7260	Oroantral fistula closure	A Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.	$280
D7261	Primary closure of a sinus perforation	A Benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Once per arch regardless of the number of teeth involved and for permanent anterior teeth only.	$185
D7280	Exposure of an unerupted tooth	Not a Benefit: a. for Members age 21 or older, or b. for third molars.	$220

Code	Description	Limitation	Cost Share
D7283	Placement of device to facilitate eruption of impacted tooth	Only for Members in active orthodontic treatment. Not a Benefit: • For Members age 21 years or older; and • For third molars unless the third molar occupies the first or second molar position.	$85
D7284	Excisional biopsy of minor salivary glands		$115
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	Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$50

Code	Description	Limitation	Cost Share
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	A Benefit regardless of the number of teeth or tooth spaces.	$120
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Once in a five-year period per arch.	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Once per arch. Not a Benefit: • 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

Code	Description	Limitation	Cost Share
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		$250
D7465	Destruction of lesion(s) by physical or chemical method, by report		$40
D7471	Removal of lateral exostosis (maxilla or mandible)	Once per quadrant and for the removal of buccal or facial exostosis only.	$140
D7472	Removal of torus palatinus	Once in the Member's lifetime.	$145
D7473	Removal of torus mandibularis	Once per quadrant.	$140
D7485	Reduction of osseous tuberosity	Once per quadrant.	$105
D7490	Radical resection of maxilla or mandible		$350
D7509	Marsupialization of odontogenic cyst		$180
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

Code	Description	Limitation	Cost Share
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Once per quadrant per date of service and only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a Benefit within 30 days of an associated extraction (D7111-D7250).	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket.	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)		$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)		$250
D7630	Mandible – open reduction (teeth immobilized, if present)		$350
D7640	Mandible – closed reduction (teeth immobilized, if present)		$350
D7650	Malar and/or zygomatic arch – open reduction		$350
D7660	Malar and/or zygomatic arch – closed reduction		$350
D7670	Alveolus – closed reduction, may include stabilization of teeth		$170
D7671	Alveolus – open reduction, may include stabilization of teeth		$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	For the treatment of simple fractures only.	$350
D7710	Maxilla – open reduction		$110
D7720	Maxilla – closed reduction		$180
D7730	Mandible – open reduction		$350
D7740	Mandible – closed reduction		$290
D7750	Malar and/or zygomatic arch – open reduction		$220
D7760	Malar and/or zygomatic arch – closed reduction		$350
D7770	Alveolus – open reduction stabilization of teeth		$135
D7771	Alveolus, closed reduction stabilization of teeth		$160

Code	Description	Limitation	Cost Share
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
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

Code	Description	Limitation	Cost Share
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
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation		$350
D7940	Osteoplasty – for orthognathic deformities		$160
D7941	Osteotomy – mandibular rami		$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		$350
D7944	Osteotomy – segmented or subapical		$275
D7945	Osteotomy – body of mandible		$350
D7946	LeFort I (maxilla – total)		$350
D7947	LeFort I (maxilla – segmented)		$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft		$350
D7949	LeFort II or LeFort III – with bone graft		$350
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Not a Benefit for periodontal grafting.	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Only for Members with authorized implant services.	$290
D7952	Sinus augmentation via a vertical approach	Only for Members with authorized implant services.	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	Not a Benefit for periodontal grafting.	$200
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a Benefit.	Not Covered

Code	Description	Limitation	Cost Share
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a Benefit.	Not Covered
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	Surgical sialolithotomy		$155
D7981	Excision of salivary gland, by report		$120
D7982	Sialodochoplasty		$215
D7983	Closure of salivary fistula		$140
D7990	Emergency tracheotomy		$350
D7991	Coronoidectomy		$345
D7995	Synthetic graft – mandible or facial bones, by report	Not a Benefit for periodontal grafting.	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers.	$60
D7999	Unspecified oral surgery procedure, by report		$350
Orthodontics Procedures (D8000-D8999)			

Code	Description	Limitation	Cost Share
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
D8091	Comprehensive orthodontic treatment with orthognathic surgery		
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)	
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).	

Code	Description	Limitation	Cost Share
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).	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery		
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).	
D8681	Removable orthodontic retainer adjustment		
D8696	Repair of orthodontic appliance – maxillary	Once per appliance. Not a Benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8697	Repair of orthodontic appliance – mandibular	Once per appliance. Not a Benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.	
D8698	Re-cement or re-bond fixed retainer – maxillary	Once per provider.	
D8699	Re-cement or re-bond fixed retainer – mandibular	Once per provider.	
D8701	Repair of fixed retainer, includes reattachment – maxillary		
D8702	Repair of fixed retainer, includes reattachment – mandibular		
D8703	Replacement of lost or broken retainer – maxillary	Once per arch and only within 24 months following the date of service of orthodontic retention (D8680).	
D8704	Replacement of lost or broken retainer – mandibular	Once per arch and only within 24 months following the date of service of orthodontic retention (D8680).	

Code	Description	Limitation	Cost Share
D8999	Unspecified orthodontic procedure, by report		
Adjunctive General Services Procedures (D9000-D9999)			
D9110	Palliative treatment of dental pain – per visit	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
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia		$45
D9222	Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof	Not a Benefit: • On the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); and • When all associated procedures on the same date of service by the same provider are denied.	$45
D9223	Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof		$45

Code	Description	Limitation	Cost Share
D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof		$65
D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof		$65
D9230	Administration of nitrous oxide	For uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: • 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	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	Not a benefit: • 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	Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	Not a Benefit: • 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
D9244	In-office administration of minimal sedation – single drug – enteral		$30

Code	Description	Limitation	Cost Share
D9245	Administration of moderate sedation – enteral		$65
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof		$65
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof		$65
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		$50
D9311	Consultation with a medical health professional		No Charge
D9410	House/extended care facility call	Once per Member per date of service and only in conjunction with procedures that are payable.	$50
D9420	Hospital or ambulatory surgical center call	A Benefit for each hour or fraction thereof as documented on the operative report.	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	Once per date of service per provider. Not a Benefit: • 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, subsequent to 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: • 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: • 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		No Charge
D9996	Teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review		No Charge
D9997	Dental case management – patients with special health care needs		No Charge
D9999	Unspecified adjunctive procedure, by report		No Charge

Trio HMO Service Area

The Trio HMO 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 Service Area may change. Visit 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
94517	94518	94519	94520

Contra Costa County			
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
93383	93384	93385	93386
93387	93388	93389	93390

Kern County			
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
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90033	90034	90035	90036
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90065	90066	90067	90068
90069	90070	90071	90072
90073	90074	90075	90076
90077	90078	90079	90080
90081	90082	90083	90084

Los Angeles County			
90086	90087	90088	90089
90090	90091	90093	90094
90095	90096	90099	90140
90189	90201	90202	90205
90209	90210	90211	90212
90213	90220	90221	90222
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90241	90242	90245	90247
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90254	90255	90260	90261
90262	90263	90264	90265
90266	90267	90270	90272
90274	90275	90277	90278
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90309	90310	90311	90312
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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	90660	90661
90662	90670	90671	90701

Los Angeles County			
90702	90703	90706	90707
90710	90711	90712	90713
90714	90715	90716	90717
90723	90731	90732	90733
90734	90744	90745	90746
90747	90748	90749	90755
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90809	90810	90813	90814
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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	91225	91226
91301	91302	91303	91304

Los Angeles County			
91305	91306	91307	91308
91309	91310	91311	91313
91316	91321	91322	91324
91325	91326	91327	91328
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91346	91350	91351	91352
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91357	91364	91365	91367
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91392	91393	91394	91395
91396	91401	91402	91403
91404	91405	91406	91407
91408	91409	91410	91411
91412	91413	91416	91423
91426	91436	91470	91482
91499	91501	91502	91503
91504	91505	91506	91507
91508	91510	91521	91522
91523	91526	91601	91602
91603	91604	91605	91606
91607	91608	91609	91610
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91723	91724	91731	91732
91733	91734	91735	91740
91741	91744	91745	91746

Los Angeles County			
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91755	91756	91765	91766
91767	91768	91769	91770
91771	91772	91773	91775
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91789	91790	91791	91792
91793	91801	91802	91803
91804	91896	91899	93161
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			
93901	93902	93905	93906
93907	93908	93912	93915
93920	93921	93922	93924
93925	93926	93933	93940
93942	93943	93944	93950
93953	93955	93960	95012
95039	96962		

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
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92617	92618	92619	92620
92623	92624	92625	92626
92627	92628	92629	92630
92637	92646	92647	92648
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92707	92708	92711	92712
92728	92735	92780	92781
92782	92799	92801	92802
92803	92804	92805	92806

Orange County			
92807	92808	92809	92811
92812	92814	92815	92816
92817	92821	92822	92823
92825	92831	92832	92833
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92838	92840	92841	92842
92843	92844	92845	92846
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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
92501	92502	92503	92504
92505	92506	92507	92508

Riverside County			
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92517	92518	92519	92521
92522	92530	92531	92532
92543	92544	92545	92546
92548	92549	92551	92552
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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
94284	94285	94287	94288
94289	94290	94291	94293
94294	94295	94296	94297

Sacramento County			
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
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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
92315	92316	92317	92318
92321	92322	92324	92325
92329	92331	92333	92334

San Bernardino County			
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
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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
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91945	91946	91948	91950
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91977	91978	91979	91980
91987	92003	92007	92008
92009	92010	92011	92013
92014	92018	92019	92020
92021	92022	92023	92024
92025	92026	92027	92028
92029	92030	92033	92036

San Diego County			
92037	92038	92039	92040
92046	92049	92051	92052
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92058	92059	92060	92061
92064	92065	92067	92068
92069	92071	92072	92074
92075	92078	92079	92081
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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
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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
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	95215	95219
95220	95227	95230	95231
95234	95236	95237	95240
95241	95242	95253	95258
95267	95269	95296	95297
95304	95320	95330	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
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
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	95620
95627	95637	95645	95653
95691	95694	95695	95697
95698	95776	95798	95799
95937			

Assisted Reproductive Technology Rider

Group Rider
HMO

ART HMO 10%
Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this assisted reproductive technology Benefit.

Benefits	Your Payment			
	When using a Participating Provider	**CYD applies**	**When using a Non-Participating Provider**	**CYD applies**
Assisted reproductive technology (ART) procedures and associated services	10% of the allowable amount		Not covered	
Assisted Reproductive Technology (ART) Procedures and Associated Services	**Lifetime Benefit Maximums**			
Natural artificial inseminations *Without ovum [oocyte or ovarian tissue (egg)] stimulation*	6/lifetime			
Stimulated artificial inseminations *With ovum [oocyte or ovarian tissue] stimulation*	3/lifetime			
Oocyte (egg) retrieval	1/lifetime			
Gamete intrafallopian transfer (GIFT)	1/lifetime			
Cryopreservation of embryos, oocytes, sperm, reproductive tissue *Retrieved from a Member. Includes one year of storage per person*	1/lifetime			

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

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

Introduction

Only the Member is entitled to Benefits under this assisted reproductive technology 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 licensed Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish Infertility in paragraph (3);
- A person's inability to reproduce either as an individual or with their partner without medical intervention; or
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having Infertility.

Benefits

Benefits are provided for a Member who meets the definition 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.

These Covered Services are not subject to the Calendar Year Medical Deductible. Cost Share for these Covered Services applies towards the Out-of-Pocket Maximum.

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 assisted reproductive technology Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology 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.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Service at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Servicio al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。