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Coverage Period: Beginning On or After 1/1/2025

Silver 94 Trio HMO

Coverage for: Individual + Family | Plan Type: HMO

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit bsca.com/policies/MH011325_EOC.pdf or call **1-844-250-2872**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call **1-866-444-3272** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and services listed in your complete terms of coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,150** per individual / **$2,300** per family for participating providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See blueshieldca.com/fad or call **1-844-250-2872** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5/visit	Not Covered	----------None----------
	Specialist visit	*Trio+ Specialist*: $8/visit *Other Specialist*: $8/visit	Not Covered	Self-referral is available for Trio+ Specialist visits.
	Preventive care/screening /immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	*Lab & Path*: $8/visit *X-Ray & Imaging*: $8/visit *Other Diagnostic Examination*: $8/visit	*Lab & Path*: Not Covered *X-Ray & Imaging*: Not Covered *Other Diagnostic Examination*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. The services listed are at a freestanding location.
	Imaging (CT/PET scans, MRIs)	*Outpatient Radiology Center*: $50/visit *Outpatient Hospital*: $50/visit	*Outpatient Radiology Center*: Not Covered *Outpatient Hospital*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1	*Retail*: $3/prescription *Mail Service*: $9/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	Preauthorization is required for select drugs. Failure to obtain preauthorization may result in non-payment of benefits. *Retail*: Covers up to a 30-day supply; *Mail Service*: Covers up to a 90-day supply.
	Tier 2	*Retail*: $10/prescription *Mail Service*: $30/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	
	Tier 3	*Retail*: $15/prescription *Mail Service*: $45/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	

*** For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/MH011325_EOC.pdf.**

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
blueshieldca.com/formulary	Tier 4	*Retail and Network Specialty Pharmacies*: 10% coinsurance up to $150/prescription *Mail Service*: 10% coinsurance up to $450/prescription	*Retail*: Not Covered *Mail Service*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. *Retail and Network Specialty Pharmacies*: Covers up to a 30-day supply; Specialty drugs must be obtained at a Network Specialty Pharmacy. *Mail Service*: Covers up to a 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Ambulatory Surgery Center*: 10% coinsurance *Outpatient Hospital*: 10% coinsurance	*Ambulatory Surgery Center*: Not Covered *Outpatient Hospital*: Not Covered	----------None----------
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	*Facility Fee*: $50/visit *Physician Fee*: No Charge	*Facility Fee*: $50/visit *Physician Fee*: No Charge	----------None----------
	Emergency medical transportation	$30/transport	$30/transport	This payment is for emergency or authorized transport.
	Urgent care	$5/visit	*Within Plan Service Area*: Not Covered *Outside Plan Service Area*: $5/visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	10% coinsurance	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office Visit*: $5/visit *Other Outpatient Services*: No Charge *Partial Hospitalization*: No Charge *Psychological Testing*: No Charge	*Office Visit*: Not Covered *Other Outpatient Services*: Not Covered *Partial Hospitalization*: Not Covered *Psychological Testing*: Not Covered	Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Inpatient services	*Physician Inpatient Services*: 10% coinsurance *Hospital Services*: 10% coinsurance *Residential Care*: 10% coinsurance	*Physician Inpatient Services:* Not Covered *Hospital Services:* Not Covered *Residential Care:* Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	No Charge	Not Covered	----------None----------
	Childbirth/delivery professional services	10% coinsurance	Not Covered	
	Childbirth/delivery facility services	10% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	$3/visit	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 visits per member per Calendar Year.
	Rehabilitation services	*Office Visit*: $5/visit *Outpatient Hospital*: $5/visit	*Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	----------None----------
	Habilitation services	*Office Visit*: $5/visit *Outpatient Hospital*: $5/visit	*Office Visit*: Not Covered *Outpatient Hospital*: Not Covered	
	Skilled nursing care	*Freestanding SNF*: 10% coinsurance *Hospital-based SNF*: 10% coinsurance	*Freestanding SNF*: Not Covered *Hospital-based SNF*: Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Coverage limited to 100 days per member per benefit period.
	Durable medical equipment	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	No Charge	Not Covered	Preauthorization is required except for pre-hospice consultation. Failure to obtain preauthorization may result in non-payment of benefits.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam per member per Calendar Year.
	Children's glasses	No Charge	Not Covered	Coverage is limited to one eyeglass frame and eyeglass lenses or contact lenses instead of eyeglasses, up to the benefit per Calendar Year. The cost listed is for Single Vision.
	Children's dental check-up	No Charge	Not Covered	Coverage for prophylaxis services (cleaning) is limited to once in a six month period.

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture
- Bariatric surgery
- Services related to Abortion

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: Blue Shield Customer Service at 1-844-250-2872. Additionally, you can contact the California Department of Managed Health Care Help at 1-888-466-2219 or visit helpline@dmhc.ca.gov or visit http://www.healthhelp.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes

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

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Does this plan meet the Minimum Value Standards? Not Applicable

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

Language Access Services:

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

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

Tagalog (Tagalog): Kung kailanganninyo ang libreng 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, kwijį' 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.

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

PRA Disclosure Statement

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

*** For more information about limitations and exceptions, see the plan or policy document at bsca.com/policies/MH011325_EOC.pdf.**

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Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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About these Coverage Examples:

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

Peg is Having a Baby
(9 months of participating pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$8
Hospital (facility) coinsurance	10%
Other copayment	$8

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,200**

Managing Joe's Type 2 Diabetes
(a year of routine participating care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$8
Hospital (facility) coinsurance	10%
Other copayment	$8

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$400**

Mia's Simple Fracture
(participating emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$8
Hospital (facility) coinsurance	10%
Other copayment	$8

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

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Evidence of Coverage and Health Service Agreement

Individual and Family Plan
Blue Shield Silver 94 Trio HMO
Provider Network: IFP Trio HMO

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Summary of Benefits

Individual and Family Plan
HMO Plan

Silver 94 Trio HMO

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

Medical Provider Network: **IFP Trio HMO Network**

This Plan uses a specific network of Health Care Providers, called the IFP Trio 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 Ultra**

Drug Formulary: **Standard Formulary**

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual
		$0: Family
Calendar Year 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 Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$1,150
Family coverage	$1,150: individual
	$2,300: Family

No Annual or Lifetime Dollar Limit

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

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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	$5/visit	
Trio+ specialist care office visit (self-referral)	$8/visit	
Other specialist care office visit (referred by PCP)	$8/visit	
Physician home visit	$5/visit	
Physician or surgeon services in an Outpatient Facility	10%	
Physician or surgeon services in an inpatient facility	10%	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, therapists, and podiatrists.*	$5/visit	
Acupuncture services	$5/visit	
Chiropractic services	Not covered	
Teladoc consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
• Infertility services	Not covered	
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.*	$50/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$5/visit	
Ambulance services *This payment is for emergency or authorized transport.*	$30/transport	
Outpatient Facility services		
Ambulatory Surgery Center	10%	
Outpatient Department of a Hospital: surgery	10%	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	
Inpatient facility services		
Hospital services and stay	10%	
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	10%	
• Physician inpatient services	10%	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*		
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*		
• Laboratory center	$8/visit	
• Outpatient Department of a Hospital	$8/visit	
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*		
• Outpatient radiology center	$8/visit	
• Outpatient Department of a Hospital	$8/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	$8/visit	
• Outpatient Department of a Hospital	$8/visit	
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*		
• Outpatient radiology center	$50/visit	
• Outpatient Department of a Hospital	$50/visit	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Rehabilitative and habilitative services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services. There is no visit limit for rehabilitative or habilitative services.		
Office location	$5/visit	
Outpatient Department of a Hospital	$5/visit	
Durable medical equipment (DME)		
DME	10%	
Breast pump	$0	
Orthotic equipment and devices	10%	
Prosthetic equipment and devices	10%	
Home health care services	$3/visit	
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.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs, medical supplies, and visits by a nurse.		
Hemophilia home infusion services	$0	
Includes blood factor products.		
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	10%	
Hospital-based SNF	10%	
Hospice program services	$0	
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.		
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	10%	
• Self-management training	$0	
• Medical nutrition therapy	$0	
Dialysis services	10%	

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

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$5/visit	
Teladoc mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	10%	
Hospital services	10%	
Residential care	10%	

Prescription Drug Benefits[7,8]	Your payment	
	When using a Participating Pharmacy[3]	CYD[2] applies
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$3/prescription	
Tier 2 Drugs	$10/prescription	
Tier 3 Drugs	$15/prescription	
Tier 4 Drugs	10% up to $150/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, for a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$9/prescription	
Tier 2 Drugs	$30/prescription	
Tier 3 Drugs	$45/prescription	
Tier 4 Drugs	10% up to $450/prescription	

Pediatric Benefits	Your payment	
Pediatric Benefits are available through the end of the month in which the Member turns 19.	**When using a Participating Dentist[3]**	**CYD[2] applies**
Pediatric dental[9]		
Diagnostic and preventive services		
• Oral exam	$0	
• Preventive – cleaning	$0	
• Preventive – x-ray	$0	
• Sealants per tooth	$0	
• Topical fluoride application	$0	
• Space maintainers - fixed	$0	
Basic services		
• Restorative procedures	20%	
• Periodontal maintenance	20%	
• Adjunctive general services	20%	
Major services		
• Oral surgery	50%	
• Endodontics	50%	
• Periodontics (other than maintenance)	50%	
• Crowns and casts	50%	
• Prosthodontics	50%	
Orthodontics (Medically Necessary)	50%	

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 *Up to two pairs per eye per Calendar Year.*	$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**
Elective (cosmetic/convenience)		
Standard and non-standard, hard	$0	
Up to a 3 month supply for each eye per Calendar Year based on lenses selected.		
Standard and non-standard, soft	$0	
Up to a 6 month supply for each eye per Calendar Year based on lenses selected.		
• Eyeglass frames		
Collection frames	$0	
Non-collection frames	All charges above $150	
• Eyeglass lenses		
Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.		
Single vision	$0	
Lined bifocal	$0	
Lined trifocal	$0	
Lenticular	$0	
Optional eyeglass lenses and treatments		
• Ultraviolet protective coating (standard only)	$0	
• Polycarbonate lenses	$0	
• Standard progressive lenses	$0	
• Premium progressive lenses	$95	
• Anti-reflective lens coating (standard only)	$35	
• Photochromic - glass lenses	$25	
• Photochromic - plastic lenses	$0	
• High index lenses	$30	
• Polarized lenses	$45	
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 Services under the Plan.

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

3 Using Participating Providers:

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

Accolade, Accolade Benefits are provided through Accolade. These mental health services provided are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

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

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

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

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

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

5 Separate Member Payments When Multiple Covered Services are Received:

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

6 Preventive Health Services:

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

7 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

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

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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.

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.

Mail service Drugs. You may receive up to a 90-day supply for maintenance Drugs from the mail service pharmacy when you pay the applicable retail pharmacy Copayment or Coinsurance for each 30-day supply.

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9 Pediatric Dental Coverage:

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

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

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.

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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.

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

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, the state's health insurance marketplace. When you purchase a plan through Covered California, they will send us your enrollment information. Once you are enrolled, Blue Shield will be your primary point of contact for questions about Benefits, Premiums, payment due dates, providers, and your Cost Share for Covered Services.

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

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

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

About this Agreement

The Evidence of Coverage and Health Service Agreement is the contract between you and Blue Shield. We will refer to it as the Agreement. The Agreement 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 Premium, Deductible, and Out-of-Pocket Maximum.

This Agreement includes a *Summary of Benefits* section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care.

Please read this Agreement 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 Agreement 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 Agreement in your files for future reference.

Tables and images

In this Agreement, 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 Agreement, "you" or "your" means any Member enrolled in the plan, including the Subscriber and all Dependents.

Capitalized words have a special meaning

Some words and phrases in this Agreement may be new to you. Key terms with a special meaning within this Agreement 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.

Questions? Visit blueshieldca.com, use the Blue Shield mobile app, or call Shield Concierge at (844) 250-2872.

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	Shield Concierge: (844) 250-2872 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Acupuncture services	American Specialty Health Plans of California, Inc. (ASH Plans): 1-800-678-9133 (TTY: (877) 710-2746) American Specialty Health Plans of California, Inc. P.O. Box 509002 San Diego, CA 92150-9002
Mental Health Service Administrator (MHSA) - Mental Health and Substance Use Disorder services, including prior authorization	MHSA Mental Health Customer Service: (877) 263-9952 Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002

Contacting customer service	
If you need information about	***You should contact***
Pediatric dental Benefits	Dental Customer Service: (800) 286-7401 Blue Shield of California Dental Plan Administrator 425 Market Street, 15th Floor San Francisco, CA 94105
Pediatric vision Benefits	Vision Customer Service: (855) 342-9105

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

This Agreement is a contract between you and Blue Shield

This Agreement is issued by Blue Shield of California (Blue Shield) to the Subscriber. Blue Shield's offer of coverage relies on statements made in the Subscriber's application. Blue Shield will provide Benefits to the Subscriber and any enrolled Dependents in consideration of timely payment of Premiums in full. The Agreement between Blue Shield and the Subscriber includes the following:

- This Evidence of Coverage and Health Service Agreement;
- The *Summary of Benefits*;
- The Premium Appendix;
- Any endorsements; and
- Any applications or enrollment forms.

IN WITNESS WHEREOF, this Evidence of Coverage and Health Service Agreement is executed by Blue Shield of California through its duly authorized officer, to take effect on the Subscriber's effective date of coverage.

Patrice Bergman
Vice President and General Manager
Individual and Family Plans
Blue Shield of California

Your bill of rights

	As a Blue Shield Member, you have the right to:
1	Receive considerate and courteous care with respect for your right to personal privacy and dignity.
2	Receive information about all health services available to you, including a clear explanation of how to obtain them.
3	Receive information about your rights and responsibilities.
4	Receive information about your Blue Shield plan, the services we offer you, and the Physicians and other Health Care Providers available to care for you.
5	Select a PCP and expect their team to provide or arrange for all the care you need.
6	Have reasonable access to appropriate medical and mental health services.
7	Participate actively with your PCP in decisions about your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8	A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your PCP, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
10	Receive Preventive Health Services.
11	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12	Have confidential health records, except when the state law (California) or federal law requires or permits disclosure. With adequate notice, you have the right to review your medical record with your PCP.
13	Communicate with, and receive information from, Shield Concierge in a language you can understand.
14	Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.

	As a Blue Shield Member, you have the right to:
15	Be fully informed about the complaint and grievance process and understand how to use it without the fear of an interruption in your health care.
16	Voice complaints or grievances about your Blue Shield plan or the care provided to you.
17	Make recommendations on Blue Shield's Member rights and responsibilities policies.

Your responsibilities

	As a Blue Shield Member, you have the responsibility to:
1	Carefully read all Blue Shield plan materials immediately after you are enrolled so you understand how to: • Use your Benefits; • Minimize your out-of-pocket costs; and • Follow the provisions of your plan as explained in the Agreement.
2	Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.
3	Provide, to the extent possible, information needed for you to receive appropriate care.
4	Understand your health problems and take an active role in developing treatment goals with your PCP, whenever possible.
5	Follow the treatment plans and instructions you and your PCP agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6	Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7	Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8	Communicate openly with your PCP so you can develop a strong partnership based on trust and cooperation.
9	Offer suggestions to improve the Blue Shield plan.
10	Help Blue Shield maintain accurate and current records by providing timely information regarding changes in your address, family status, and other plan coverage.
11	Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints or grievances.
12	Treat all Blue Shield personnel respectfully and courteously.
13	Pay your Premiums, Copayments, Coinsurance, and charges for non-Covered Services in full and on time.

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.

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 Services. 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 Services may be provided by a Non-Participating Provider. Your Cost Share will be the same as the amount due to a Participating Provider under similar circumstances, and you will not be responsible for additional charges above the

Allowed Charges, unless the Non-Participating Provider provides you written notice of what they may charge and you consent to those terms.

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 Service from a Benefit Administrator, you should interact with the Benefit Administrator in the same way you would otherwise interact with your PCP.

Blue Shield's Benefit Administrators	
Benefit Administrator	***Benefit***
Dental Plan Administrator (DPA)	Pediatric dental Benefits
Vision Plan Administrator (VPA)	Pediatric vision Benefits
Mental Health Service Administrator (MHSA)	Mental Health and Substance Use Disorder services
ASH Plans	Acupuncture services

Your Primary Care Physician

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

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

Selecting a PCP

Blue Shield may initially choose an Accolade Care virtual PCP for you, but you can change this selection. Members under age 18 will be assigned to an in-person network PCP. 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 Services;
- Ensure that a full panel of Specialists are available to you; and
- Have admission arrangements with Blue Shield's contracted Hospitals within the Medical Group Service Area.

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, the Medical Group, or the MHSA no longer contracts with your Former Participating Provider for the services you are receiving;

- You are a newly-covered Member whose coverage choices do not include out-of-network benefits; or
- You are a newly-covered Member whose previous health plan was withdrawn from the market.

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

You can request to continue treatment with your Former 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 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, the Medical Group's, or the MHSA'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 BlueCard® Program. The Blue Cross Blue Shield Association can help you access care in those geographic areas.

This Blue Shield plan provides limited coverage for health care services received outside of the Plan Service Area. Out-of-Area Covered Health Care Services are restricted to Emergency Services, Urgent Services, and Out-of-Area Follow-up Care. Any other

services will not be covered when processed through an Inter-Plan Arrangement unless prior authorized by Blue Shield.

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. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

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

If you cannot find a Participating Provider

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

Other ways to access care

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

Teladoc

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

How to access Teladoc

Teladoc service	*Ways to access*	*Availability*
General medical	Phone: 1-800-835-2362 Online: blueshieldca.com/teladoc	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/teladoc	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 and Substance Use Disorders are available through MHSA Participating Providers and are a Covered Service regardless of your age. Telebehavioral health includes counseling services, psychotherapy, and medication management with a mental health provider. If you are currently receiving telebehavorial health services for Mental Health and Substance Use Disorders, you can continue to receive those services with the MHSA

Participating Provider rather than switching to a Third-Party Corporate Telehealth Provider. Visit blueshieldca.com and click on Find a Doctor to access the MHSA network.

Urgent care centers

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

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

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

Ambulatory Surgery Centers

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

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

When your appointment will occur	
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
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.

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 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 and Substance Use Disorder services with an MHSA Participating Provider.

Prescription Drugs administered by a Health Care Provider

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

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

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 and Substance Use Disorder, dental, and vision requests	Within five business days
Expedited medical, Mental Health and Substance Use Disorder, dental, and vision requests	Within 72 hours
Routine prescription Drug requests	Within 72 hours
Expedited prescription Drug requests	Within 24 hours

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

The Subscriber is responsible for a monthly payment to Blue Shield for health care coverage. This monthly payment is a Premium. The Premium Appendix is a document the Subscriber receives at the time of enrollment or renewal. It includes the monthly Premium for this plan.

How to pay Premiums

Blue Shield offers a variety of ways for the Subscriber to pay Premiums.

Premium payments	
Payment method	***How to pay***
Mail	Mail payment to: Blue Shield of California P.O. Box 4700 Whittier, CA 90607-4700
Phone	Call (844) 250-2872
Online	Log in to blueshieldca.com and click on Payment Center
Auto-pay	Easy$Pay℠ from your checking or savings account

Visit blueshieldca.com for more information on Premium payment options.

Changes to Premiums

Blue Shield may change your Premium as the law permits. Blue Shield can change your Premium if:

- A federal, state, or other taxing or licensing authority imposes a tax or fee;
- Blue Shield's federal income tax associated with federal excise tax increases;
- Federal or state law requires it; or
- You relocate to a different geographic rating region.

Premiums may vary due to differences in the cost of health care services within each geographic rating region.

Blue Shield will give the Subscriber written notice at least 10 days before the open enrollment period each year, or 60 days prior to renewal, of any Premium change.

Your Premiums may change without written notice when:

- You move to a new geographic rating region. Your new Premium is effective the first of the month after your last billing cycle.
- You add or drop a Dependent. For more information about changing Dependents, see the *Enrollment and effective dates of coverage* section.

Paying for Covered Services

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

Your Cost Share includes any:

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

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Allowed Charges and capitation

Participating Providers agree to accept the Allowed Charges as payment in full for Covered Services provided or arranged by Blue Shield, except as stated in the *Exception for other coverage* and *Reductions – third party liability* sections.

Covered Services provided or arranged by the Medical Group are paid for by capitation payments. Every month, Blue Shield pays a set dollar amount to the Medical Group for each enrolled Member. The capitation payments are available to cover the cost of services when you need them. If 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 Services you receive, the Participating Provider must resolve that dispute with Blue Shield. You are not required to pay for Blue Shield's portion of the Allowed Charges. You are only required to pay your Cost Share for those services.

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

Calendar Year Deductible

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

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

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

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

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

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

See the *Summary of Benefits* section for details on which Covered Services are subject to the Deductible and how the Deductible works for your plan.

Copayment and Coinsurance

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

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

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

Calendar Year Out-of-Pocket Maximum

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

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

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

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

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

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

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

See the *Summary of Benefits* section for details on how the Out-of-Pocket Maximum works for your plan.

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

EXAMPLE

Cost to visit the doctor

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

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

Deductible: **$500**

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

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

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

Participating Provider Copayment: **$30**

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

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

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

Claims for Emergency or Urgent Services

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

reimbursement. Blue Shield may send the payment to the Subscriber or directly to the Non-Participating Provider.

Claim forms are available at blueshieldca.com/covered-california-policies. Please submit your claim form and medical records 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

Covered California determines if you are a Qualified Individual eligible to enroll and continue enrollment in this plan. To enroll in this plan, you must be a Resident of California.

Visit **coveredca.com** for more information about ***Covered California eligibility requirements***.

Dependent eligibility

To be eligible for coverage as a Dependent, the individual must meet all eligibility requirements listed above, as well as certain Covered California Dependent eligibility requirements. The individual must:

- Be listed on the enrollment form completed by the Subscriber; and
- Be the Subscriber's spouse, Domestic Partner, qualifying parent or stepparent, 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.
    - A qualifying parent or stepparent has a Calendar Year gross income as provided in Section 151(d) of the United States Code and the Subscriber provides more than half of their financial support during the Calendar Year.
    - "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.
        - Blue Shield will send a notice of termination due to loss of eligibility 90 days before the date coverage will end. The Subscriber must inform Covered California of the Dependent's eligibility for continuation of

coverage within 60 days of receipt of this notice in order to continue coverage.

- The Subscriber must submit proof of continued eligibility for the Dependent at Blue Shield's request. Blue Shield may not request this information again for two years after the initial determination. Blue Shield may request this information no more than once a year after that. The Subscriber's failure to provide this information could result in termination of a Dependent's coverage.

Enrollment and effective dates of coverage

As the Subscriber, you can apply for coverage for yourself and your Dependents during the annual open enrollment period. You can also apply for coverage for yourself and your Dependents if you qualify for a special enrollment period.

This Agreement covers the Subscriber and any enrolled Dependents for one plan year. A plan year begins on January 1 and ends on December 31 of that same year.

The date coverage starts for the Subscriber and any enrolled Dependents is the effective date of coverage. 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. Blue Shield will notify you of your effective date of coverage.

Open enrollment period

The open enrollment period is the time when most people apply for coverage or change coverage. California law establishes the open enrollment period each year. Visit blueshieldca.com for more information about open enrollment, including this year's dates.

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 Triggering Event.

A special enrollment period gives you at least 60 days from a Triggering Event to apply for or change coverage for yourself or your Dependents. See the *Special enrollment period* section for more information. You should notify Covered California as soon as possible if you experience a Triggering Event that requires a change in your coverage.

If you qualify for a special enrollment period and coverage begins in the middle of a plan year, your coverage under this Agreement will be less than a full year and will end on December 31 of the year coverage began.

Common Triggering Events
Change in Dependents
Move within California under certain circumstances

Common Triggering Events
Loss of minimum essential coverage
Loss of eligibility in a government program

For a complete list of Triggering Events, see ***Special enrollment period*** on page 96 in the ***Other important information about your plan*** section.

Effective date of coverage for most special enrollment periods

If enrolled during open enrollment, Dependents 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 Subscriber submits an application or request for special enrollment, the effective date of coverage will be the 1st of the next month.

Effective date of coverage for a new spouse or Domestic Partner

The effective date of coverage for a new spouse or Domestic Partner will be the 1st of the month following the date the Subscriber submits the Dependent enrollment application. This applies regardless of what day of the month the Subscriber submits the application.

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 ***enroll the child through Covered California within 60 days*** of birth, adoption, placement for adoption, placement in foster care, or the date of court-ordered guardianship.

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.

Terms of coverage

The Subscriber's option to renew this coverage is guaranteed, except as the law permits. The Subscriber must pay Premiums in full within the required timeframe, and the Subscriber and Dependents must maintain eligibility.

The Subscriber must notify Covered California within 60 days of any changes that will affect the eligibility of the Subscriber or an enrolled Dependent. Blue Shield is not obligated to pay for Benefits for an ineligible individual, even if the Subscriber continues to pay Premiums for that individual.

Blue Shield has the right to change this plan, as the law permits. This includes changes to:

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

Blue Shield will not change terms and conditions, Benefits, or limitations and exclusions on an individual basis. If Blue Shield changes this Agreement, the change will affect everyone covered under this plan. Blue Shield will give the Subscriber written notice of any changes to the Agreement. We will send this notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal.

Your Premiums may change without written notice when you initiate the type of change described in the *Changes to Premiums* section.

When coverage ends

Your coverage will end if:

- The Subscriber cancels or does not renew coverage;
- Blue Shield or Covered California cancels or does not renew coverage; or
- Blue Shield or Covered California rescinds coverage.

There is no right to receive the Benefits of this plan after coverage ends, except as described in the *Continuity of care* section.

If the Subscriber pays Premiums beyond the date coverage ends, those Premiums are unearned. Blue Shield will refund unearned Premiums to the Subscriber, minus any amount Blue Shield pays for Benefits received after the date coverage ends. Blue Shield will only issue a refund to the Subscriber if the amount the Subscriber paid in unearned Premiums is more than the amount Blue Shield pays for Benefits after coverage ends.

If the Subscriber cancels or does not renew coverage

The Subscriber can cancel coverage by giving Covered California 14 days' notice. Coverage will end at 11:59 p.m. Pacific Time on the effective date of termination.

If the Subscriber decides to cancel coverage, the actual date coverage ends is based on when the Subscriber gives notice to Covered California. Once the Subscriber's coverage is terminated, coverage under this plan cannot be reinstated. However, you may reapply for coverage during open enrollment, or if you qualify for special enrollment.

When coverage ends if the Subscriber cancels or does not renew

If the Subscriber gives	*Date coverage ends*
14 days' notice or more	The date the Subscriber selects
Less than 14 days' notice	A date Covered California selects that is at least 14 days after receipt of your notice

If Blue Shield or Covered California cancels or does not renew coverage

Blue Shield or Covered California can cancel coverage or deny renewal, as the law permits. If this happens, the date coverage ends depends on the reason for cancellation or non-renewal.

Cancellation for Subscriber's nonpayment of Premiums

Blue Shield can cancel your coverage if the Subscriber does not pay the required Premiums in full and on time. The Subscriber is responsible for all Premiums during the term of coverage, including the grace period. If Blue Shield cancels coverage due to nonpayment of Premiums, Blue Shield will send the Notice of Termination to the Subscriber within five business days of the cancellation. This notice will state:

- That the Agreement has been canceled;
- The reasons for cancellation; and
- The specific date and time when your coverage will end.

Premium grace period if you do not receive Advance Payments of Premium Tax Credits

The Subscriber has a 30-day grace period to pay all outstanding Premiums before coverage is canceled due to nonpayment of Premiums. Coverage will continue during the grace period. Blue Shield will send a Notice of Start of Grace Period to the Subscriber after the last date of paid coverage. The 30-day grace period begins on the day the Notice of Start of Grace Period is dated. If the Subscriber does not pay all outstanding Premiums within the grace period, coverage will end the day following the 30-day grace period. The Subscriber will be liable for all Premiums owed, even if coverage is canceled. This includes Premiums owed for coverage during the 30-day grace period.

Premium grace period if you receive Advance Payments of Premium Tax Credits and/or State Advanced Premium Assistance Subsidy

If the Subscriber previously paid Blue Shield at least one full month's Premium during the benefit year and is late on a Premium payment, Blue Shield will notify the Subscriber and the Subscriber will have a grace period of three consecutive months from the due date to pay all outstanding Premiums. Blue Shield will pay claims for Covered Services during the first month (or first 30 days, whichever is greater) of the grace period. Coverage will be suspended for the second and third months of the grace period until the Subscriber pays all Premiums owed.

If the three-month grace period expires before the Subscriber pays all outstanding Premiums, Blue Shield will terminate coverage. The last day of coverage will be the last day of the first month of the three-month grace period (or 30 days from the first day of the first month, whichever is later).

Cancellation for fraud or intentional misrepresentation of material fact

Blue Shield or Covered California may cancel your coverage for fraud or intentional misrepresentation of material fact if you:

- Intentionally provide false or misleading information to Blue Shield or Covered California on the enrollment application or otherwise. This includes incorrect or incomplete material information such as failing to provide Blue Shield with required or requested information in a timely manner;
- Let someone else use your ID card to receive services; or
- Receive, or attempt to receive, services by means of false, materially misleading, or fraudulent information, acts, or omissions.

Blue Shield or Covered California rescinds coverage

IF THE SUBSCRIBER OR ANY ENROLLED DEPENDENT COMMITS FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT DURING THE APPLICATION PROCESS, BLUE SHIELD OR COVERED CALIFORNIA CAN RETROACTIVELY CANCEL COVERAGE. THIS INCLUDES FAILURE TO DISCLOSE ANY NEW OR CHANGED FACTS PERTAINING TO THE APPLICATION THAT ARISE AFTER SUBMISSION OF THE APPLICATION BUT BEFORE THE EFFECTIVE DATE OF COVERAGE. THIS RETROACTIVE CANCELLATION IS RESCISSION.

If Blue Shield or Covered California rescinds coverage, Blue Shield will provide the Subscriber with a 30-day written notice. This notice will state:

- The reason for the rescission;
- Information about the Subscriber's right to appeal, including the right to request assistance from the Department of Managed Health Care;
- Clarification that individuals whose application information was not false or incomplete are entitled to new coverage, and:
  - How those individuals may obtain new coverage; and
  - How Blue Shield will determine Premiums for those individuals.

After your contract has been in effect for 24 months, Blue Shield or Covered California cannot rescind coverage for any reason. If Blue Shield or Covered California rescinds coverage, the Subscriber and any enrolled Dependents will lose

all coverage dating back to the original effective date of coverage. It will be as if coverage never existed.

When Blue Shield or Covered California cancels, does not renew, or rescinds coverage

Reason	*Date coverage ends*
Failure to pay Premiums in full and on time, including the grace period	30 days after the date on the Notice of Start of Grace Period
Fraud or intentional misrepresentation of a material fact during the application process	The initial effective date of coverage
Fraud or intentional misrepresentation of a material fact after enrollment	30 days afterwritten notice to the Subscriber
Loss of Subscriber eligibility	30 days after written notice to the Subscriber
Loss of Dependent eligibility for a spouse or Domestic Partner	If notice of ineligibility is sent before the 15th of the month: The first day of the month after notice is sent If notice of ineligibility is sent after the 15th of the month: The first day of the second month after notice is sent
Loss of Dependent eligibility for a child	The last day of the year in which the Dependent turns 26
Subscriber changes from one health plan to another during open or special enrollment period	The day before the effective date of coverage in the Subscriber's new plan
Request to enroll a newborn, adopted child, or child placed for adoption is not received within 60 days of the initial coverage date	Day 31 following the initial coverage date
Blue Shield no longer offers this Individual and Family Plan	90 days after written notice to the Subscriber
Blue Shield no longer offers any Individual and Family Plans	180 days after written notice to the Subscriber

When Blue Shield or Covered California cancels, does not renew, or rescinds coverage	
Reason	***Date coverage ends***
Subscriber was enrolled in a Qualified Health Plan without his or her knowledge or consent by a third party, including by a third party with no connection to Covered California	The initial effective date of coverage

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 Agreement.

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 services help your provider ensure that your care is provided safely and effectively in a setting that is appropriate to your needs. Your Cost Share for outpatient Benefits may vary depending on where you receive them.

See the *Exclusions and limitations* section for more information about Benefit exclusions and limitations.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Acupuncture services

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

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

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

Allergy testing and immunotherapy Benefits

Benefits are available for allergy testing and immunotherapy services.

Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests;

- Preparation and provision of allergy serum; and
- Allergy serum injections.

This Benefit does not include:

- Blood testing for allergies.

Ambulance services

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

Benefits include:

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

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

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

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

- The investigational item, device, or service itself;
- Drugs or devices not approved by the U.S. Food and Drug Administration (FDA);
- Travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;

- Services normally provided by the research sponsor free for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening diseases or conditions, and the study or investigation meets one of the following requirements:

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

Diabetes care services

Benefits are available for devices, equipment, supplies, and self-management training to help manage your diabetes. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately-licensed Health Care Provider who is certified as a diabetes educator.

Devices, equipment, and supplies

Covered diabetic devices, equipment, and supplies include:

- Blood glucose monitors, including 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.

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;
- 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;
- 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;
- DME rental fees, up to the purchase price; and
- Breast pumps.

Benefits do not include:

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

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

See the *Diabetes care services* section for more information about devices, equipment, and supplies for the management and treatment of diabetes.

Orthotic equipment and devices

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

Benefits include:

- Shoes only when permanently attached to orthotic devices;
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or developmental disability;
- Knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

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

Prosthetic equipment and devices

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

Benefits include:

- Tracheoesophageal voice prosthesis (e.g.Blom-Singer device) and artificial larynx for speech after a laryngectomy;
- Artificial limbs and eyes;
- Internally-implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if surgery to implant the device is covered;
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or to treat aphakia following cataract surgery when no intraocular lens has been implanted;
- Supplies necessary for the operation of prostheses;
- Device fitting and adjustment;
- Device replacement at the end of its expected lifespan; and
- Repair due to normal wear and tear.

Benefits do not include:

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

Emergency Benefits

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

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

Benefits include:

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

After your condition stabilizes

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

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

Stabilization is medical treatment necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, your release from medical care or transfer from a facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or unborn child, stabilize means delivery, including the placenta. Post-stabilization care is Medically Necessary treatment received after the treating Physician determines the Emergency Medical Condition is stabilized.

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

Family planning Benefits

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.

Fertility preservation services

Fertility preservation services are covered for Members undergoing treatment or receiving Covered Services that may directly or indirectly cause iatrogenic Infertility. Under these circumstances, standard fertility preservation services are a Covered Service.

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

Benefits include:

- Pre-Hospice consultation to discuss care options and symptom management;
- Advance care planning;
- Skilled Nursing Services;
- Medical direction and a written treatment plan approved by a Physician;
- Continuous Nursing Services provided by registered or licensed vocational nurses, eight to 24 hours per day;
- Home Health Aide services, supervised by a nurse;

- Homemaker services, supervised by a nurse, to help you maintain a safe and healthy home environment;
- Medical social services;
- Dietary counseling;
- Volunteer services by a Hospice agency;
- Short-term inpatient, Hospice house, or Hospice care, if required;
- Drugs, medical equipment, and supplies;
- Physical therapy, occupational therapy, and speech-language pathology services to control your symptoms or help your ability to perform Activities of Daily Living;
- Respiratory therapy;
- Occasional, short-term inpatient respite care when necessary to relieve your primary caregiver or family members, up to five days at a time;
- Bereavement services for your family; and
- Social services, counseling, and spiritual services for you and your family.

Benefits do not include:

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

Hospital services

Benefits are available for inpatient care in a Hospital.

Benefits include:

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

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

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

Benefits include:

- Treatment of 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 and Substance Use Disorder Benefits

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

Accolade and Teladoc are administered by Blue Shield, not the MHSA. See the *Accolade* and *Teladoc* sections for more information.

Mental Health and 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.

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

The MHSA Participating Provider network is separate from Blue Shield's Participating Provider network. Visit blueshieldca.com and click on Find a Doctor to access the MHSA Participating Provider network.

If you are unable to schedule an appointment with a Participating Provider for Mental Health and Substance Use Disorder services, contact Mental Health Customer Service. The MHSA will help you either schedule an appointment with a Participating Provider, or select a Non-Participating Provider in your area within five calendar days and contact you regarding available appointment times. For any Covered Services, you will be responsible for no more than the Cost Share for using an MHSA Participating Provider. The MHSA 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 and Substance Use Disorder benefits and services.

Office visits

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

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

Other Outpatient Mental Health and Substance Use Disorder Services

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

For Behavioral Health Crisis Services rendered by a Non-Participating Provider, you will pay the same Cost Share for Covered Services 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 the MHSA 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 a seizure, used in the treatment of severe depression;
- Intensive Outpatient Program – outpatient care for mental health or substance use disorders when your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week;
- Office-based opioid treatment – substance use disorder maintenance therapy, including methadone maintenance treatment;
- Partial Hospitalization Program – an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services at least five hours per day, four days per week when you are admitted directly or transferred from acute inpatient care following stabilization;
- Psychological Testing – testing to diagnose a mental health condition; and
- Transcranial magnetic stimulation – a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Benefits do not include:

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

Inpatient Services

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

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

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

Pediatric dental Benefits

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

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

To confirm that your Dental Provider is a DPA Participating Provider, or if you have any questions about pediatric dental Benefits, visit blueshieldca.com, use the Blue Shield mobile app, or contact dental customer service at (800) 286-7401.

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

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

With this plan, you can see any DPA Participating Provider in your Plan Service Area. You are not required to select a primary Dental Provider.

You do not need a referral to see a Specialist who is a DPA Participating Provider.

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

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 renders vision services to Members. The VPA also serves as the claims administrator for processing claims received from VPA Participating Providers and Non-Participating Providers.

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

To confirm that your provider is a VPA Participating Provider, or if you have any questions about Benefits, visit blueshieldca.com, use the Blue Shield mobile app, or contact vision customer service at (855) 342-9105.

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 the employer 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 Agreement.
- 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 general medical consultations.

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

PKU formulas and special food products

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

Benefits include:

- Enteral formulas;
- 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.

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 Shield Concierge 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***.

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 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 tier 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 the difference in cost between the Brand Drug and Generic Drug equivalent or Biosimilar Drug through the Blue Shield prior authorization process. The request will be reviewed for Medical Necessity. If the request is approved, you will 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 Shield Concierge at the number listed on their Identification Card.

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

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

Obtaining outpatient prescription Drugs from the mail service pharmacy

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

You must pay the applicable 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 mail service pharmacy.

Obtaining Specialty Drugs from a Network Specialty Pharmacy

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

Specialty Drugs are only available from a Network Specialty Pharmacy. 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 drugs, 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 drugs.

You, your Physician, or your Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. If the request does not include all necessary supporting information, Blue Shield will notify the requestor within 72 hours in routine circumstances or within 24 hours in exigent circumstances. Once Blue Shield receives all required supporting information, Blue Shield will provide prior authorization approval or denial within 72 hours of receipt in

routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when you have a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or you are undergoing a current course of treatment using a non-Formulary Drug.

To request coverage for a non-Formulary Drug, you, your representative, your Physician, or your Health Care Provider may submit an exception request to Blue Shield. 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 from the mail service pharmacy. If your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable mail service 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. Blue Shield only covers Preventive Health Services when you receive them from a Participating Provider.

Benefits include:

- Evidence-based items, drugs, or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), such as:
  - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer;
  - Screening for HPV;
  - Screening for osteoporosis; and
  - Health education;
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration, including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning;
- 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. 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 and therapeutic treatment to develop, improve, and maintain your musculoskeletal, neuromuscular, and respiratory systems. Physical agents and therapeutic treatments include but are not limited to:

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

Occupational therapy

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

Speech therapy

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

- A communication impairment;
- A swallowing disorder;

- An expressive or receptive language disorder; and
- An abnormal delay in speech development.

Skilled Nursing Facility (SNF) services

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

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

Transplant services

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

Tissue and kidney transplants

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

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

Special transplants

Benefits are available for special transplants only if:

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

Special transplants are:

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

Donor services

Transplant Benefits include coverage for donation-related services for a living donor, including a potential donor, or a transplant organ bank. Donor services must be directly related to a covered transplant for a Member of this plan.

Donor services include:

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

Urgent care services

Benefits are available for urgent care services you receive at an urgent care center, 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

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

This section has the following tables:

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

	General exclusions and limitations
1	This plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.
2	Routine physical examinations solely for: • Immunizations and vaccinations, by any mode of administration, for the purpose of travel; or • Licensure, employment, insurance, court order, parole, or probation. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
3	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
4	Routine foot care items and services that are not Medically Necessary, including: • 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. This exclusion does not apply to items or services provided through a Participating Hospice Agency or covered under the diabetes care Benefit.
5	Home services, hospitalization, or confinement in a health facility primarily for rest, custodial care, or domiciliary care. Custodial care is assistance with Activities of Daily Living furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board.

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

General exclusions and limitations	
	fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.
14	Services for anyone in connection with a Surrogacy Arrangement, except for Covered Services provided to a Member who is a surrogate. For more information, see the *Reductions – Surrogacy Arrangement* section.
15	Home testing devices and monitoring equipment. This exclusion does not apply to COVID-19 at-home testing kits, sexually transmitted disease home testing kits, or items specifically described in the *Durable medical equipment* or *Diabetes care services* sections.
16	Preventive Health Services performed by a Non-Participating Provider, except laboratory services under the California Prenatal Screening Program.
17	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
18	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
19	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services. This exclusion does not apply to Behavioral Health Treatment Benefits listed under the *Mental Health and Substance Use Disorder Benefits* section or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided by an individual trainee, associate or applicant for licensure who is supervised as required by applicable law.
20	Select physical and occupational therapies, such as: • Massage therapy, unless it is performed as part of a rehabilitative or habilitative physical therapy treatment plan by a licensed or certified Health Care Provider. Massage is considered not Medically Necessary when performed as the solitary treatment or prescribed to an individual who presents with no complications;

General exclusions and limitations	
	• Training or therapy for the treatment of learning disabilities or behavioral problems; • Social skills training or therapy; • Vocational, educational, recreational, art, dance, music, or reading therapy; and • Testing for intelligence or learning disabilities. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
21	Weight control programs and exercise programs. This exclusion does not apply to nutritional counseling provided under the *Diabetes care services* section, or to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder, or Preventive Health Services.
22	Services or Drugs that are Experimental or Investigational in nature.
23	Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), including, but not limited to: • Drugs; • Medicines; • Supplements; • Tests; • Vaccines; • Devices; and • Radioactive material. However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.
24	The following non-prescription (over-the-counter) medical equipment or supplies: • Oxygen saturation monitors; • Prophylactic knee braces; and • Bath chairs.
25	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, and food delivery services.
26	Disposable supplies for home use except as provided under the *Durable medical equipment*, *Home health services*, and *Hospice program services* sections, or the Prescription Drug Benefit.
27	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

	General exclusions and limitations
	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.
28	Chiropractic spinal manipulation and adjustment.
29	Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van).
30	Drugs dispensed by a Physician or Physician's office for outpatient use.
31	Hospital care programs or services provided in a home setting (Hospital-at-home programs).

	Outpatient prescription Drug exclusions and limitations
1	Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion will not apply to items used for the administration of diabetes or asthma Drugs.
2	Drugs when prescribed for cosmetic purposes. This includes, but is not limited to, Drugs used to slow or reverse the effects of skin aging or to treat hair loss.
3	Medical devices or supplies, except as listed in the *Durable medical equipment* section. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices.
4	Non-Formulary Drugs, unless an exception request is approved. See the *Prescription Drug Benefits* section for more information.
5	Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained on an emergency or urgent basis.
6	Drugs obtained from a pharmacy that is not licensed by the State Board of Pharmacy, or included on a government exclusion list.
7	Drugs that are available without a prescription (over-the-counter), including drugs for which there is an over-the-counter drug that has the same active ingredient and dosage as the prescription Drug. This exclusion will not apply to over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B when prescribed by a Physician or to over-the-counter contraceptive Drugs and devices.

	General exclusions and limitations
8	Prescription Drugs that are repackaged by an entity other than the original manufacturer.
9	Replacement of lost, stolen, or destroyed Drugs.
10	Immunizations and vaccinations solely for the purpose of travel.
11	Compounded medications unless all of the following requirements are met: • A compounded medication includes at least one Drug; • The compounded medication does not contain a bulk chemical (except for bulk chemicals that meet FDA criteria for use as part of a Medically Necessary compound); • There are no FDA-approved, commercially-available, medically-appropriate alternatives; and • The compounded medication is self-administered.
12	A manufacturer's product may be excluded when the same or similar Drug (one with the same active ingredient or same therapeutic effect) is available under this Prescription Drug Benefit. Any dosage or formulation of a Drug may be excluded when the same Drug is available under the *Prescription Drug Benefit* in a different dosage or formulation.
13	Drugs for weight loss when prescribed solely for the purpose of losing weight, except for Medically Necessary treatment of Class III obesity when prior authorized. This exclusion does not apply to items or services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

	Pediatric dental exclusions
1	Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member.
2	General anesthesia or intravenous/conscious sedation unless specifically listed as a Benefit in the *Summary of Benefits* section or on the pediatric dental Benefits table, or administered by a Dentist for a covered oral surgery.
3	Cosmetic dental care.
4	Treatment for which payment is made by any governmental agency, including any foreign government.
5	Services of Dentists or other practitioners of healing arts not associated with the plan, except upon referral arranged by a Dental Provider and authorized by the DPA, or when required in a covered emergency.

General exclusions and limitations	
6	Hospital charges of any kind.
7	Procedures, appliances, or restorations to correct congenital or developmental malformations, unless specifically listed in the *Summary of Benefits* section or on the pediatric dental Benefits table.
8	Malignancies.
9	Drugs not normally supplied in a dental office.
10	Dental Care Services administered by a pediatric Dentist, except when: • 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;

General exclusions and limitations	
	• 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; • 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);

General exclusions and limitations	
	• 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) **(D6200-D6999)**	• Fixed partial dentures (bridgework); however, the fabrication of a fixed partial denture shall be considered 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

General exclusions and limitations

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:
  - 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;

General exclusions and limitations	
	○ Myofunctional therapy; ○ Macroglossia; ○ Hormonal imbalances; ○ Orthodontic retreatment when initial treatment was rendered under this plan or changes in orthodontic treatment necessitated by any kind of accident; ○ Palatal expansion appliances; ○ Services performed by outside laboratories; and ○ Replacement or repair of lost, stolen or broken appliances damaged due to the neglect of the Member.

Grievance process

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

Submitting a grievance

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

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

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

Where to mail grievances

Type of grievance	*Address*
Medical and prescription Drug Benefits	Blue Shield of California Shield Concierge Appeals and Grievance P.O. Box 5588 El Dorado Hills, CA 95762
Mental Health and Substance Use Disorder services from an MHSA Participating Provider	Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171
Pediatric dental Benefits	Blue Shield of California Dental Plan Administrator 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 MHSA 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 and 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) 250-2872** 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.

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.

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 46 in the ***Your coverage*** section.

A special enrollment period is a timeframe outside of open enrollment when a Qualified Individual can enroll in, or change enrollment in, a health plan. The special enrollment period is 60 days following the date of a Triggering Event, unless a different period is 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 Subscriber:
        - 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 or complete loss of employer premium contributions or governmental subsidies.

- 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. The special enrollment period begins 60 days before the Triggering Event and ends 90 days after the Triggering Event.
- Loss of Medi-Cal medically needy coverage (only once per calendar year). The special enrollment period begins 60 days before the Triggering Event and ends 90 days after the Triggering Event.
- Acquiring or becoming a Dependent through marriage, establishment of domestic partnership, becoming a qualifying parent or stepparent, 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.
- A Qualified Individual'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 Blue Shield, Covered California, or the Department of Health and Human Services (HHS), evaluated and determined by Covered California. In such cases the action may be taken to correct or eliminate the effects of such error, misrepresentation, or inaction.
- A Qualified Individual 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.
- A Qualified Individual 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.
- A Qualified Individual or Dependent gains access to a new health plans as a result of a permanent move.
- A Qualified Individual or Dependent is determined newly eligible for advance payments of the premium tax credit or for cost-sharing reductions. Additional 60-day period before Triggering Event applies.
- A Qualified Individual or Dependent is determined newly ineligible for advance payments of the premium tax credit or for cost-sharing reductions.

- A Qualified Individual or Dependent has been released from incarceration.
- A Qualified Individual 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.
- A Qualified Individual or Dependent:
    - Applies for coverage from Covered California 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.
- A Qualified Individual or Dependent was receiving services from a contracting provider under another health plan for one of the conditions eligible for completion of Covered Services and that provider is no longer participating in the other health plan.
- A Qualified Individual 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.
- A Qualified Individual or Dependent is enrolled in an eligible employer-sponsored plan that will no longer be affordable or provide minimum value.
- A Qualified Individual or Dependent gains access to and enrolls in a qualified small employer health reimbursement arrangement (QSEHRA) or an individual coverage health reimbursement arrangement (ICHRA).
    - The special enrollment period is 60 days before the Triggering Event if the Qualified Individual receives a written notice of eligibility from the QSHRA or ICHRA at least 90 days before the beginning of the QSHRA or ICHRA plan year.
    - The special enrollment period is 60 days before or after the Triggering Event if the Qualified Individual does not receive a written notice of eligibility from the QSEHRA or ICHRA at least 90 days before the beginning of the QSHRA or ICHRA plan year.
- A Qualified Individual or Dependent is enrolled in a Qualified Health Plan that is decertified.
- An individual or Dependent is deemed a Qualified Individual because he or she is no longer incarcerated or considered a non-resident.
- A Qualified Individual or Dependent demonstrates to the exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the exchange may allow.
- 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.
- National public health emergency or pandemic that results in a declaration of state of emergency at the state or national level.

Out-of-area services

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

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

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

See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Arrangements

Emergency Services

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

BlueCard® Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, Blue Shield will remain responsible for the provisions of this Agreement. However, the Host Blue is

responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

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

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

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

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

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

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

Non-Participating Providers outside of California

Coverage for health care services provided outside of California and within the BlueCard® Service Area by non-participating providers is limited to Out-of-Area Covered Health Care Services. The amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, or the pricing arrangements required by applicable state 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 BlueCard® Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Blue Shield of California for reimbursement. Blue Shield will review your claim and notify you of its coverage determination within 30 days after receipt of the

claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Your Cost Share for out-of-network Emergency Services will be the same as the amount due to a Participating Provider for such Covered Services, as listed in the Summary of Benefits.

Blue Shield Global® Core

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

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

Submitting a Blue Shield Global® Core claim

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

If you receive Medicare, Blue Shield will provide your Benefits but Medicare will typically be the primary payor and Blue shield will be the secondary payor as determined by Medicare regulations.

When Blue Shield is the secondary payor, your combined Benefits from Medicare and Blue Shield will equal but not exceed what Blue Shield would pay if you were not eligible for Medicare. Blue Shield's payment will be based on an amount that may be lower than the Medicare allowed amount but will not exceed the Medicare allowed amount. You must pay any applicable Deductibles, Copayments, and Coinsurance for your Blue Shield plan before Blue Shield will provide Benefits.

Medi-Cal

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

Qualified veterans

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

Coverage by another government agency

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

Exception for other coverage

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

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

Reductions – third-party liability

If you are injured or become ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to services required as a result of that injury, provide the Benefits of the plan and have an equitable right to restitution, reimbursement, or other available remedy to recover the amounts Blue Shield paid for services provided to you on a fee-for-service basis from any recovery (defined below) obtained by or on your behalf, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

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, or from uninsured or underinsured motorist coverage, 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.

You are required to:

- Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or have brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party;
- Cooperate with Blue Shield to execute any forms or documents needed to enable Blue Shield to enforce its right to restitution, reimbursement, or other available remedies;
- Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage;
- Provide Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and
- Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten days after any Recovery has been obtained.

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.

Reductions – Surrogacy Arrangement

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse Blue Shield for Covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with the Surrogacy. This Surrogacy Arrangement section does not affect your obligation to pay your Cost Share for these Covered Services. After you surrender a baby to the legal parents, the legal parents are financially responsible for any services that the baby receives. You are not obligated to reimburse Blue Shield for any services that the baby receives.

By receiving Covered Services in connection with a Surrogacy Arrangement, you automatically assign to Blue Shield your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments and amounts in any account that holds those payments will first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to Blue Shield under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the Surrogacy Arrangement;
- Names, addresses, and telephone numbers of any escrow agent or trustee;
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Covered Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover services that the baby (or babies) receive;
- A signed copy of any contracts and other documents explaining the Surrogacy Arrangement; and
- Any other information we request in order to satisfy our rights.

Please send this information to:

Blue Shield of California
Surrogacy Mailbox
P.O. Box 3008
Lodi, Ca 95241-1912

You must complete and send Blue Shield all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this Surrogacy Arrangement section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this Surrogacy Arrangement section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator will be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. Blue Shield may assign our rights to enforce our liens and other rights.

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

Coverage under this Agreement may not be assigned. To be entitled to the Benefits of this Agreement, you must be a Subscriber or Dependent who has been enrolled by Blue Shield and who has maintained eligibility and enrollment under the terms of this Agreement. Possession of a Blue Shield ID card without enrollment confers no rights to the Benefits of this Agreement.

The Benefits of this Agreement may not be assigned without the written consent of Blue Shield. Participating Providers are paid directly by Blue Shield or the Medical Group. When you are authorized to receive Covered Services from a Non-Participating Provider, Blue Shield, at its sole discretion, may make payment to the

Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider.

Plan interpretation

Blue Shield shall have the power and authority to construe and interpret the provisions of this Agreement, to determine the Benefits of this Agreement and to implement eligibility determinations made by Covered California. Blue Shield shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Agreement.

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, and Subscriber 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, from Covered California or other entities, or from the Member, in order to administer the Benefits and eligibility provisions of this Agreement. 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.

Legal process

Legal process or service upon Blue Shield must be served upon Blue Shield's Registered Agent for Service of Process or upon Blue Shield at Blue Shield's corporate offices at 601 12th Street, Oakland, California 94607.

Notice of Participating Provider's inability to perform, breach, or termination

If a Participating Provider's inability to perform, breach of the Agreement to furnish services, or contract termination materially and adversely affects the Member, Blue Shield will, within a reasonable time, advise the Member in writing of such inability to perform, breach, or termination.

Entire Agreement: changes

This Agreement, including the Evidence of Coverage and Health Service Agreement, the Summary of Benefits, enrollment applications and forms, and appendices, constitutes the entire agreement between the parties. Any statement made by a Blue Shield representative shall, in the absence of fraud, be deemed a representation and not a warranty.

No change to this Agreement shall be valid unless approved by a corporate officer of Blue Shield and documented in a written endorsement issued by Blue Shield. No representative has the authority to change this Agreement or to waive any of its provisions. The terms of this Agreement, including but not limited to Benefits, exclusions, Cost Share, and Premiums, are subject to change as permitted by law. Blue Shield will give the Subscriber written notice of Premium rates or coverage changes, unless otherwise specified in the *Changes to Premiums* section. We will send this notice at least 10 days before the open enrollment period each year, or 60 days prior to plan renewal.

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.

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.

Endorsements and appendices

Attached to, or incorporated by reference into, this Agreement are appendices pertaining to Premiums. Endorsements may be issued from time to time subject to the

notice provisions in the section entitled *Entire Agreement: changes*. The issuance of an endorsement shall not affect this Agreement, except as expressly provided in the endorsement.

Notices

Any notice required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield.

Notice to Blue Shield may be mailed to:

Blue Shield of California
601 12th Street
Oakland, CA 94607

Statutory requirements

This Agreement is subject to applicable state law and related regulations, including the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations, or in the alternative the Insurance Code, and Title 10 of the California Code of Regulations. Any provision required to be in this Agreement based on such state law or regulation shall be binding upon the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

In addition, this Agreement is subject to applicable federal law, including the Patient Protection and Affordable Care Act of 2010 (PPACA), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and related regulations. Any provision required to be in this Agreement based on such federal law or regulation shall be binding upon the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

Blue Cross Blue Shield Association Disclosure

The Subscriber hereby expressly acknowledges his or her understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association (Association), an association of independent Blue Cross and Blue Shield licensees, permitting Blue Shield to use the Blue Shield Service Mark in the State of California and that Blue Shield is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that he or she has not entered into this Agreement based upon representations by any person other than Blue Shield or Blue Shield's authorized representative and that neither the Association nor any person, entity or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any Blue Shield obligations created under this Agreement. This paragraph shall not create any additional obligations to the Subscriber whatsoever on the part of Blue Shield, other than those obligations created under other provisions of this Agreement.

Definitions

Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
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.
Agreement (Evidence of Coverage and Health Service Agreement)	Evidence of Coverage and Health Service Agreement, Summary of Benefits, all endorsements, appendices, and all applications and forms for coverage.
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.
Anticancer Medications	Drugs used to kill or slow the growth of cancerous cells.
ASH Participating Provider	A Physician or Health Care Provider under contract with ASH Plans to provide Covered Services to Members.
Behavioral Health 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 Services)	Medically Necessary services and supplies you are entitled to receive pursuant to this Agreement.
Benefit Administrator	Administrator for specialized Benefits such as pediatric dental, pediatric vision, or Mental Health and Substance Use Disorder Benefits.
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 Agreement as Blue Shield.
BlueCard® 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.
Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.

Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to this Agreement.
Deductible	The Calendar Year amount you must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to this Agreement.
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	An individual who meets one of the following eligibility requirements: • A qualifying parent or stepparent. • 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 Agreement. • 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 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: o not currently married to someone else or a member of another domestic partnership; and o 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 • Both partners must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code. The domestic partnership is deemed created on the date when both partners meet the above requirements.
Drugs	Drugs include the following: • FDA-approved medications that require a prescription either by California or Federal law; • Insulin

	• Pen delivery systems for the administration of insulin, as Medically Necessary;
	• Self-applied continuous blood glucose monitors, and all related necessary supplies;
	• Diabetic testing supplies, including the following:
	  o Lancets;
	  o Lancet puncture devices;
	  o Blood and urine testing strips; and
	  o Test tablets;
	• Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;
	• Contraceptive drugs, devices, and products, including the following:
	  o Diaphragms;
	  o Cervical caps;
	  o Contraceptive rings;
	  o Contraceptive patches;
	  o Oral contraceptives;
	  o Emergency contraceptives; and
	  o Over-the-counter contraceptive products;
	• Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers.

DPA Participating Provider	A provider who has an agreement in effect with the Dental Plan Administrator (DPA) for the provision of pediatric dental Benefits under this plan.
Emergency Dental Condition	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	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.

Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; • Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital; and • Solely to the extent required under the federal law, Emergency Services also include any additional items or services that are covered under the plan and furnished by a Non-Participating Provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies shall be considered experimental or investigational if, as determined by Blue Shield, at least one of the following elements is met: • Requires approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered; or • Is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue, but nevertheless is authorized by law or by a government agency for use; or • Is not approved or recognized in accordance with accepted professional medical standards, but

	nevertheless is authorized by law or by a government agency for use in testing, trials, or other studies on human patients; or • Is not recognized or not recommended by nationally recognized treatment guidelines by a specialty society or medical review organization, if applicable, or where the consensus amongst experts in recognized published medical literature is that further studies or experience are necessary to determine effectiveness and net health benefit in treatment of the illness, injury, or condition at issue, but nevertheless are authorized by law or by a government agency for use.
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 or an MHSA Participating Provider, but at the time of the provider's contract termination with Blue Shield or the MHSA, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section. • A Non-Participating Provider to a newly-covered Member whose health plan was withdrawn from the market, and at the time your coverage with Blue Shield became effective, you were receiving Covered Services from that provider for one of the conditions listed in the *Continuity of care with a Former Participating Provider* table in the *Continuity of care* section.
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 of Mental Health and 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 United States Food and Drug Administration.
Generic Drugs	Drugs that are approved by the U.S. Food and Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent to the Brand Drug. Generic Drugs contain the same active ingredient(s) as Brand Drugs.
Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Associate clinical social worker; • Associate marriage and family therapist or marriage and family therapist trainee; • Associate professional clinical counselor or professional clinical counselor trainee; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Psychology trainee or person supervised as required by law;

	• Qualified autism service provider or qualified autism service professional certified by a national entity; • Registered dietician; • Registered nurse; • Registered psychological assistant; • Registered respiratory therapist; • Speech and language pathologist.
Hemophilia Home Infusion Provider	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 BlueCard® Service Area.
Infertility	May be either of the following: • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.
Intensive Outpatient Program	An outpatient treatment program for mental health or substance use disorders that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.

Inter-Plan Arrangements	Blue Shield's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
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.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are: • Consistent with Blue Shield medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician's office, the Outpatient Department of a Hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

	Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants. This definition does not apply to Mental Health and Substance Use Disorders. Medically Necessary Treatment of a Mental Health or Substance Use Disorder is defined separately.
Medically Necessary Treatment of a Mental Health or Substance Use Disorder	A Covered Service or product addressing the specific needs of a Member, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: • In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care; • Clinically appropriate in terms of type, frequency, extent, site, and duration; and • Not primarily for the economic benefit of the disability insurer and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.
Member	An individual who is enrolled and maintains coverage in the plan pursuant to this Agreement as either a Subscriber or a Dependent. Use of "you" in this document refers to the Member.
Mental Health and Substance Use Disorder(s)	A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases or listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Mental Health Service Administrator (MHSA)	The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to administer Blue Shield's

	Mental Health and Substance Use Disorder services through a separate network of MHSA Participating Providers.
MHSA Non-Participating Provider	A provider who does not have an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.
MHSA Participating Provider	A provider who has an agreement in effect with the MHSA for the provision of mental health or substance use disorder services.
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 Services. Also referred to as an out-of-network provider.
Non-Participating Pharmacy	A pharmacy that does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.
Other Outpatient Mental Health and Substance Use Disorder Services	Outpatient Facility and professional services for the diagnosis and treatment of Mental Health and 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 • Psychological Testing. These services may also be provided in the office, home, or other non-institutional setting.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area.

Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area.
Out-of-Pocket Maximum	The highest Deductible, Copayment, and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the *Summary of Benefits* section. Charges for services that are not covered, charges in excess of the Allowed Charges or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization Program (Day Treatment)	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.
Participating Dentist	A Doctor of Dental Surgery or Doctor of Dental Medicine who has contracted with the DPA to provide dental services to Members.
Participating Hospice or Participating Hospice Agency	An entity that has either contracted with Blue Shield or has received prior approval from Blue Shield to provide Hospice service Benefits.
Participating (Participating Provider)	A provider who participates in this plan's network and contracts with Blue Shield to accept Blue Shield's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Participating Pharmacy	A pharmacy that has contracted with Blue Shield to provide covered Drugs at certain rates. A Participating Pharmacy participates in the Blue Shield Pharmacy Network.
Physician	An individual licensed and authorized to engage in the practice of medicine.
Plan Service Area	A geographical area designated by the plan within which a plan shall provide health care services.

Premium (Dues)	The monthly prepayment amount made to Blue Shield on behalf of each Member by the Contractholder for coverage under this Agreement.
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.
Psychological Testing	Testing to diagnose a mental health condition when referred by an MHSA Participating Provider.
Qualified Health Plan (QHP)	A health plan that has been certified for sale through Covered California.
Qualified Individual	An enrollee deemed eligible for coverage by Covered California.
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.
Resident of California	An individual who spends in the aggregate more than 180 days each year within the State of California and has not

	established a permanent residence in another state or country.
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.
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 individual who is a resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield, and has maintained Blue Shield membership in accord with this Agreement.
Surrogacy Arrangement	An arrangement in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person (or persons) who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.
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.
Triggering Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
Urgent Services	Those Covered Services rendered outside of the Medical Group Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Medical Group Service Area.
Vision Plan Administrator (VPA)	Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered 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).
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

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 provided under the *Continuity of care* section when applicable. Blue Shield may change Benefits during the term of coverage as specifically stated in this Agreement. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

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

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

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

You can receive Covered Services on an in-person basis or via telehealth, if available, from your PCP, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with existing timeliness and geographic access standards. See the Timely Access to Care section for more information.

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

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

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.comF

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
Diagnostic Procedures (D0100-D0999)		
D0120	Periodic oral evaluation - established patient	Once every 6 months, per provider or after 6 months have elapsed following comprehensive oral evaluation (D0150), same provider.
D0140	Limited oral evaluation – problem focused	Once per Member per provider.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	
D0150	Comprehensive oral evaluation – new or established patient	Once per Member per provider for the initial evaluation.
D0160	Detailed and extensive oral evaluation – problem focused, by report	Once per Member per provider.
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 6 times in a 3 month period; and • Up to a maximum of 12 in a 12 month period.
D0171	Re-evaluation – post-operative office visit	
D0180	Comprehensive periodontal evaluation – new or established patient	
D0190	Screening of a patient	Not a Benefit.
D0191	Assessment of a patient	Not a Benefit.
D0210	Intraoral - comprehensive series of radiographic images	Once per provider every 36 months.
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

Code	Description	Limitation
		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.
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.
D0240	Intraoral - occlusal radiographic image	Up to a maximum of two in a 6 month period per provider.
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	Once per date of service.
D0251	Extra-oral posterior dental radiographic image	Up to a maximum of 4 on the same date of service.
D0270	Bitewing - single radiographic image	Once per date of service. Not a Benefit for a totally edentulous area.
D0272	Bitewings - 2 radiographic images	Once every 6 months per provider. Not a Benefit: • Within 6 months of intraoral complete series of radiographic images (D0210), same provider; and • For a totally edentulous area.
D0273	Bitewings - 3 radiographic images	
D0274	Bitewings - 4 radiographic images	Once every 6 months per provider. Not a Benefit: • Within 6 months of intraoral-complete series of radiographic images (D0210), same provider; • For Members under the age of 10; and • For a totally edentulous area.
D0277	Vertical bitewings - 7 to 8 radiographic images	
D0310	Sialography	

Code	Description	Limitation
D0320	Temporomandibular joint arthrogram, including injection	Limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.
D0322	Tomographic survey	Up to twice in a 12 month period per provider.
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).
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	Twice in a 12 month period per provider.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Up to a maximum of 4 per date of service.
D0396	3D printing of a 3D dental surface scan	
D0419	Assessment of salivary flow by measurement	Not a Benefit.
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.
D0460	Pulp vitality tests	
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.
D0502	Other oral pathology procedures, by report	Must be provided by a certified oral pathologist.
D0601	Caries risk assessment and documentation, with a finding of low risk	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	

Code	Description	Limitation
D0603	Caries risk assessment and documentation, with a finding of high risk	
D0701	Panoramic radiographic image – image capture only	
D0702	2-D cephalometric radiographic image – image capture only	
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	
D0705	Extra-oral posterior dental radiographic image – image capture only	
D0706	Intraoral – occlusal radiographic image – image capture only	
D0707	Intraoral – periapical radiographic image – image capture only	
D0708	Intraoral – bitewing radiographic image – image capture only	
D0709	Intraoral – comprehensive series of radiographic images – image capture only	
D0801	3D dental surface scan – direct	
D0802	3D dental surface scan – indirect	
D0803	3D facial surface scan – direct	
D0804	3D facial surface scan – indirect	
D0999	Unspecified diagnostic procedure, by report	
Preventive Procedures (D1000-D1999)		
D1110	Prophylaxis - adult	

Code	Description	Limitation
D1120	Prophylaxis – child	Once in a 6 month period.
D1206	Topical application of fluoride varnish	Once in a 6 month period.
D1208	Topical application of fluoride – excluding varnish	Once in a 6 month period.
D1310	Nutritional counseling for control of dental disease	
D1320	Tobacco counseling for the control and prevention of oral disease	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	
D1330	Oral hygiene instructions	
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.
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Limited to the for first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed.
D1353	Sealant repair – per tooth	
D1354	Interim caries arresting medicament application – per tooth	
D1355	Caries preventive medicament application – per tooth	
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.
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 for Members under the age of 18.

Code	Description	Limitation
		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.
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 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.
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.
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 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.
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 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.
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.

Code	Description	Limitation
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.
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.
D1556	Removal of fixed unilateral space maintainer – per quadrant	not a Benefit to the original provider who placed the space maintainer.
D1557	Removal of fixed bilateral space maintainer – maxillary	not a Benefit to the original provider who placed the space maintainer.
D1558	Removal of fixed bilateral space maintainer – mandibular	not a Benefit to the original provider who placed the space maintainer.
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant	
Restorative Procedures (D2000-D2999)		
D2140	Amalgam – 1 surface, primary or permanent	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2150	Amalgam – 2 surfaces, primary or permanent	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2160	Amalgam – 3 surfaces, primary or permanent	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2161	Amalgam – 4 or more surfaces, primary or permanent	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2330	Resin-based composite – 1 surface, anterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2331	Resin-based composite – 2 surfaces, anterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2332	Resin-based composite – 3 surfaces, anterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2335	Resin-based composite – 4 or more surfaces (anterior)	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
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.

Code	Description	Limitation
D2391	Resin-based composite – 1 surface, posterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2392	Resin-based composite – 2 surfaces, posterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2393	Resin-based composite – 3 surfaces, posterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2394	Resin-based composite – 4 or more surfaces, posterior	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2542	Onlay - metallic – 2 surfaces	Not a Benefit.
D2543	Onlay - metallic – 3 surfaces	Not a Benefit.
D2544	Onlay - metallic – 4 or more surfaces	Not a Benefit.
D2642	Onlay - porcelain/ceramic – 2 surfaces	Not a Benefit.
D2643	Onlay - porcelain/ceramic – 3 surfaces	Not a Benefit.
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	Not a Benefit.
D2662	Onlay - resin-based composite – 2 surfaces	Not a Benefit.
D2663	Onlay - resin-based composite – 3 surfaces	Not a Benefit.
D2664	Onlay - resin-based composite – 4 or more surfaces	Not a Benefit.
D2710	Crown – resin-based composite (indirect)	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period and for any resin based composite crown that is indirectly fabricated.

Code	Description	Limitation
		Not a Benefit: • For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and • For use as a temporary crown.
D2712	Crown - 3/4 resin-based composite (indirect)	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period and for any resin based composite crown that is indirectly fabricated. Not a Benefit: • For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and • For use as a temporary crown.
D2720	Crown - resin with high noble metal	Not a Benefit.
D2721	Crown – resin with predominantly base metal	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2722	Crown - resin with noble metal	Not a Benefit.
D2740	Crown – porcelain/ceramic	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2750	Crown - porcelain fused to high noble metal	Not a Benefit.
D2751	Crown – porcelain fused to predominantly base metal	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Code	Description	Limitation
D2752	Crown - porcelain fused to noble metal	Not a Benefit.
D2753	Crown – porcelain fused to titanium and titanium alloys	Not a Benefit.
D2780	Crown - 3/4 cast high noble metal	Not a Benefit.
D2781	Crown – 3/4 cast predominantly base metal	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2782	Crown - 3/4 cast noble metal	Not a Benefit.
D2783	Crown – 3/4 porcelain/ceramic	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2790	Crown - full cast high noble metal	Not a Benefit.
D2791	Crown – full cast predominantly base metal	Permanent anterior teeth and permanent posterior teeth (ages 13 or older): Once in a 5 year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2792	Crown - full cast noble metal	Not a Benefit.
D2794	Crown – titanium and titanium alloys	Not a Benefit.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Once in a 12 month period, per provider.

Code	Description	Limitation
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	
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.
D2921	Reattachment of tooth fragment, incisal edge or cusp	
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Once in a 12 month period.
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Once in a 12 month period.
D2930	Prefabricated stainless steel crown – primary tooth	Once in a 12 month period.
D2931	Prefabricated stainless steel crown – permanent tooth	Once in a 36 month period. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2932	Prefabricated resin crown	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2933	Prefabricated stainless steel crown with resin window	Once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2940	Protective 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.
D2941	Interim therapeutic restoration – primary dentition	
D2949	Restorative foundation for an indirect restoration	
D2950	Core buildup, including any pins when required	

Code	Description	Limitation
D2951	Pin retention – per tooth, in addition to restoration	For permanent teeth only; when performed on the same date of service with an amalgam or composite; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves 3 or more connected surfaces and at least 1 cusp; or, for an anterior restoration when extensive coronal destruction involves the incisal angle.
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.
D2953	Each additional indirectly fabricated post – same tooth	
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.
D2955	Post removal	
D2957	Each additional prefabricated post - same tooth	
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	
D2976	Band stabilization – per tooth	
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.
D2989	Excavation of a tooth resulting in the determination of non-restorability	
D2991	Application of hydroxyapatite regeneration medicament – per tooth	
D2999	Unspecified restorative procedure, by report	
Endodontics Procedures (D3000-D3999)		
D3110	Pulp cap – direct (excluding final restoration)	

Code	Description	Limitation
D3120	Pulp cap – indirect (excluding final restoration)	
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.
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.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Once per permanent tooth. Not a Benefit: • For primary teeth; • For 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and • On the same date of service as any other endodontic procedures for the same tooth.
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.
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.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Once per tooth for initial root canal therapy treatment.

Code	Description	Limitation
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Once per tooth for initial root canal therapy treatment.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Once per tooth for initial root canal therapy treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3331	Treatment of root canal obstruction; non-surgical access	
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy – anterior	Once per tooth after more than 12 months has elapsed from initial treatment.
D3347	Retreatment of previous root canal therapy – premolar	Once per tooth after more than 12 months has elapsed from initial treatment.
D3348	Retreatment of previous root canal therapy – molar	Once per tooth after more than 12 months has elapsed from initial treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
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 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and • On the same date of service as any other endodontic procedures for the same tooth.
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 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and • On the same date of service as any other endodontic procedures for the same tooth.

Code	Description	Limitation
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Not a Benefit.
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.
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 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3425	Apicoectomy – molar (first root)	For permanent 1st and 2nd molar teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
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.
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	
D3430	Retrograde filling – per root	
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	

Code	Description	Limitation
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not a Benefit.
D3450	Root amputation - per root	Not a Benefit.
D3471	Surgical repair of root resorption – anterior	
D3472	Surgical repair of root resorption – premolar	
D3473	Surgical repair of root resorption – molar	
D3910	Surgical procedure for isolation of tooth with rubber dam	
D3920	Hemisection (including any root removal), not including root canal therapy	Not a Benefit.
D3950	Canal preparation and fitting of preformed dowel or post	Not a Benefit.
D3999	Unspecified endodontic procedure, by report	
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.
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.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Not a Benefit.
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Not a Benefit.

Code	Description	Limitation
D4249	Clinical crown lengthening – hard tissue	For Members age 13 or older.
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.
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.
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	Not a Benefit.
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	Not a Benefit.
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	For Members age 13 or older.
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	Not a Benefit.
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	Not a Benefit.
D4270	Pedicle soft tissue graft procedure	Not a Benefit.
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a Benefit.
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.

Code	Description	Limitation
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.
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.
D4286	Removal of non-resorbable barrier	Not a Benefit.
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.
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.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	For Members age 13 or older.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	For Members age 13 or older.
D4910	Periodontal maintenance	Once in a calendar quarter and only in the 24 month period following the last periodontal scaling and root planing (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planing and will be a Benefit only after completion of all necessary scaling and root planing and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not

Code	Description	Limitation
		a Benefit in the same calendar quarter as scaling and root planing.
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).
D4999	Unspecified periodontal procedure, by report	For Members age 13 or older.
Prosthodontics, removable Procedures (D5000-D5899)		
D5110	Complete denture – maxillary	Once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.
D5120	Complete denture – mandibular	Once in a 5 year period from a previous complete, immediate or overdenture- complete denture. A laboratory reline (D5751) or chairside reline (D5731) is a Benefit 12 months after the date of service for this procedure.
D5130	Immediate denture – maxillary	Once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 6 months after the date of service for this procedure.
D5140	Immediate denture – mandibular	Once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture.
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	
D5214	Mandibular partial denture – cast metal framework with	

Code	Description	Limitation
	resin denture bases (including retentive/clasping materials, rests and teeth)	
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	Once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: • 5 posterior permanent teeth are missing, (excluding 3rd molars), or • All 4 1st and 2nd permanent molars are missing, or • The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures.
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	Once in a 5 year period and when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: • 5 posterior permanent teeth are missing, (excluding 3rd molars); • All 4 1st and 2nd permanent molars are missing; or • The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures.
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: • 5 posterior permanent teeth are missing, (excluding 3rd molars); • All 4 1st and 2nd permanent molars are missing; or • The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures.
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:

Code	Description	Limitation
		• 5 posterior permanent teeth are missing, (excluding 3rd molars); • All 4 1st and 2nd permanent molars are missing; or • The 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures.
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Not a Benefit.
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials,rests, and teeth)	Not a Benefit.
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit.
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	Not a Benefit.
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not a Benefit.
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not a Benefit.
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	Not a Benefit.
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materiasl, rests, and teeth), per quadrant	Not a Benefit.

Code	Description	Limitation
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 6 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 6 months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850); and • Same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).
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 6 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 6 months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851); and • Same date of service or within 6 months of the date of service of repair broken complete denture base (D5511 & D5512) and replace missing or broken teeth complete denture (D5520).
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 6 months of the date of service of a maxillary partial resin base (5211) or maxillary partial denture cast metal framework with resin denture bases (D5213); • Same date of service or within 6 months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850); and • Same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture

Code	Description	Limitation
		(D5650) and add clasp to existing partial denture (D5660).
D5422	Adjust partial denture – mandibular	Once per date of service per provider and no more than twice in a 12month period per provider. Not a Benefit: • Same date of service or within 6 months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214); • Same date of service or within 6 months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851); and • Same date of service or within 6 months of the date of service of repair resin denture base (D5611 & D5612), repair cast framework (D5621 & D5622), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).
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).
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).
D5520	Replace missing or broken teeth – complete denture (each tooth)	Up to a maximum of 4, per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
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).
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

Code	Description	Limitation
		partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5621	Repair cast framework, mandibular	Once per date of service per provider and no more than twice in a 12 month period per provider.
D5622	Repair cast framework, maxillary	Once per date of service per provider and no more than twice in a 12 month period per provider.
D5630	Repair or replace broken clasp – per tooth	Up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5640	Replace broken teeth – per tooth	Up to a maximum of 4, per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only.
D5650	Add tooth to existing partial denture	Once per tooth and up to a maximum of 3, per date of service per provider. Not a Benefit for adding 3rd molars.
D5660	Add clasp to existing partial denture – per tooth	Up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit.
D5710	Rebase complete maxillary denture	Not a Benefit.
D5711	Rebase complete mandibular denture	Not a Benefit.
D5720	Rebase maxillary partial denture	Not a Benefit.
D5721	Rebase mandibular partial denture	Not a Benefit.
D5730	Reline complete maxillary denture (chairside)	Once in a 12 month period; 6 months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture- complete (D5863 & D5865) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5863 & D5865) that did

Code	Description	Limitation
		not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
D5731	Reline complete mandibular denture (chairside)	Once in a 12 month period; 6 months after the date of service for a 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).
D5740	Reline maxillary partial denture (chairside)	Once in a 12 month period; 6 months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions; or 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
D5741	Reline mandibular partial denture (chairside)	Once in a 12 month period; 6 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture resin base (D5212) or mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).
D5750	Reline complete maxillary denture (laboratory)	Once in a 12 month period; 6 months after the date of service for a 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).
D5751	Reline complete mandibular denture (laboratory)	Once in a 12 month period; 6 months after the date of service for a 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).

Code	Description	Limitation
D5760	Reline maxillary partial denture (laboratory)	Once in a 12 month period and 6 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit: • Within 12 months of a reline maxillary partial denture (chairside) (D5740); and • For maxillary partial denture resin base (D5211).
D5761	Reline mandibular partial denture (laboratory)	Once in a 12 month period; 6 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit: • Within 12 months of a reline mandibular partial denture (chairside) (D5741); and • For a mandibular partial denture resin base (D5212).
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.
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.
D5862	Precision attachment, by report	
D5863	Overdenture – complete maxillary	Once in a 5 year period.
D5864	Overdenture – partial maxillary	Once in a 5 year period.

Code	Description	Limitation
D5865	Overdenture – complete mandibular	Once in a 5 year period.
D5866	Overdenture – partial mandibular	Once in a 5 year period.
D5876	Add metal substructure to acrylic full denture (per arch)	Not a Benefit.
D5899	Unspecified removable prosthodontic procedure, by report	
Maxillofacial Prosthetics Procedures (D5900-D5999)		
D5911	Facial moulage (sectional)	
D5912	Facial moulage (complete)	
D5913	Nasal prosthesis	
D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5916	Ocular prosthesis	Not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	
D5923	Ocular prosthesis, interim	Not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5924	Cranial prosthesis	
D5925	Facial augmentation implant prosthesis	
D5926	Nasal prosthesis, replacement	
D5927	Auricular prosthesis, replacement	
D5928	Orbital prosthesis, replacement	
D5929	Facial prosthesis, replacement	
D5931	Obturator prosthesis, surgical	Not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

Code	Description	Limitation
D5932	Obturator prosthesis, definitive	Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
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).
D5934	Mandibular resection prosthesis with guide flange	
D5935	Mandibular resection prosthesis without guide flange	
D5936	Obturator prosthesis, interim	Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).
D5937	Trismus appliance (not for TMD treatment)	
D5951	Feeding aid	For Members under the age of 18 only.
D5952	Speech aid prosthesis, pediatric	For Members under the age of 18 only.
D5953	Speech aid prosthesis, adult	For Members under the age of 18 only.
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis, definitive	Not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).
D5958	Palatal lift prosthesis, interim	Not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
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).
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).
D5982	Surgical stent	
D5983	Radiation carrier	

Code	Description	Limitation
D5984	Radiation shield	
D5985	Radiation cone locator	
D5986	Fluoride gel carrier	A Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.
D5987	Commissure splint	
D5988	Surgical splint	
D5991	Vesiculobullous disease medicament carrier	
D5999	Unspecified maxillofacial prosthesis, by report	
Implant Services Procedures (D6000-D6199)		
D6010	Surgical placement of implant body: endosteal implant	
D6011	Surgical access to an implant body (second stage implant surgery)	
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	
D6013	Surgical placement of mini implant	
D6040	Surgical placement: eposteal implant	
D6050	Surgical placement: transosteal implant	
D6055	Connecting bar - implant supported or abutment supported	
D6056	Prefabricated abutment - includes modification and placement	
D6057	Custom fabricated abutment - includes placement	
D6058	Abutment supported porcelain/ceramic crown	

Code	Description	Limitation
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	
D6062	Abutment supported cast metal crown (high noble metal)	
D6063	Abutment supported cast metal crown (predominantly base metal)	
D6064	Abutment supported cast metal crown (noble metal)	
D6065	Implant supported porcelain/ceramic crown	
D6066	Implant supported crown – porcelain fused to high noble alloys	
D6067	Implant supported crown – high noble alloys	
D6068	Abutment supported retainer for porcelain/ceramic FPD	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	

Code	Description	Limitation
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	
D6075	Implant supported retainer for ceramic FPD	
D6076	Implant supported retainer FPD – porcelain fused to high noble alloys	
D6077	Implant supported retainer for metal FPD – high noble alloys	
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	
D6082	Implant supported crown – porcelain fused to predominantly base alloys	
D6083	Implant supported crown – porcelain fused to noble alloys	
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	
D6085	Interim implant crown	
D6086	Implant supported crown – predominantly base alloys	
D6087	Implant supported crown – noble alloys	
D6088	Implant supported crown – titanium and titanium alloys	

Code	Description	Limitation
D6089	Accessing and retorquing loose implant screw – per screw	
D6090	Repair implant supported prosthesis, by report	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	
D6092	Re-cement or re-bond implant/abutment supported crown	Not a Benefit within 12 months of a previous recementation by the same provider.
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.
D6094	Abutment supported crown – titanium and titanium alloys	
D6095	Repair implant abutment, by report	
D6096	Remove broken implant retaining screw	
D6097	Abutement supported crown – porcelain fused to titanium and titanium alloys	
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	
D6100	Surgical removal of implant body	
D6105	Removal of implant body not requiring bone removal or flap elevation	
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	

Code	Description	Limitation
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	
D6121	Implant supported retainer for metal FPD – predominantly base alloys	
D6122	Implant supported retainer for metal FPD – noble alloys	
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	

Code	Description	Limitation
D6190	Radiographic/surgical implant index, by report	
D6191	Semi-precision abutment – placement	
D6192	Semi-precision attachment – placement	
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	
D6195	Abutement supported retainer – porcelain fused to titanium and titanium alloys	
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	
D6198	Remove interim implant component	
D6199	Unspecified implant procedure, by report	
Prosthodontics, fixed Procedures (D6200-D6999)		
D6205	Pontic – indirect resin based composite	Not a Benefit.
D6210	Pontic – cast high noble metal	Not a Benefit.
D6211	Pontic – cast predominately base metal	Once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6212	Pontic – cast noble metal	Not a Benefit.

Code	Description	Limitation
D6214	Pontic – titanium and titanium alloys	Not a Benefit.
D6240	Pontic –porcelain fused to high noble metal	Not a Benefit.
D6241	Pontic – porcelain fused to predominantly base metal	Once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6242	Pontic - porcelain fused to noble metal	Not a Benefit.
D6243	Pontic – porcelain fused to titanium and titanium alloys	Not a Benefit.
D6245	Pontic – porcelain/ceramic	Once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6250	Pontic - resin with high noble metal	Not a Benefit.
D6251	Pontic - resin with predominantly base metal	Once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6252	Pontic - resin with noble metal	Not a Benefit.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not a Benefit.

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

Code	Description	Limitation
D6740	Retainer crown – porcelain/ceramic	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6750	Retainer crown – porcelain fused to high noble metal	Not a Benefit.
D6751	Retainer crown – porcelain fused to predominantly base metal	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6752	Retainer crown – porcelain fused to noble metal	Not a Benefit.
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	Not a Benefit.
D6781	Retainer crown – 3/4 cast predominantly base metal	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6782	Retainer crown - 3/4 cast noble metal	Not a Benefit.
D6783	Retainer crown – 3/4 porcelain/ceramic	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6784	Retainer crown – 3/4 porcelain fused to titanium and titanium alloys	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6791	Retainer crown – full cast predominantly base metal	Once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6794	Retainer crown – titanium and titanium alloys	Not a Benefit.
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.

Code	Description	Limitation
D6980	Fixed partial denture repair necessitated by restorative material failure	Not a Benefit within 12 months of initial placement or previous repair, same provider.
D6999	Unspecified fixed prosthodontic procedure, by report	
Oral Maxillofacial Prosthetics Procedures (D7000-D7999)		
D7111	Extraction, coronal remnants – primary tooth	Not a Benefit for asymptomatic teeth.
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.
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.
D7220	Removal of impacted tooth – soft tissue	A Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
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.
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.
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.
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.
D7260	Oroantral fistula closure	A Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
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.

Code	Description	Limitation
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.
D7280	Exposure of an unerupted tooth	Not a Benefit: • For Members age 19 or older; or • For 3rd molars.
D7283	Placement of device to facilitate eruption of impacted tooth	Only for Members in active orthodontic treatment. Not a Benefit: • For Members age 19 years or older; and • For 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
D7284	Excisional biopsy of minor salivary glands	
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.
D7286	Incisional biopsy of oral tissue – soft	For the removal of the specimen only and up to a maximum of 3 per date of service. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous
D7287	Exfoliative cytological sample collection	Not a Benefit.
D7288	Brush biopsy - transepithelial sample collection	Not a Benefit.
D7290	Surgical repositioning of teeth	For permanent teeth only; once per arch; and only for Members in active orthodontic treatment.
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Once per arch and only for Members in active orthodontic treatment.
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	A Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.
D7311	Alveoloplasty in conjunction with extractions - one to three	

Code	Description	Limitation
	teeth or tooth spaces, per quadrant	
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.
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Once in a 5 year period per arch.
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.
D7410	Excision of benign lesion up to 1.25 cm	
D7411	Excision of benign lesion greater than 1.25 cm	
D7412	Excision of benign lesion, complicated	A Benefit when there is extensive undermining with advancement or rotational flap closure.
D7413	Excision of malignant lesion up to 1.25 cm	
D7414	Excision of malignant lesion greater than 1.25 cm	
D7415	Excision of malignant lesion, complicated	A Benefit when there is extensive undermining with advancement or rotational flap closure.
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	

Code	Description	Limitation
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7465	Destruction of lesion(s) by physical or chemical method, by report	
D7471	Removal of lateral exostosis (maxilla or mandible)	Once per quadrant and for the removal of buccal or facial exostosis only.
D7472	Removal of torus palatinus	Once in the Member's lifetime.
D7473	Removal of torus mandibularis	Once per quadrant.
D7485	Reduction of osseous tuberosity	Once per quadrant.
D7490	Radical resection of maxilla or mandible	
D7509	Marsupialization of odontogenic cyst	
D7510	Incision and drainage of abscess – intraoral soft tissue	Once per quadrant, same date of service.
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Once per quadrant, same date of service.
D7520	Incision and drainage of abscess – extraoral soft tissue	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	

Code	Description	Limitation
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).
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).
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).
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.
D7610	Maxilla – open reduction (teeth immobilized, if present)	
D7620	Maxilla – closed reduction (teeth immobilized, if present)	
D7630	Mandible – open reduction (teeth immobilized, if present)	
D7640	Mandible – closed reduction (teeth immobilized, if present)	
D7650	Malar and/or zygomatic arch – open reduction	
D7660	Malar and/or zygomatic arch – closed reduction	
D7670	Alveolus – closed reduction, may include stabilization of teeth	
D7671	Alveolus – open reduction, may include stabilization of teeth	
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	For the treatment of simple fractures only.
D7710	Maxilla – open reduction	
D7720	Maxilla – closed reduction	

Code	Description	Limitation
D7730	Mandible – open reduction	
D7740	Mandible – closed reduction	
D7750	Malar and/or zygomatic arch – open reduction	
D7760	Malar and/or zygomatic arch – closed reduction	
D7770	Alveolus – open reduction stabilization of teeth	
D7771	Alveolus – closed reduction stabilization of teeth	
D7780	Facial bones – complicated reduction with fixation and multiple approaches	For the treatment of compound fractures only.
D7810	Open reduction of dislocation	
D7820	Closed reduction of dislocation	
D7830	Manipulation under anesthesia	
D7840	Condylectomy	
D7850	Surgical discectomy, with/without implant	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthroscopic lysis and lavage	
D7872	Arthroscopy – diagnosis, with or without biopsy	

Code	Description	Limitation
D7873	Arthroscopy – lavage and lysis of adhesions	
D7874	Arthroscopy – disc repositioning and stabilization	
D7875	Arthroscopy – synovectomy	
D7876	Arthroscopy – discectomy	
D7877	Arthroscopy – debridement	
D7880	Occlusal orthotic device, by report	Not a Benefit for the treatment of bruxism.
D7881	Occlusal orthotic device adjustment	
D7899	Unspecified TMD therapy, by report	Not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.
D7910	Suture of recent small wounds up to 5 cm	Not a Benefit for the closure of surgical incisions.
D7911	Complicated suture – up to 5 cm	Not a Benefit for the closure of surgical incisions.
D7912	Complicated suture – greater than 5 cm	Not a Benefit for the closure of surgical incisions.
D7920	Skin graft (identify defect covered, location and type of graft)	Not a Benefit for periodontal grafting.
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	
D7940	Osteoplasty – for orthognathic deformities	
D7941	Osteotomy – mandibular rami	
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	

Code	Description	Limitation
D7944	Osteotomy – segmented or subapical	
D7945	Osteotomy – body of mandible	
D7946	LeFort I (maxilla – total)	
D7947	LeFort I (maxilla – segmented)	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	
D7949	LeFort II or LeFort III – with bone graft	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Not a Benefit for periodontal grafting.
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Only for Members with authorized implant services.
D7952	Sinus augmentation via a vertical approach	Only for Members with authorized implant services.
D7955	Repair of maxillofacial soft and/or hard tissue defect	Not a Benefit for periodontal grafting.
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a Benefit.
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a Benefit.
D7961	Buccal/labial frenectomy (frenulectomy)	Once per arch per date of service and only when the permanent incisors and cuspids have erupted.
D7962	Lingual frenectomy (frenulectomy)	Once per arch per date of service and only when the permanent incisors and cuspids have erupted.
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.

Code	Description	Limitation
D7970	Excision of hyperplastic tissue – per arch	Once per arch per date of service.
D7971	Excision of pericoronal gingiva	
D7972	Surgical reduction of fibrous tuberosity	Once per quadrant per date of service.
D7979	Non-surgical sialolithotomy	
D7980	Surgical sialolithotomy	
D7981	Excision of salivary gland, by report	
D7982	Sialodochoplasty	
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft – mandible or facial bones, by report	Not a Benefit for periodontal grafting.
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.
D7999	Unspecified oral surgery procedure, by report	
Orthodontics Procedures (D8000-D8999)		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8210	Removable appliance therapy	Once per Member and for Members ages 6 through 12.
D8220	Fixed appliance therapy	Once per Member and for Members ages 6 through 12.
D8660	Pre-orthodontic treatment examination to monitor growth and development	Once every 3 months for a maximum of 6 and must be done prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.

Code	Description	Limitation
D8670	Periodic orthodontic treatment visit - handicapping malocclusion	Once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8670	Periodic orthodontic treatment visit cleft palate - primary dentition	Up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit cleft palate - mixed dentition	Up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit cleft palate - permanent dentition	Up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity)
D8670	Periodic orthodontic treatment visit facial growth management - primary dentition	Up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management - mixed dentition	Up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management - permanent dentition	Up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance – maxillary	Once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
D8697	Repair of orthodontic appliance – mandibular	Once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

Code	Description	Limitation
D8698	Re-cement or re-bond fixed retainer – maxillary	Once per provider.
D8699	Re-cement or re-bond fixed retainer – mandibular	Once per provider.
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	Once per arch and only within 24 months following the date of service of orthodontic retention (D8680).
D8704	Replacement of lost or broken retainer – mandibular	Once per arch and only within 24 months following the date of service of orthodontic retention (D8680).
D8999	Unspecified orthodontic procedure, by report	
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.
D9120	Fixed partial denture sectioning	A Benefit when at least one of the abutment teeth is to be retained.
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.
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia in conjunction with operative or surgical procedures	

Code	Description	Limitation
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	
D9222	Deep sedation/general anesthesia – first 15 minutes	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.
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	For uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: • 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.
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	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.
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	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.
D9248	Non-intravenous conscious sedation	Once per date of service; for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's

Code	Description	Limitation
		attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration. Not a Benefit: • On the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9243); and • When all associated procedures on the same date of service by the same provider are denied.
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	
D9311	Consultation with a medical health professional	
D9410	House/extended care facility call	Once per Member per date of service and only in conjunction with procedures that are payable.
D9420	Hospital or ambulatory surgical center call	A Benefit for each hour or fraction thereof as documented on the operative report.
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.
D9440	Office visit – after regularly scheduled hours	Once per date of service per provider and only with treatment that is a Benefit.
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a Benefit.
D9610	Therapeutic parenteral drug, single administration	Up to a maximum of 4 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.

Code	Description	Limitation
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	
D9910	Application of desensitizing medicament	Once in a 12 month period per provider and for permanent teeth only.
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.
D9942	Repair and/or reline of occlusal guard	Not a Benefit.
D9943	Occlusal guard adjustment	Not a Benefit.
D9944	Occlusal guard – hard appliance, full arch	Not a Benefit.
D9945	Occlusal guard – soft appliance, full arch	Not a Benefit.
D9946	Occlusal guard – hard appliance, partial arch	Not a Benefit.
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.
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.
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.
D9995	Teledentistry – synchronous; real-time encounter	

Code	Description	Limitation
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	
D9997	Dental case management – patients with special health care needs	
D9999	Unspecified adjunctive procedure, by report	

IFP Trio HMO Plan Service Area

The IFP Trio HMO Plan Service Area consists of the counties, and ZIP codes listed within those counties, on the charts below. You must reside, live or work within one of these ZIP codes to be eligible for a Trio HMO plan. The IFP Trio HMO Plan 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

Kern County			
93383	93384	93385	93386
93387	93388	93389	93390
93501	93502	93504	93505
93516	93518	93531	93560
93561	93596		

Kings County			
93202	93212	93230	93245
93631			

Los Angeles County			
90001	90002	90003	90004
90005	90006	90007	90008
90009	90010	90011	90012
90013	90014	90015	90016
90017	90018	90019	90020
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90025	90026	90027	90028
90029	90030	90031	90032
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90037	90038	90039	90040
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90045	90046	90047	90048
90049	90050	90051	90052
90053	90054	90055	90056
90057	90058	90059	90060
90061	90062	90063	90064
90065	90066	90067	90068
90069	90070	90071	90072

Los Angeles County			
90073	90074	90075	90076
90077	90078	90079	90080
90081	90082	90083	90084
90086	90087	90088	90089
90091	90093	90094	90095
90096	90099	90101	90103
90189	90201	90202	90209
90210	90211	90212	90213
90220	90221	90222	90223
90224	90230	90231	90232
90233	90239	90240	90241
90242	90245	90247	90248
90249	90250	90251	90254
90255	90260	90262	90263
90264	90265	90266	90267
90270	90272	90274	90275
90277	90278	90280	90290
90291	90292	90293	90294
90295	90296	90301	90302
90303	90304	90305	90306
90307	90308	90309	90310
90311	90312	90401	90402
90403	90404	90405	90406
90407	90408	90409	90410
90411	90501	90502	90503
90504	90505	90506	90507
90508	90509	90510	90601
90602	90603	90604	90605
90606	90607	90608	90609
90610	90637	90638	90639

Los Angeles County			
90640	90650	90651	90652
90660	90661	90662	90670
90671	90701	90702	90703
90706	90707	90710	90711
90712	90713	90714	90715
90716	90717	90723	90731
90732	90733	90734	90744
90745	90746	90747	90748
90749	90755	90801	90802
90803	90804	90805	90806
90807	90808	90809	90810
90813	90814	90815	90822
90831	90832	90833	90834
90835	90840	90842	90844
90846	90847	90848	90853
90895	90899	91001	91003
91006	91007	91008	91009
91010	91011	91012	91016
91017	91020	91021	91023
91024	91025	91030	91031
91040	91041	91042	91043
91046	91066	91077	91101
91102	91103	91104	91105
91106	91107	91108	91109
91110	91114	91115	91116
91117	91118	91121	91123
91124	91125	91126	91129
91182	91184	91185	91188
91189	91199	91201	91202
91203	91204	91205	91206

Los Angeles County			
91207	91208	91209	91210
91214	91221	91222	91224
91225	91226	91301	91302
91303	91304	91305	91306
91307	91308	91309	91310
91311	91313	91316	91321
91322	91324	91325	91326
91327	91328	91330	91331
91333	91334	91335	91337
91340	91341	91342	91343
91344	91345	91346	91350
91351	91352	91353	91354
91355	91356	91357	91361
91364	91365	91367	91371
91372	91376	91380	91381
91382	91383	91384	91385
91386	91387	91390	91392
91393	91394	91395	91396
91401	91402	91403	91404
91405	91406	91407	91408
91409	91410	91411	91412
91413	91416	91423	91426
91436	91470	91482	91499
91501	91502	91503	91504
91505	91506	91507	91508
91510	91521	91522	91523
91526	91601	91602	91603
91604	91605	91606	91607
91608	91609	91610	91614
91615	91616	91617	91618

Los Angeles County			
91702	91706	91711	91714
91715	91716	91722	91723
91724	91731	91732	91733
91734	91735	91740	91741
91744	91745	91746	91747
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91755	91756	91765	91766
91767	91768	91769	91770
91771	91772	91773	91775
91776	91778	91780	91788
91789	91790	91791	91792
91793	91795	91801	91802
91803	91804	91896	91899
93510	93563		

Marin County			
94901	94903	94904	94912
94913	94914	94915	94920
94924	94925	94930	94933
94937	94938	94939	94940
94941	94942	94945	94946
94947	94948	94949	94950
94956	94957	94960	94963
94964	94965	94966	94970
94971	94973	94974	94976
94977	94978	94979	94998

Monterey County			
93901	93902	93905	93906
93907	93908	93912	93915
93920	93921	93922	93923
93924	93925	93926	93933
93940	93942	93943	93944
93950	93953	93955	93960
93962	95012	95039	

Nevada County			
95712	95924	95945	95946
95949	95959	95960	95975
95986			

Orange County			
90620	90621	90622	90623
90624	90630	90631	90632
90633	90638	90680	90720
90721	90740	90742	90743
92602	92603	92604	92605
92606	92607	92609	92610
92612	92614	92615	92616
92617	92618	92619	92620
92623	92624	92625	92626
92627	92628	92629	92630
92637	92646	92647	92648
92649	92650	92651	92652
92653	92654	92655	92656
92657	92658	92659	92660
92661	92662	92663	92672

Orange County			
92673	92674	92675	92676
92677	92678	92679	92683
92684	92685	92688	92690
92691	92692	92693	92694
92697	92698	92701	92702
92703	92704	92705	92706
92707	92708	92711	92712
92725	92728	92735	92780
92781	92782	92799	92801
92802	92803	92804	92805
92806	92807	92808	92809
92811	92812	92814	92815
92816	92817	92821	92822
92823	92825	92831	92832
92833	92834	92835	92836
92837	92838	92840	92841
92842	92843	92844	92845
92846	92850	92856	92857
92859	92861	92862	92863
92864	92865	92866	92867
92868	92869	92870	92871
92885	92886	92887	92899

Placer County			
95602	95603	95604	95648
95650	95658	95661	95663
95677	95678	95713	95746
95747	95765		

Riverside County			
91752	92201	92202	92203
92210	92211	92220	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
92509	92513	92514	92515
92516	92517	92518	92519
92521	92522	92530	92531
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92546	92548	92549	92551
92552	92553	92554	92555
92556	92557	92562	92563
92564	92567	92570	92571
92572	92581	92582	92583
92584	92585	92586	92587
92589	92590	92591	92592
92593	92595	92596	92599
92860	92877	92878	92879
92880	92881	92882	92883

Sacramento County			
94203	94204	94205	94206
94207	94208	94209	94211
94229	94230	94232	94234
94235	94236	94237	94239

Sacramento County			
94240	94244	94245	94246
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	94286
94287	94288	94289	94290
94291	94293	94294	94295
94296	94297	94298	94299
95608	95609	95610	95611
95615	95621	95624	95626
95628	95630	95632	95638
95639	95652	95655	95660
95662	95670	95671	95673
95683	95693	95741	95742
95757	95758	95759	95763
95811	95812	95813	95814
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95835	95837	95838	95840
95841	95842	95843	95851
95852	95853	95860	95864
95865	95866	95867	95887
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
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92340	92341	92342	92344
92345	92346	92350	92352
92354	92356	92357	92358
92359	92368	92369	92371
92372	92373	92374	92375
92376	92377	92378	92382
92385	92386	92391	92392
92393	92394	92395	92397
92399	92401	92402	92403
92404	92405	92406	92407
92408	92410	92411	92412
92413	92414	92415	92418
92423	92424	92427	

San Diego County			
91901	91902	91903	91905
91906	91908	91909	91910
91911	91912	91913	91914

San Diego County			
91915	91916	91917	91921
91931	91932	91933	91935
91941	91942	91943	91944
91945	91946	91947	91948
91950	91951	91962	91963
91976	91977	91978	91979
91980	91987	92003	92007
92008	92009	92010	92011
92013	92014	92018	92019
92020	92021	92022	92023
92024	92025	92026	92027
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92036	92037	92038	92039
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92093	92096	92101	92102
92103	92104	92105	92106
92107	92108	92109	92110
92111	92112	92113	92114
92115	92116	92117	92118
92119	92120	92121	92122
92123	92124	92126	92127
92128	92129	92130	92131
92132	92134	92135	92136

San Diego County			
92137	92138	92139	92140
92142	92143	92145	92147
92149	92150	92152	92153
92154	92155	92158	92159
92160	92161	92162	92163
92164	92165	92166	92167
92168	92169	92170	92171
92172	92173	92174	92175
92176	92177	92178	92179
92182	92184	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	94153	94154
94156	94158	94159	94160
94161	94162	94163	94164
94171	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	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

San Mateo County			
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

Santa Clara County			
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	93013
93015	93016	93020	93021
93022	93023	93024	93030
93031	93032	93033	93034
93035	93036	93040	93041

Ventura County			
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			

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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 Care 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 Atención 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)**。