Effective: January 1, 2017

Important disclosures

for Blue Shield Individual and Family Plans

blue of california

This disclosure form is only a summary of what the Individual and Family Plans (IFP) from Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) cover and do not cover. It also includes other helpful general information such as:

- Whom to contact with questions
- Which providers are available to you
- What members pay
- When coverage can terminate or change
- Ways to file a grievance

The *Evidence of Coverage and Health Service Agreement* (EOC) or Policy for Individuals and Families (Policy) discloses the terms and conditions of coverage and should be consulted to determine governing contractual provisions. You have the right to review this document prior to enrollment and can request a copy by contacting us at (888) 256-3650.

Reproductive health service

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, Independent Practice Association, or clinic, or call Blue Shield Customer Service at the following telephone numbers: If you purchased your coverage directly from Blue Shield, please call (888) 256-3650 or if you purchased your coverage through Covered California, please call (855) 836-9705. Blue Shield is committed to ensuring that you can obtain the healthcare services that you need.

This disclosure form and the EOC/Policy should be read completely and carefully. Individuals with special needs should carefully read those provisions that apply to them.

This booklet is provided with a benefits and coverage matrix. You can receive additional information about any Blue Shield IFP plan by contacting us at the following telephone numbers: **If you purchased your coverage directly from Blue Shield, please call (888) 256-3650, or if you purchased your coverage through Covered California, please call (855) 836-9705**.

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Enrollment and renewal

For coverage purchased through Covered California

Covered California, California's Health Benefit Exchange (the "Exchange"), will determine eligibility for coverage. An eligible individual may enroll in any Blue Shield IFP plan currently sold in the market during an open enrollment or special enrollment period. Any questions regarding enrollment in coverage including eligibility or subsidies, for a benefit plan purchased through the Exchange, should be directed to Covered California at **(800) 300-1506**.

For coverage purchased directly from Blue Shield

An individual and their dependents may enroll in any Blue Shield IFP plan currently sold in the Off-Exchange market during an open enrollment or special enrollment period. When coverage is purchased directly from Blue Shield, eligibility and continued eligibility for coverage is determined by Blue Shield. Any questions regarding enrollment in coverage for a benefit plan purchased directly from Blue Shield should be directed to Blue Shield at **(888) 256-3650**.

Enrolling new dependents

Newborn infants and children placed for adoption automatically will receive coverage on your plan for a 31-day period starting at birth or the date you or your spouse/domestic partner gain the right to control an adopted child's healthcare decisions. You must officially add the child to your plan within 60 days to continue the child's coverage beyond this initial 31-day period.

A new spouse or new domestic partner may be added to your coverage within 60 days of marriage or establishment of the domestic partnership.

You can call Blue Shield Customer Service at the following telephone numbers to add a new dependent: If you purchased your coverage directly from Blue Shield, please call **(888) 256-3650**, or if you purchased your coverage through Covered California, please call **(855) 836-9705**.

Renewal provisions

Blue Shield health coverage is "guaranteed renewable," which means it cannot be cancelled by Blue Shield and will remain in effect as long as your premiums are paid in advance – except under the conditions listed in the Termination of Benefits section. Blue Shield will provide at least 60 days' prior written notice before modifying the EOC/Policy, premium amount or coverage.

No person has the right to receive the benefits of any Blue Shield health plan for services provided following termination of coverage. Benefits of this plan are available only for services provided during the term the plan is in effect, and while the individual claiming benefits is actually covered by the EOC/Policy. Benefits may be modified during the term of coverage or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services provided on or after the effective date of the modification. There is no vested right to receive the benefits of any Blue Shield plan as outlined in the EOC/Policy.

What members pay

Prepayment fees

The monthly rates for each plan are shown in the brochure *Monthly Rates for Individuals and Families*.

Other charges

You are responsible for paying any applicable deductible or integrated medical and pharmacy deductible, copayment or coinsurance up to a certain limit each calendar year. The plan's deductible, copayment, coinsurance and out-of-pocket maximum are shown in the *Benefit Summary Guide*. Please refer to the EOC/Policy for further details.

Plan deductible

If your plan has a calendar-year deductible or integrated medical and pharmacy deductible, you will pay 100% of the cost for services that are subject to the deductible, until you meet the deductible.

The full amount you pay – up to the allowable amount for that covered service – will count toward your deductible or integrated medical and pharmacy deductible. Once you meet the plan deductible or plan integrated medical and pharmacy deductible, Blue Shield will pay

the allowable amount for covered services for the remainder of the calendar year, less the copayment or coinsurance that you pay for the covered service per your plan.

Some covered services, such as preventive care, are never subject to a plan deductible or plan integrated medical and pharmacy deductible, so Blue Shield pays benefits for these covered services right away.

Calendar-year out-of-pocket maximum

To limit the total amount you might have to pay for certain medical expenses in a calendar year, the medical plans offered by Blue Shield include a calendar-year out-of-pocket maximum. Bear in mind that copayments or coinsurance for some covered services do not count toward the out-of-pocket maximum, and continue to apply after the out-of-pocket maximum has been met.

If you reach a calendar-year out-of-pocket maximum, Blue Shield will then pay 100% of the allowable amount for covered services you receive through the remainder of the calendar year. There are some exceptions and any specified benefit maximums continue to apply.

Certain benefits under pediatric vision coverage require copayments and payment for charges in excess of benefit maximums and/or may be subject to maximum payments by Blue Shield.

Termination of benefits

When coverage is purchased through Covered California

Covered California will determine eligibility and continued eligibility for coverage. Notices or questions regarding cancelling or termination of coverage should be directed to Covered California at **(800) 300-1506**.

When coverage is purchased directly from Blue Shield

When coverage is purchased directly from Blue Shield, eligibility and continued eligibility for coverage are determined by Blue Shield. Notices or questions regarding cancellation or termination of coverage should be directed to Blue Shield at **(888) 256-3650**.

Termination by the member

Members can terminate their Blue Shield coverage by giving 30 days' prior written notice.

Termination by Blue Shield

Blue Shield may terminate or rescind plan coverage in accordance with applicable laws as set forth in the EOC/Policy. We can terminate the EOC/Policy for nonpayment of premiums. (If you are hospitalized or undergoing treatment for an ongoing condition and your plan is terminated, you will no longer receive the benefits of the plan.) Blue Shield has the right to rescind an EOC/Policy if the information contained in the application, or otherwise provided to Blue Shield by the member or anyone acting on his or her behalf in connection with the application, was intentionally and materially inaccurate or incomplete. See the EOC/Policy for further information. Blue Shield may terminate any subscriber's EOC/Policy, together with all like EOCs/Policies for the plan type, by giving 90 days' written notice. Blue Shield may terminate the EOC/Policy with a 30-day advance written notice under certain circumstances including:

- The subscriber moves out of the service area or California.
- Coverage is arranged through a bona fide association, and the subscriber's association membership ends.

Blue Shield may also terminate the subscriber's EOC/Policy through cancellation for cause, effective immediately upon written notice, for certain circumstances including:

- Fraud or deception in obtaining, or attempting to obtain, benefits under the EOC/Policy
- Knowingly permitting fraud or deception by another person such as, without limitation, permitting someone to use your ID card or otherwise seeking benefits under the EOC/Policy

Other coverage information

No pre-existing condition exclusions

Your coverage from Blue Shield contains no pre-existing condition or waiting period provisions.

Utilization review process

Blue Shield will disclose to members and health plan providers the process used to authorize or deny healthcare services under the plan. Blue Shield has documented its utilization review process. To learn more, please see your EOC/ Policy, or to request a copy of this process, please call Blue Shield Customer Service at the following telephone numbers: If you purchased your coverage directly from Blue Shield, please call **(888) 256-3650**, or if you purchased your coverage through Covered California, please call **(855) 836-9705** to request a copy of this process.

Continuity of care by a terminated provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children under 36 months of age; or who have received authorization for surgery or another procedure from a provider who is no longer participating in the provider network for their benefit plan as part of a documented course of treatment can request completion of care from this provider by calling Blue Shield Customer Service at the following telephone numbers: If you purchased your coverage directly from Blue Shield, please call **(888) 256-3650**, or if you purchased your coverage through Covered California, please call **(855) 836-9705**.

Continuity of care for new members by non-contracting providers

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

Member financial responsibility for continuity of care services

For plan members who are entitled to receive services from a terminated provider under the continuity of care provision, the financial responsibility of the member to that provider for services rendered under that provision shall be no greater than for the same services rendered by a participating provider in the same geographic area.

Ratio of healthcare services

For Blue Shield individual and family health plans in 2014, the ratio of the value of health services provided to the amount Blue Shield and Blue Shield Life collected in dues/premiums was 75.6%, which means that for each dollar of dues/ premium it collected, Blue Shield paid $0.76 for healthcare services. This ratio was calculated after provider discounts were applied.

Payment of providers

For PPO plans ONLY: Providers do not receive financial incentives or bonuses from Blue Shield. If you want to know more about this payment system, contact Blue Shield Customer Service at the following telephone numbers: If you purchased your coverage directly from Blue Shield, please call **(888) 256-3650** or if you purchased your coverage through Covered California, please call **(855) 836-9705**.

For HMO plans ONLY: Blue Shield generally contracts with groups of physicians to provide services to members. A fixed, monthly fee is paid to the groups of physicians for each member whose Personal Physician is in the group. This payment system, referred to as capitation, includes incentives to the groups of physicians to manage all services provided to members in an appropriate manner consistent with the contract.

Members who want to know more about this payment system may contact the Blue Shield Customer Service Department or talk to their plan provider.

Mental health, behavioral health and substance use disorder benefits

Blue Shield has contracted with a specialized healthcare service plan to act as our mental health service administrator (MHSA). Except for emergency or urgent services, mental health

services are delivered to our members through the MHSA's network of participating providers.

The MHSA must provide prior authorization for non-emergency inpatient mental health, behavioral health, and substance use disorder hospital services and non-routine mental health and behavioral health services.

Reimbursement provisions

The MHSA participating providers agree to accept MHSA's payment, plus your payment of any applicable deductible or integrated medical and pharmacy deductible, and copayment, or amounts in excess of benefit dollar maximums specified, as payment in full for covered mental health services. To find an MHSA participating provider, refer to the Blue Shield of California Behavioral Health Provider Directory, or call **(877) 263-9952** toll-free.

Prior authorization of selected drugs

Selected drugs and drug dosages require prior authorization by Blue Shield for medical necessity, including appropriateness of therapy and efficacy of lower-cost alternatives. Your physician can request prior authorization from Blue Shield Pharmacy Services.

Pediatric dental

Blue Shield has contracted with a dental plan administrator (DPA). All pediatric dental plans will be administered by the DPA. Pediatric dental benefits are available for members through the end of the month in which the member turns 19. Dental services are delivered to our members through the DPA's network of participating providers. The DPA also serves as the claims administrator for processing claims received from non-participating dentists.

All individual and family medical plans include an embedded pediatric dental benefit. For purposes of coordinating benefits, the medical plan is the primary dental benefit plan and the family pediatric dental plan is the secondary dental benefit plan.

If you have any questions regarding the dental information in this booklet, need assistance, or have any problems, you may contact your dental Member Services Department at **(888) 679-8928**.

General and eligibility inquiries:

In California .....**(800) 585-8111**

Outside California ..... **(800) 323-7201**

Problem resolution and/or grievances:

In California .....**(800) 585-8111**

Outside California ..... **(800) 323-7201**

Before obtaining dental services

You are responsible for assuring that the dentist you choose is a participating dentist. Note: A participating dentist's status may change. It is your obligation to verify whether the dentist you choose is currently a participating dentist in case there have been any changes to the list of participating dentists. A list of participating dentists located in your area can be obtained by contacting the DPA at **(888) 679-8928**. You may also access a list of participating dentists through Blue Shield of California's website at **blueshieldca.com**. You are also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the dentist obtains pre-certification of benefits.

NOTE: The DPA will respond to all requests for pre-certification and prior authorization within five business days from receipt of the request. For urgent services in situations in which the routine decision-making process might seriously jeopardize the life or health of a member or when the member is experiencing severe pain, the DPA will respond within 72 hours from receipt of the request.

Failure to meet these responsibilities may result in the denial of benefits. However, by following the pre-certification process, both you and the dentist will know in advance which services are covered and the benefits that are payable.

Pediatric vision

For pediatric vision plan copayments, please refer to the Benefit Summary, which is included as part of this Disclosure Form. You may also refer to the EOC, which you will receive after you enroll. These materials offer more detailed information on the benefits and coverages included in the pediatric vision plan.

Blue Shield's vision plans are administered by the contracted Vision Plan Administrator (VPA).

The contracted VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this vision plan through a network of participating providers. The contracted VPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from non-participating providers.

Pediatric vision benefits are available for members through the end of the month in which the member turns 19. Vision services are delivered to our members through their network of participating providers.

A participating provider will submit a claim for covered services online to the VPA or by claim form. Participating providers will accept Blue Shield of California's payment for covered services as payment in full except as noted in the Benefit Summary.

Information regarding your pediatric vision benefits can be found by consulting your benefit information or by calling Blue Shield of California's customer service at **(877) 601-9083**.

Vision plan providers do not receive financial incentives or bonuses from Blue Shield.

Principal benefits and coverage

The benefits of these plans, including acute and sub-acute care, are provided only for services that are medically necessary. Prior authorization may be required, as set forth in the EOC/Policy.

Please see the *Benefit Summary Guide* for a summary of each plan's covered services and supplies. Also, refer to the EOC/Policy, which you will receive after you enroll or which you can request prior to enrollment, for more detailed information on the benefits and coverage included in your benefit plan.

Blue Shield Trio ACO HMO plan specifics

The following information applies only to Blue Shield Trio ACO HMO plans.

Choice of physicians and providers

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

An HMO offers members a choice of providers within a contracted network of physicians, hospitals, and non-physician health care practitioners. Each member will select a Personal Physician from the Blue Shield Trio ACO HMO Plan Directory of general practitioners, family practitioners, internists, obstetricians, gynecologists and pediatricians. Members within the same family may select a different Personal Physician.

All covered services must be provided by or arranged through the member's Personal Physician, except for the following:

1. Services received during an Access+ *Specialist*[SM] visit
2. OB/GYN Services provided by an obstetrician/gynecologist or a family practice Physician within the same medical group/IPA as the Personal Physician
3. Emergency services
4. Urgent services outside the Personal Physician's service area
5. Mental health services, behavioral health treatment and substance use disorder services.*

The member's Personal Physician will manage obtaining prior authorization for services, when needed. A decision will be made on requests for prior authorization of services as follows:

- For urgent services, as soon as possible to accommodate the member's condition not to exceed 72 hours from receipt of the request;
- For other services, within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours

* Mental health services, behavioral health treatment and substance use disorder services must be arranged and provided through the mental health service administrator (MHSA). See the mental health, behavioral health and substance use disorder services paragraphs later in this section.

followed by written notice to the provider and member within two business days of the decision.

HMO plans with ACO network

Trio ACO HMO plans offer a limited selection of IPAs and medical groups to members from which to choose. The IPAs and medical groups in Trio participate in accountable care organization (ACO) collaborations with Blue Shield.

It is important for members to review the list of providers within the Trio ACO HMO Physician and Hospital Directory before enrolling in this health plan. In many areas, there may only be one (1) IPA or medical group from which to select a Personal Physician or to receive covered services.

Referral to specialty services

When the Personal Physician determines that specialty services are medically necessary, he or she will initiate a referral to a designated plan provider and request necessary authorization. The Personal Physician will generally refer the member to a specialist or other healthcare provider within the same medical group/IPA. The specialist or other health care provider will send a report to the Personal Physician.

In the event no plan provider is available to perform the needed services, the Personal Physician will refer the member to a non-plan provider after obtaining authorization.

A member with a condition or disease that is life-threatening, degenerative or disabling and which requires specialized medical care over a prolonged period of time may be eligible to receive a standing referral to a specialist. To receive more information regarding standing referrals, contact Customer Service.

Members who have questions about their diagnosis, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may request a referral from their Personal Physician to another physician for a second medical opinion. The member's Personal Physician may also offer a referral to another physician for a second opinion. State law requires that health plans disclose to members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, please call Customer Service.

If the second opinion involves care provided by the member's Personal Physician, the second opinion will be provided by a physician within the same medical group/IPA. If the second opinion involves care received from a specialist, the second opinion may be provided by any Blue Shield specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the medical group/IPA.

Access+ *Specialist*

Through Access+ *Specialist*, a member may arrange an office visit with a plan specialist in the same medical group or IPA as the Personal Physician without a referral from the Personal Physician. This benefit is subject to the limitations described in the EOC. The applicable copayment and coinsurance amounts for Access+ *Specialist* visits are indicated in the Benefit Summary, which is included as part of this Disclosure Form.

Liability of subscriber for payment

For most covered services, a member pays a copayment at the time of service. Some covered services are covered at no cost-share to the member.

The member's Personal Physician will either provide or arrange for the provision of covered services, with the exception of emergency services or urgent care services when the member is out of the service area. the member's Personal Physician will also manage obtaining prior authorization for services, when needed.

The member is responsible for payment for any services that are not covered, or not authorized or rendered by plan providers (except for emergency services or urgent care services) when the member is out of the service area).

Reimbursement provisions

Except as identified, members do not need to submit claim forms. Members pay a copayment or coinsurance at the time services are received. Coinsurance is calculated based on the negotiated rate with the plan provider. Some services are covered at no charge to the member.

If emergency services are received and expenses are incurred by the member for services other than medical transportation, the member must submit a complete claim with the emergency service record for payment to Blue Shield within one year after the first provision of emergency services for which payment is requested. In the event covered medical transportation services are obtained in such an emergency situation, Blue Shield shall pay the medical transportation provider directly.

If out-of-area urgent services were received from a provider who is not a plan provider or a BlueCard* provider, the member must submit a complete claim with the urgent service record for payment to Blue Shield within one year after the first provision of urgent services for which payment is requested. The services will be reviewed retrospectively by Blue Shield to determine whether the services were urgent services. If Blue Shield determines that the services are not covered, it will notify the member of that determination. Blue Shield will notify the member of its determination within 30 days from receipt of the claim.

Facilities

The Blue Shield Trio ACO HMO plan has a network of physicians, hospitals, participating hospice agencies, and non-physician health care practitioners in the member's Personal Physician service area. The specific network associated with the Trio ACO HMO plan is identified in the health plan Summary of Benefits and EOC.

Contact Customer Service for information on non-physician health care practitioners in your Personal Physician service area.

The directory of plan providers for the Trio ACO HMO plan can be located on Blue Shield's website at **blueshieldca.com/FAP** or by calling the Customer Service Department.

Services for emergency care

Benefits will be provided for emergency services received anywhere in the world.

1. A member who reasonably believes that he or she has an emergency medical condition or mental health condition that requires an emergency response is encouraged to appropriately use the "911" emergency response system (where available) or seek immediate care from the nearest hospital.
2. Members should notify their Personal Physician within 24 hours of receiving emergency services or as soon as reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for a medical condition for which a reasonable person would have believed that she or he had an emergency medical condition.
3. For medically necessary emergency care, the member is only responsible for the applicable deductible, copayment or coinsurance as shown in the Summary of Benefits, and is not responsible for any allowed charges Blue Shield is obligated to pay.
4. If the member did not have a medical condition for which a reasonable person would have believed that he or she had an emergency, services will not be covered.
5. For urgent care within the Personal Physician service area, a member should call his or her Personal Physician.

Utilization management

State law requires that health plans disclose to members and health plan providers the process used to authorize or deny healthcare services under the health plan.

Blue Shield has documentation of this process as required under Section 1363.5 of the California Health and Safety Code.

To request a copy of the document describing this Utilization Management Program, call Customer Service.

* BlueCard is a network of Blue Shield participating providers available to a member while temporarily traveling outside of the service area. A member who utilizes a BlueCard provider is responsible for applicable copayment and coinsurance amounts, as indicated on the Benefit Summary, which is included as part of this Disclosure Form; no claim form is required. Complete information on the BlueCard program is contained in the EOC.

Trio ACO HMO service area chart

The Trio ACO HMO service area consists of only the counties, and ZIP codes listed within those counties, on the chart below. Note: The Trio ACO HMO service area may change. To verify service area information, you can access Blue Shield's website at **blueshieldca.com** or call Shield Concierge at the telephone number provided at the back of this booklet.

Alameda County (only those ZIP codes shown here): 94550, 94551, 94566, 94568 and 94588.

Contra Costa County (only those ZIP codes shown here): 94506, 94507, 94509, 94511, 94513, 94514, 94516, 94517, 94518, 94519, 94520, 94521, 94522, 94523, 94524, 94526, 94527, 94528, 94529, 94531, 94548, 94549, 94553, 94556, 94561, 94563, 94564, 94565, 94570, 94575, 94582, 94583, 94595, 94596, 94597 and 94598.

El Dorado County (only those ZIP codes shown here): 95664, 95672, 95682 and 95762.

Kern County (only those ZIP codes shown here): 93203, 93205, 93206, 93215, 93216, 93220, 93224, 93225, 93226, 93240, 93241, 93250, 93251, 93252, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314, 93380, 93383, 93384, 93385, 93386, 93387, 93388, 93389, 93390, 93501, 93502, 93504, 93505, 93516, 93518, 93531, 93560, 93561, and 93596.

Los Angeles County (only those ZIP codes shown here): 90001, 90002, 90003, 90004, 90005, 90006, 90007, 90008, 90009, 90010, 90011, 90012, 90013, 90014, 90015, 90016, 90017, 90018, 90019, 90020, 90021, 90022, 90023, 90024, 90025, 90026, 90027, 90028, 90029, 90030, 90031, 90032, 90033, 90034, 90035, 90036, 90037, 90038, 90039, 90040, 90041, 90042, 90043, 90044, 90045, 90046, 90047, 90048, 90049, 90050, 90051, 90052, 90053, 90054, 90055, 90056, 90057, 90058, 90059, 90060, 90061, 90062, 90063, 90064, 90065, 90066, 90067, 90068, 90069, 90070, 90071, 90072, 90073, 90074, 90075, 90076, 90077, 90078, 90079, 90080, 90081, 90082, 90083, 90084, 90086, 90087, 90088, 90089, 90090, 90091, 90093, 90094, 90095, 90096, 90099, 90189, 90201, 90202, 90209, 90210, 90211, 90212, 90213, 90220, 90221, 90222, 90223, 90224, 90230, 90231, 90232, 90233, 90239, 90240, 90241, 90242, 90245, 90247, 90248, 90249, 90250, 90251, 90254, 90255, 90260, 90261, 90262, 90263, 90264, 90265, 90266, 90267, 90270, 90272, 90274, 90275, 90277, 90278, 90280, 90290, 90291, 90292, 90293, 90294, 90295, 90296, 90301, 90302, 90303, 90304, 90305, 90306, 90307, 90308, 90309, 90310, 90311, 90312, 90401, 90402, 90403, 90404, 90405, 90406, 90407, 90408, 90409, 90410, 90411, 90501, 90502, 90503, 90504, 90505, 90506, 90507, 90508, 90509, 90510, 90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609, 90610, 90637, 90638, 90639, 90640, 90650, 90651, 90652, 90660, 90661, 90662, 90670, 90671, 90701, 90702, 90703, 90706, 90707, 90710, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90723, 90731, 90732, 90733, 90734, 90744, 90745, 90746, 90747, 90748, 90749, 90755, 90801, 90802, 90803, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90813, 90814, 90815, 90822, 90831, 90832, 90833, 90834, 90835, 90840, 90842, 90844, 90846, 90847, 90848, 90853, 90895, 90899, 91001, 91003, 91006, 91007, 91008, 91009, 91010, 91011, 91012, 91016, 91017, 91020, 91021, 91023, 91024, 91025, 91030, 91031, 91040, 91041, 91042, 91043, 91046, 91066, 91077, 91101, 91102, 91103, 91104, 91105, 91106, 91107, 91108, 91109, 91110, 91114, 91115, 91116, 91117, 91118, 91121, 91123, 91124, 91125, 91126, 91129, 91182, 91184, 91185, 91188, 91189, 91199, 91201, 91202, 91203, 91204, 91205, 91206, 91207, 91208, 91209, 91210, 91214, 91221, 91222, 91224, 91225, 91226, 91301, 91302, 91303, 91304, 91305, 91306, 91307, 91308, 91309, 91310, 91311, 91313, 91316, 91321, 91322, 91324, 91325, 91326, 91327, 91328, 91329, 91330, 91331, 91333, 91334, 91335, 91337, 91340, 91341, 91342, 91343, 91344, 91345, 91346, 91350, 91351, 91352, 91353, 91354, 91355, 91356, 91357, 91364, 91365, 91367, 91371, 91372, 91376, 91380, 91381, 91382, 91383, 91384, 91385, 91386, 91387, 91390, 91392, 91393, 91394, 91395, 91396, 91401, 91402, 91403, 91404, 91405, 91406, 91407, 91408, 91409, 91410, 91411, 91412, 91413, 91416, 91423, 91426, 91436, 91470, 91482, 91495, 91496, 91499, 91501, 91502, 91503, 91504, 91505, 91506, 91507, 91508, 91510, 91521, 91522, 91523, 91526, 91601, 91602, 91603, 91604, 91605, 91606, 91607, 91608, 91609, 91610, 91611, 91612, 91614, 91615, 91616, 91617, 91618, 91702, 91706, 91711, 91714, 91715, 91716, 91722, 91723, 91724, 91731, 91732, 91733, 91734, 91735, 91740, 91741, 91744, 91745, 91746, 91747, 91748, 91749, 91750, 91754, 91755, 91756, 91765, 91766, 91767, 91768, 91769, 91770, 91771, 91772, 91773, 91775, 91776, 91778, 91780, 91788, 91789, 91790, 91791, 91792, 91793, 91801, 91802, 91803, 91804, 91896, 91899, 93510 and 93563.

Trio ACO HMO service area chart

The Trio ACO HMO service area consists of only the counties, and ZIP codes listed within those counties, on the chart below. Note: The Trio ACO HMO service area may change. To verify service area information, you can access Blue Shield's website at **blueshieldca.com** or call Shield Concierge at the telephone number provided at the back of this booklet.

Nevada County (only those ZIP codes shown here): 95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975 and 95986.

Orange County (only those ZIP codes shown here): 90620, 90621, 90622, 90623, 90624, 90630, 90631, 90632, 90633, 90680, 90720, 90721, 90740, 90742, 90743, 92602, 92603, 92604, 92605, 92606, 92607, 92609, 92610, 92612, 92614, 92615, 92616, 92617, 92618, 92619, 92620, 92623, 92624, 92625, 92626, 92627, 92628, 92629, 92630, 92637, 92646, 92647, 92648, 92649, 92650, 92651, 92652, 92653, 92654, 92655, 92656, 92657, 92658, 92659, 92660, 92661, 92662, 92663, 92672, 92673, 92674, 92675, 92676, 92677, 92678, 92679, 92683, 92684, 92685, 92688, 92690, 92691, 92692, 92693, 92694, 92697, 92698, 92701, 92702, 92703, 92704, 92705, 92706, 92707, 92708, 92711, 92712, 92728, 92735, 92780, 92781, 92782, 92799, 92801, 92802, 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 and 92899.

Placer County (only those ZIP codes shown here): 95602, 95603, 95604, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95713, 95746, 95747 and 95765.

Riverside County (only those ZIP codes shown here): 91752, 92220, 92223, 92230, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92515, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92543, 92544, 92545, 92546, 92548, 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 and 92882.

Sacramento County (only those ZIP codes shown here): 94203, 94204, 94205, 94206, 94207, 94208, 94209, 94211, 94229, 94230, 94232, 94234, 94235, 94236, 94237, 94239, 94240, 94244, 94245, 94247, 94248, 94249, 94250, 94252, 94254, 94256, 94257, 94258, 94259, 94261, 94262, 94263, 94267, 94268, 94269, 94271, 94273, 94274, 94277, 94278, 94279, 94280, 94282, 94283, 94284, 94285, 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, 95815, 95816, 95817, 95818, 95819, 95820, 95821, 95822, 95823, 95824, 95825, 95826, 95827, 95828, 95829, 95830, 95831, 95832, 95833, 95834, 95835, 95836, 95837, 95838, 95840, 95841, 95842, 95843, 95851, 95852, 95853, 95860, 95864, 95865, 95866, 95867, 95894 and 95899.

San Bernardino County (only those ZIP codes shown here): 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 92301, 92305, 92307, 92308, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92329, 92331, 92333, 92334, 92335, 92336, 92337, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423 and 92427.

Trio ACO HMO service area chart

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San Diego County (only those ZIP codes shown here): 91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 91987, 92003, 92007, 92008, 92009, 92010, 92011, 92013, 92014, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92036, 92037, 92038, 92039, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92064, 92065, 92067, 92068, 92069, 92071, 92072, 92074, 92075, 92078, 92079, 92081, 92082, 92083, 92084, 92085, 92088, 92091, 92092, 92093, 92096, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92134, 92135, 92136, 92137, 92138, 92139, 92140, 92142, 92143, 92145, 92147, 92149, 92150, 92152, 92153, 92154, 92155, 92158, 92159, 92160, 92161, 92163, 92165, 92166, 92167, 92168, 92169, 92170, 92171, 92172, 92173, 92174, 92175, 92176, 92177, 92178, 92179, 92182, 92186, 92187, 92190, 92191, 92192, 92193, 92195, 92196, 92197, 92198 and 92199.

San Francisco County (only those ZIP codes shown here): 94102, 94103, 94104, 94105, 94107, 94108, 94109, 94110, 94111, 94112, 94114, 94115, 94116, 94117, 94118, 94119, 94120, 94121, 94122, 94123, 94124, 94125, 94126, 94127, 94129, 94130, 94131, 94132, 94133, 94134, 94137, 94139, 94140, 94141, 94142, 94143, 94144, 94145, 94146, 94147, 94151, 94158, 94159, 94160, 94161, 94163, 94164, 94172, 94177 and 94188.

San Joaquin County (only those ZIP codes shown here): 95201, 95202, 95203, 95204, 95205, 95206, 95207, 95208, 95209, 95210, 95211, 95212, 95213, 95215, 95219, 95220, 95227, 95230, 95231, 95234, 95236, 95237, 95240, 95241, 95242, 95253, 95258, 95267, 95269, 95296, 95297, 95304, 95320, 95330, 95336, 95337, 95366, 95376, 95377, 95378, 95385, 95391 and 95686.

San Mateo County (only those ZIP codes shown here): 94002, 94005, 94010, 94011, 94014, 94015, 94016, 94017, 94018, 94019, 94020, 94021, 94025, 94026, 94027, 94028, 94030, 94037, 94038, 94044, 94060, 94061, 94062, 94063, 94064, 94065, 94066, 94070, 94074, 94080, 94083, 94128, 94401, 94402, 94403, 94404 and 94497.

Santa Clara County (only those ZIP codes shown here): 94022, 94023, 94024, 94035, 94039, 94040, 94041, 94042, 94043, 94085, 94086, 94087, 94088, 94089, 94301, 94302, 94303, 94304, 94305, 94306, 94309, 95002, 95008, 95009, 95011, 95013, 95014, 95015, 95020, 95021, 95026, 95030, 95031, 95032, 95035, 95036, 95037, 95038, 95042, 95044, 95046, 95050, 95051, 95052, 95053, 95054, 95055, 95056, 95070, 95071, 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 and 95196.

Santa Cruz County (only those ZIP codes shown here): 95001, 95003, 95005, 95006, 95007, 95010, 95017, 95018, 95019, 95033, 95041, 95060, 95061, 95062, 95063, 95064, 95065, 95066, 95067, 95073, 95076 and 95077.

Solano County (only those ZIP codes shown here): 94503, 94510, 94589, 94592 and 95620.

Stanislaus County (only those ZIP codes shown here): 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 and 95397.

Tulare County (only those ZIP codes shown here): 93219, 93256 and 93260.

Trio ACO HMO service area chart

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Ventura County (only those ZIP codes shown here): 91319, 91320, 91358, 91359, 91360, 91361, 91362, 91377, 93010, 93011, 93012, 93015, 93016, 93020, 93021, 93040, 93062, 94063, 93064, 93065, 93066, 93094 and 93099.

Yolo County (only those ZIP codes shown here): 95605, 95606, 95607, 95612, 95616, 95617, 95618, 95627, 95637, 95645, 95653, 95691, 95694, 95695, 95697, 95698, 95776, 95798, 95799 and 95937.

Subscribers must reside in the plan service area to enroll in this plan and to maintain eligibility for coverage in this plan.

Blue Shield PPO plans

This information applies only to Blue Shield PPO plans.

Choice of physicians and providers

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

Blue Shield's PPO plan is designed to allow you to obtain services from Blue Shield participating providers and MHSA participating providers. However, you may choose to seek services from non-participating providers for most services. Covered services obtained from non-participating providers will usually result in a higher share of cost for you. Some services are not covered unless obtained from participating providers, which are listed in our provider directories and online in the *Find a Provider* section of **blueshieldca.com**.

Blue Shield provider network, including facilities

We update our provider directories periodically to reflect changes in our provider networks. It is the member's obligation to verify whether the provider chosen is a participating provider or an MHSA participating provider prior to obtaining coverage.

For the most up-to-date listings, check our online directories in the *Find a Provider* section of **blueshieldca.com**. You can also request a directory from your Blue Shield authorized account representative, or by calling Blue Shield Customer Service at the following telephone numbers: If you purchased your coverage directly from Blue Shield, please call **(888) 256-3650**, or if you purchased your coverage through Covered California, please call **(855) 836-9705**.

Participating providers

Participating providers agree to accept Blue Shield's payment, plus your payment of any applicable deductible and copayment/ coinsurance, or amounts in excess of benefit dollar maximums specified, as payment in full for covered services.

Reimbursement provisions

When you use participating providers, you generally won't have to pay for services at the time of your visit. Most participating providers will bill Blue Shield directly, and then bill you for your payment responsibility. We will apply the appropriate amount toward any applicable deductible. For pediatric vision, payment in excess of covered benefits is typically due at time of service.

Non-participating providers

Blue Shield's payment for non-participating providers may be substantially less than the amount billed. You are responsible for the difference between the amount we pay and the amount billed by non-participating providers. In some instances, we cover services only if rendered by a participating provider, so using a non-participating provider could result in lower or no payment by Blue Shield for these services.

To ensure enrollees are not balanced-billed unreasonable amounts by non-participating providers, Blue Shield's payment for non-participating providers must be at least the greater of: (1) the median negotiated contract rate for the services, (2) the amount determined using the method Blue Shield generally uses to calculate payments to non-participating providers, or (3) the Medicare payment amount.

Reimbursement provisions

When you use non-participating providers, you must pay the provider directly for the entire cost of your care, either at the time of your visit or when they bill you. Once you receive the bill, simply submit a copy of it with a claim form to Blue Shield. We will apply the appropriate amount to your plan deductible, or reimburse you for the applicable percentage of the Blue Shield allowable amount if you've already met your plan deductible.

Obtaining emergency services worldwide

With all Blue Shield plans, emergency services are covered anywhere in the world. An emergency is defined as an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of

immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to your life or health
- Serious impairment to your bodily functions
- Serious dysfunctions of any bodily organ or part

For emergency services from either a participating or non-participating provider, the member is only responsible for the applicable deductible, copayment, or coinsurance as shown in the Summary of Benefits, and is not responsible for any allowable amount Blue Shield is obligated to pay.

Obtaining urgent care away from home – the BlueCard Program

With the BlueCard® Program, members can access urgent care through the BlueCard network of providers when they are away from home (members can access urgent care from any provider, but they will pay less when they go to a BlueCard network provider). The program has specific guidelines for obtaining care, and these guidelines are explained in each health plan's EOC or Policy. More than 85% of all hospitals and physicians nationwide participate in the BlueCard Program.

Please note, it is not necessary to obtain emergency or urgent care solely from BlueCard providers.

General exclusions and limitations on benefits

For all Blue Shield health plans for individuals and families

No benefits are provided for the following:

1. Routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;
2. For hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
3. Routine foot care items and services that are not medically necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a participating hospice agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
4. Services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a participating hospice agency or through a palliative care program offered by Blue Shield;
5. Home services, hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, or domiciliary care, except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
6. Services in connection with private-duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a participating hospice agency;
7. Prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a participating hospice agency;
8. Hearing aids;
9. Eye exams and refractions, lenses, and frames for eyeglasses, lens options and treatments and contact lenses for members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;
10. Surgery to correct refractive error (such as, but not limited to, radial keratotomy, refractive keratoplasty);

11. Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
12. For dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
13. For or incident to services and supplies for treatment of the teeth and gums of members 19 years and older (except for tumors, preparation of the member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures including, but not limited to, diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints, or Jaw Bones Benefits, Pediatric Dental Benefits, and Hospital Benefits (Facility Services);
14. For cosmetic surgery except for medically necessary treatment of resulting complications (e.g., infections or hemorrhages);
15. For reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;
16. For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;
17. For or incident to the treatment of infertility, including the cause of infertility, or any form of assisted reproductive technology, including, but not limited to, reversal of surgical sterilization, or any resulting complications, except for medically necessary treatment of medical complications;
18. Any services related to assisted reproductive technology including, but not limited to, the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;
19. Services incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits;
20. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;
21. Genetic testing except as described in the sections on outpatient X-ray, Imaging, Pathology and Laboratory Benefits and the Pregnancy and Maternity Care Benefits;
22. Preventive Health benefits by non-participating providers;
23. Services performed in a hospital by house officers, residents, interns and others in training;
24. Services performed by a close relative or by a member who ordinarily resides in the member's home;
25. Services provided by an individual or entity that is not appropriately licensed or certified by the state to provide healthcare services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under Mental Health,

Behavioral Health, and Substance Use Disorder Benefits;

26. Massage therapy that is not physical therapy or a component of a multiple-modality rehabilitation treatment plan;
27. For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for severe mental illnesses or serious emotional disturbances of a child;
28. Learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for severe mental illnesses or serious emotional disturbances of a child;
29. Services which are experimental or investigational in nature, except for services for members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;
30. Drugs, medicines, supplements, tests, vaccines, devices, radioactive materials, and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;
31. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, Home Infusion/ Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;
32. Patient convenience items such as telephone, television, guest trays and personal hygiene items;
33. For disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home health care, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits;
34. Services for which the member is not legally obligated to pay, or for services for which no charge is made;
35. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;
36. For spinal manipulation and adjustment, except as specifically provided under Professional (Physician) Benefits (other than for Mental Health, Behavioral Health, and Substance Use Disorder Benefits) in the Plan Benefits section;
37. For transportation services other than provided under Ambulance Benefits in the Plan Benefits section;
38. For inpatient and Non-Routine Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services unless authorized by the MHSA;
39. Drugs dispensed by a Physician or Physician's office for outpatient use; and
40. Services not specifically listed as a benefit.

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Also excluded from Trio ACO HMO plans

In addition to the exclusions listed above, the Trio ACO HMO plan does not provide benefits for the following:

1. For services, including hospice services rendered by a participating hospice agency, not provided, prescribed, referred or authorized as described herein except for Access+ *Specialist* visits, OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same medical group/IPA as the Personal Physician, emergency services or urgent services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section.

General exclusions and limitations for outpatient prescription drug coverage

No benefits are provided under Outpatient Prescription Drug Benefits unless they meet the requirements set forth in the EOC (see Outpatient Prescription Drug Benefits section) and are prescribed by the member's Physician. (Please note, certain services excluded below may be covered under other benefits. Refer to the applicable section of the EOC/Policy to determine if drugs are covered under that benefit.) No benefits are provided for the following:

1. Any drug the member receives while an inpatient, in a physician's office, skilled nursing facility or outpatient facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of the EOC/Policy;
2. Take home drugs received from a hospital, skilled nursing facility, or similar facilities. See the Hospital Benefits and Skilled Nursing Facility Benefits sections of the EOC/Policy;
3. Unless listed as covered under this Outpatient Prescription Drug Benefit, drugs that are available without a prescription (OTC), including drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug;
4. Drugs not listed on the formulary. These drugs may be covered if medically necessary and prior authorization is obtained from Blue Shield. See the Prior Authorization/ Exception Request Process section of this *Evidence of Coverage;*
5. Drugs for which the member is not legally obligated to pay, or for which no charge is made;
6. Drugs that are considered to be experimental or investigational;
7. Medical devices or supplies except as listed as covered herein. See the Prosthetic Appliances Benefits, Durable Medical Equipment Benefits, and the Orthotics Benefits sections of your EOC/Policy. This exclusion also applies to prescription preparations applied to the skin that are approved by the FDA as medical devices;
8. Blood or blood products. See the Hospital Benefits (Facility Services) section of the EOC/Policy;
9. 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;
10. Medical food, dietary or nutritional products. See the Home Health Care section, Home Infusion/Home Injectable Therapy section and PKU Related Formulas and Special Food Product section of the EOC/Policy;
11. Any drugs which are not considered to be safe for self-administration. These medications may be covered under the Home Health Care Benefits, Home Infusion/ Home Injectable Therapy Benefits, the Hospice Program Benefits and Family Planning Benefits sections of the EOC/Policy;
12. All drugs for the treatment of infertility;
13. Appetite suppressants or drugs for body weight reduction. These drugs may be covered if medically necessary for the treatment of morbid obesity. In these cases, prior authorization by Blue Shield is required;
14. Contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a physician or health care provider, (3) are generally purchased at an outpatient pharmacy and (4) are self-administered;

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15. Compounded medications which do not meet all the following requirements: (1) the compounded medications(s) includes at least one drug, (2) there are no FDA-approved, commercially available, medically appropriate alternative(s), (3) the compounded medication(s) is self-administered, and (4) medical literature supports its use for the requested diagnosis;
16. Replacement of lost, stolen or destroyed drugs;
17. If the member is enrolled in a hospice program through a participating hospice agency, drugs that are medically necessary for the palliation and management of terminal illness and related conditions. These drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the Hospice Program Benefits section of the *Evidence of Coverage;*
18. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to (1) antibiotics prescribed to treat infection, (2) drugs prescribed to treat pain, or (3) drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;
19. Except for a covered emergency, drugs obtained from a pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list;
20. Immunizations and vaccinations solely for the purpose of travel;
21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the drug is not otherwise available without the non-prescription convenience items. This exclusion shall not apply to items used for the administration of diabetes or asthma drugs; and
22. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Also excluded from Trio ACO HMO outpatient prescription drug coverage

Blue Shield does not provide coverage in the HMO outpatient prescription drug benefit for the following item. The member may receive coverage for certain services excluded below under other benefits. Refer to the General Exclusions and Limitations for Outpatient Prescription Drug Coverage section above and to the applicable section(s) of this *Evidence of Coverage* and Health Service Agreement to determine if the plan covers drugs under that benefit.

1. Drugs obtained from a non-participating pharmacy. This exclusion does not apply to drugs obtained for a covered emergency. Nor does it apply to drugs obtained for an urgently needed service for which a participating pharmacy was not reasonably accessible.

Please note: Blue Shield's drug formulary is a list of preferred generic and brand drugs maintained by Blue Shield's Pharmacy and Therapeutics Committee. It is designed to assist physicians and health care providers in prescribing drugs that are medically necessary and cost-effective. The Formulary is updated periodically. Members should always present their Blue Shield ID card to obtain benefits at a participating (network) pharmacy. Except for covered emergencies, prescription drugs obtained from non-participating pharmacies are not covered. Call **(800) 351-2465** to find out if a particular drug is on the Blue Shield Drug Formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield website at **blueshieldca.com**.

Specific exclusions and limitations to the pediatric dental plan

1. Dental services in excess of the limits specified in the Limitations section of the EOC;
2. Dental services that are received in an emergency care setting for conditions that are not emergencies if the member reasonably should have known that an emergency care situation did not exist;
3. Hospital charges of any kind;
4. Loss of theft of dentures or bridgework;
5. Surgical removal of implants;
6. Services of a pedodontist/pediatric dentist for a member except when a member child

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is unable to be treated by his or her dental provider or treatment is dentally necessary or his or her dental provider is a pedodontist/ pediatric dentist;

7. Non-medically necessary orthodontia is not a covered benefit;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;
11. Myofunctional therapy;
12. Changes in treatment necessitated by an accident;
13. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;
14. Special orthodontic appliances including, but not limited to, Invisalign, lingual, or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
15. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
16. Reimbursement for any services after the 24 months of treatment for which a claim has not been submitted; and
17. In the event of a member's loss of coverage for any reason, if at the time of loss of coverage the member is still receiving orthodontic treatment during the 24-month treatment period, the member and not the dental plan administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining.

Specific limitations:

1. Restorations are limited as follows:
    a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional;
    b. Composite resin or acrylic restorations in posterior teeth are optional services and if rendered, will be paid at the equivalent amalgam restoration fee;
    c. Micro-filled resin restorations which are non-cosmetic; and
    d. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary;
2. Oral surgery is limited as follows:
    a. Surgical removal of impacted teeth is a covered service only when evidence of pathology exists;
3. Endodontics: Retreatment of root canals is a covered service only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered service;
4. Periodontics: Periodontal scaling and root planing and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months;
5. Crowns and fixed bridges. Five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction.
    a. Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:
        i. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan administrator;
        ii. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown;

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iii. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling; and

iv. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown;

b. Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

i. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment;

ii. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer;

iii. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic;

iv Fixed bridges are optional when provided in connection with a partial denture on the same arch; and

v. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair;

6. Removable prosthetics

a. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

i. Partial dentures are not to be replaced within 36 consecutive months, unless 1) it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) the denture is unsatisfactory and cannot be made satisfactory;

ii. Benefits for partial dentures are limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the Dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges;

iii. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional;

iv. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair; and

v. Benefits for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges;

b. Office or laboratory relines or rebases are limited to one per arch in any 12 consecutive months;

c. Tissue conditioning is limited to two per denture;

d. Implants are considered an optional service; and

e. Stayplates are a covered service only when used as anterior space maintainers for children.

Orthodontic limitations and exclusions for the pediatric dental plan

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

Those immediate qualifying conditions are:

1. Cleft lip and/or palate deformities.
2. Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite.)
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bilateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.
6. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

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

Excluded are the following conditions:

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

General exclusions and limitations for Blue Shield pediatric vision plans

1. Orthoptics or vision training, subnormal vision aids, or non-prescription lenses for glasses when no prescription change is indicated;
2. Replacement or repair of lost or broken lenses or frames except as provided for under this Policy;
3. Any eye examination required by an employer as a condition of employment;
4. Medical or surgical treatment of the eyes;
5. Contact lenses, except as specifically provided;
6. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of the injury or disease;
7. Services required by any government agency or program, federal, state, or subdivision thereof;

8. Services and materials for which the member is not legally obligated to pay, or services or materials for which no charge is made;
9. Services not specifically listed as a benefit; and
10. Comprehensive examination benefit does not include fitting and evaluation fees for contact lenses.

Blue Shield dental plans

Dental plan information

Dental PPO, Dental HMO, and Specialty Duo℠ Dental Plan* benefits are separate from the medical benefits of the Blue Shield health plans:

- Dental PPO, Dental HMO and Specialty Duo Dental Plan benefits are not subject to the deductible or integrated medical and pharmacy deductible requirements of the health plan and do not accumulate toward the maximum calendar-year copayment/ coinsurance maximum of the health plan.
- Dental benefits for the Dental PPO and Dental HMO will be administered by Blue Shield's DPA.
- If your dental coverage is cancelled for any reason by you or by Blue Shield, you may apply for reinstatement.
- You may access a Directory of Participating Dentists by going to Blue Shield's website at **blueshieldca.com** and clicking on the *Find a Provider* section. The names of participating dentists in your area may also be obtained by contacting the DPA at **(888) 679-8928**.
- For the dental PPO and Specialty Duo plans:
  - The Blue Shield of California Dental PPO Plan is specifically designed for you to use participating dentists. Participating dentists agree to accept the DPA's payment, plus your payment of any applicable deductible and copayment, as payment in full for covered services. This is not true of non-participating dentists.
  - If you go to a non-participating dentist, you will be reimbursed up to a predetermined maximum amount for covered services. Your reimbursement may be substantially less than the billed amount. The subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by non-participating dentists. It is therefore to your advantage to obtain dental services from participating dentists.
  - Participating providers submit claims for payment after their services have been rendered. These payments go directly to the participating provider. You or your non-participating providers submit claims for reimbursement after services have been rendered. If you receive services from non-participating providers, you have the option of having payments sent directly to the non-participating provider or sent directly to you. The DPA will notify you of its determination within 30 days after receipt of the claim.
- For the dental HMO plans:
  - Blue Shield of California dental HMO plan contracts with the DPA to provide services to our members. A monthly fee is paid to the DPA for each member. This payment system includes incentives to the DPA to manage all covered services provided to members in an appropriate manner consistent with this contract. If you want to know more about this payment system, contact dental Member Services at **(888) 679-8928** or talk to your plan provider.
  - The DPA is responsible for providing covered services and/or referring the member to plan specialists and providers. Your dental provider must obtain authorization from the DPA before referring you to providers outside of the Dental Center.
  - You or a dependent may change dental providers without cause at the following times:
    1. When your change in residence or work address prevents you or a dependent from continuing with the same dental provider;
    2. One (1) other time during the calendar year.

If you want to change dental providers at any of the above times, you may call Dental Member

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Services at **(888) 679-8928**. Before changing dental providers, you must pay any outstanding copayment balance owed to your existing dental provider. The change will be effective the first day of the month following notice of approval by the Plan.

- All specialty dental care services must be provided by or arranged for by the dental provider. Referral by a dental provider does not guarantee coverage for the services for which the member is being referred. The benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a plan specialist within the Dental Center. However, you may also be referred to a plan specialist outside of the Dental Center if the type of specialty service needed is not available within your Dental Center.
- If the dental provider determines specialty dental care services are necessary, they will complete a referral form and you will then be able to schedule an appointment with the specialist. When no plan provider is available to perform the needed service, the dental provider will refer you to a non-plan provider after obtaining authorization from the DPA. This authorization procedure is handled for you by your dental provider.

Dental plans general exclusions and limitations

For all Blue Shield dental plans, including Specialty Duo Dental Plan

The following is a summary of services and supplies not covered by Blue Shield dental plans. For a complete list of dental coverage exclusions and limitations, please refer to the EOC/Policy for your dental plan.

General exclusions

1. Services not listed as covered in the member's EOC/Policy/Summary of Benefits;
2. Services to be paid by the member's Blue Shield health plan;
3. Services begun prior to the patient's effective date of coverage;
4. Services performed or supplies provided in a hospital or any place other than a dental office;
5. Unnecessary, investigational, experimental, cosmetic or elective services; services for which the prognosis is not favorable, as determined by the dental plan administrator;
6. Services performed by a close relative or someone who lives in the member's home; services for which the member is not obligated to pay or services performed at no charge;
7. Services paid for by any governmental agency;
8. Implants, except when covered in specific plans;
9. Vestibuloplasy, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;
10. Treatment of congenital anomalies or developmental malformation;
11. Treatment to correct malignancies, cysts, tumors and neoplasm;
12. Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;
13. Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation; accidental injury means a condition or injury caused by external, violent or accidental means, rather than by dental illness (e.g., injury caused by a fall or car accident);
14. General anesthesia or intravenous or inhalation sedation, unless medically necessary;
15. Prescription or non-prescription drugs;
16. Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
17. Removal of wisdom teeth unless of dental necessity;
18. Any services Blue Shield or the dental plan administrator determines not to be of dental necessity as defined in the EOC/Policy/ Summary of Benefits;
19. Temporary dental services. Charges for temporary dental services are considered an integral part of the final dental service and will not be separately payable;
20. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings,

appliances or any other method that splints or connects teeth together;

21. Services provided by an individual or entity that is not licensed or certified by the state to provide healthcare services, or is not operating within the scope of such license or certification, except as specifically stated herein;
22. Any service, procedure or supply for which the prognosis for long-term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;
23. Services and/or appliances that alter the vertical dimension including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;
24. Procedures that are principally cosmetic in nature including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures; and
25. Charges for saliva and bacterial testing when caries management procedures D0601, D0602 and D0603 are performed.

General limitations

1. Periodic oral exam, routine prophylaxis, fluoride treatment, bitewing X-rays (maximum of four per occurrence), and recementations (if the crown was provided by other than the original dentist; not eligible if the dentist is doing the recementation of service he/she provided within 12 months) are covered services every 6-month period;
2. Denture (complete and partial) relines and oral cancer screenings (this benefit only applies to the Dental PPO and Specialty Duo Dental Plan*) are covered services every 12-month period;
3. Gingival flap surgery per quad, diagnostic casts, sealants and occlusal guards are covered services every 24-month period;
4. Full-mouth debridement, mucogingival surgery per area, osseous surgery per quad, gingivectomy per quad, gingivectomy per tooth, bone replacement grafts for periodontal purposes, guided tissue regeneration for periodontal purposes, full-mouth series and panoramic X-rays are covered services every 36-month period;
5. Single crowns and onlays, single post and core buildups, crown buildup including pins, prefabricated post and core, cast post and core in addition to crown, complete dentures, partial dentures, fixed partial denture (bridge) pontics, fixed partial denture (bridge) abutments, abutment post and core buildups are covered services every five-year period;
6. Space maintainers are only eligible for members through age 15 (for Dental PPO and Specialty Duo plans) or through age 11 (for the Dental HMO and Enhanced Dental HMO $0 plans) when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not developed, or will never develop;
7. Sealants are only eligible for members one per tooth per two-year period through age 15 (for the Dental HMO plan) or through age 11 (for the Dental PPO and Specialty Duo plans) on permanent first and second molars;
8. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy and crown lengthening;
9. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than three teeth missing in one quadrant or in the anterior region. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP;
10. General IV or inhalation sedation is covered for the following:

    A. Three or more surgical extractions;

    B. One or more impactions;

    C. Full-mouth or arch alveoloplasty;

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D. Surgical root recovery from sinus;

E. Medical problem contraindicates local anesthesia; and

F. Children under the age of seven (7) years old.

(General or IV sedation is not a covered benefit for dental-phobic reasons);

11. Restorations, crowns, inlays and onlays are covered only if necessary to treat diseased or accidentally fractured teeth;
12. Root canal treatment is covered one per tooth per lifetime;
13. Root canal retreatment is covered one per tooth per lifetime;
14. Pulpal therapy is covered through age 5 on primary anterior teeth and through age 11 on primary posterior teeth;
15. For mucogingival surgeries, one site is equal to two consecutive teeth or bonded spaces;
16. Scaling and root planing are covered once for each of the four quadrants of the mouth in a 24-month period. Scaling and root planing is limited to two quadrants of the mouth per visit;
17. Cone Beam CT (D0367) is a benefit only when placing an implant. This procedure cannot be used for orthodontics or periodontics. This is a once-in-a-lifetime benefit and is limited to projection of upper and lower jaws only; and
18. You must be 21 or older to be eligible for dental implant benefits due to continued growth and development of the mid-face and jaws. If there are bilaterally missing teeth or more than three (3) teeth missing in a quadrant, or more than three (3) teeth missing in the anterior region, the member will be given an alternate benefit of a partial denture. If the member elects a different procedure, payment will be based on the partial denture benefit.

Specific exclusions and limitations to dental HMO plans

In addition to the general exclusions listed above in this section, the following exclusions apply:

1. Services not performed, prescribed or authorized by the member's dental provider, unless authorized by the plan or when required in an emergency, as stated in the contract;
2. Precious metals;
3. Services of prosthodontists, and procedures requiring fixed prosthodontic restoration for complete oral rehabilitation or reconstruction;
4. Unauthorized second opinions;
5. House calls for dental services;
6. Dental implants (Enhanced Dental HMO $0 only) – surgical insertion and/or removal, transplants, ridge augmentations or socket preservation and appliance and/or crown attached to implants;
7. Duplicate dentures, prosthetic devices or any other duplicate appliance;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;
11. Myofunctional therapy;
12. Changes in treatment necessitated by an accident;
13. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;
14. Special orthodontic appliances including, but not limited to, Invisalign, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
15. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
16. Reimbursement for any services after the 24 months of treatment for which a claim has not been submitted;
17. In the event of a member's loss of coverage for any reason, if at the time of loss of coverage the member is still receiving orthodontic treatment during the 24-month treatment period, the member and not the dental plan administrator will be responsible for the remainder of the cost for that

* Underwritten by Blue Shield of California Life & Health Insurance Company.

treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining; and

18. If the member elects to use the Invisalign system, additional costs beyond what Blue Shield will pay for "standard" orthodontic treatment (i.e., braces and bands) will be paid by the member.

Specific limitations:

1. Referral to a specialty care dentist is limited to orthodontics, oral surgery, periodontics, endondontics and pediatrics;
2. Coverage for referral to a pediatric specialty care dentist is covered up to the age of six (6) and is contingent on dental necessity. However, exceptions for physical or mental handicaps or medically compromised children over the age of six (6), when confirmed by a physician, may be considered on an individual basis with prior approval;
3. Payment for orthodontic treatment is made in installments. If for any reason orthodontic services are terminated or coverage is terminated before completion of the approved orthodontics treatment, the responsibility of the contracted Dental plan administrator will cease with payment through the month of termination; and
4. In the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than 50 miles from the member's home, the plan covers necessary diagnostic and therapeutic dental procedures administered by an out-of-network dentist up to the difference between the out-of-network dentist's charge and the member's copayment up to a maximum of $50 for each emergency visit.

Specific exclusions and limitations to dental PPO plans

In addition to the general exclusions and limitations listed above in this section, the following exclusions and limitations apply:

1. Any inlay restorations;
2. Crowns or onlays installed as multiple abutments;
3. Prosthetic appliance related to periodontics;
4. Charges for missed appointments;
5. Alloplastic bone grafting materials;
6. Bone grafting done for socket preservation after tooth extraction or in preparation for implants (unless your plan provides special implant benefits – please see the Summary of Benefits to determine if you have implant benefits);
7. Charges for services in connection with orthodontia when rendered by a non-participating provider;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;
11. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;
12. Special orthodontic appliance including, but not limited to, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
13. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
14. Treatment exceeding 24 months except for treatment prior approved by Blue Shield as dentally necessary;
15. In the event of a member's loss of coverage for any reason, if at the time of loss of coverage the member is still receiving orthodontic treatment during the 24-month treatment period, the member and not a contracted dental plan administrator will be responsible for the remainder of the cost for that treatment at the participating orthodontist's billed charges, prorated for the number of months remaining;
16. If the insured is reinstated after cancellation, there are no orthodontic benefits for treatment begun prior to his or her reinstatement effective date;
17. There is a 12-month waiting period before beginning orthodontic treatment;
18. If the member elects to use the Invisalign system, additional costs beyond what Blue Shield will

pay for "standard" orthodontic treatment (i.e., braces and bands) will be paid by the member;

19. Benefits for the initial placement will not exceed 20% of the lifetime maximum benefit amount for orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment are all subject to the orthodontia coinsurance level and lifetime maximum benefit amount; and
20. Orthodontic benefits end at cancellation of coverage.

Specific exclusions to Specialty Duo Dental Plan*

1. Any inlay restorations.
2. Alloplastic bone grafting materials.
3. Bone grafting done for socket preservation after tooth extraction or in preparation for implants.

Blue Shield vision plans

Vision plan information

All Vision plans including Specialty Duo Vision*

Ultimate Vision 15/25/150* and Specialty Duo Vision Plan* benefits are separate from the medical benefits of the Blue Shield health plans:*

- Ultimate Vision and Specialty Duo Vision Plan benefits are not subject to the deductible or integrated medical and pharmacy deductible requirement of the health plan and do not accumulate toward the calendar-year out-of-pocket maximum of the health plan.
- All vision plans will be administered by the Vision Plan Administrator (VPA).
- If your vision coverage is cancelled for any reason by you or Blue Shield, you may apply for reinstatement.

You may obtain services from a list of participating providers by contacting customer service at **(877) 601-9083** or via our website at **blueshieldca.com**. Participating providers receive payment directly from the plan.

You may also obtain services from non-participating providers. If you use a non-participating provider, you will be required to pay the provider's bill at the time of service. You can get reimbursed by logging in to **blueshieldca.com**.

A participating provider will submit a claim for covered services online to the VPA or by claim form. Participating providers will accept Blue Shield of California's payment for covered services as payment in full except as noted in the Benefit Summary. When covered services are provided by a non-participating provider, you or the non-participating provider must submit a Vision Service Report Form (claim form C-4669-61) which can be obtained from our website at **blueshieldca.com**. This form must be completed in full and submitted with all related receipts to:

Blue Shield of California
P.O. Box 25208
Santa Ana, CA 92799-5208

Covered services provided by a non-participating provider are reimbursed up to the allowed amount under the Benefit Summary. Blue Shield of California will send payments directly to you. You are responsible for the difference between the non-participating provider's charges and the allowed amount under the Benefit Summary as well as any applicable copayment and/or charges for frames or lenses above the allowed amount.

Information regarding your benefits can be found by consulting your benefit information or by calling Blue Shield of California's customer service at **(877) 601-9083**.

Vision plan providers do not receive financial incentives or bonuses from Blue Shield.

General exclusions and limitations for all Blue Shield vision plans including Specialty Duo Vision* plan

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

2. Replacement or repair of lost or broken lenses or frames except as provided for under this Policy;
3. Any eye examination required by an employer as a condition of employment;
4. Medical or surgical treatment of the eyes;
5. Contact lenses, except as specifically provided;
6. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if Blue Shield provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of the injury or disease;
7. Services required by any government agency or program, federal, state, or subdivision thereof;
8. Services and materials for which the member is not legally obligated to pay, or services or materials for which no charge is made;
9. Services not specifically listed as a benefit; and
10. Comprehensive examination benefit does not include fitting and evaluation fees for contact lenses.

Grievance process

Blue Shield of California and Blue Shield of California Life & Health Insurance Company have established a grievance procedure for receiving, resolving and tracking members' grievances with Blue Shield. For more information on this process, see the Grievance Process section in the plan's EOC/Policy.

External independent medical review

State law requires Blue Shield to disclose to members the availability of an external independent review process when a member's grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not medically necessary or is experimental/ investigational. Members of a Blue Shield of California medical or specialty benefits (dental or vision) plan can make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. Members of a Blue Shield Life medical insurance or specialty insurance plan (dental, vision, Specialty Duo) can request an external independent review through the California Department of Insurance. A member can determine which company underwrites their coverage by looking at their member identification (ID) card.

Department of Managed Health Care review

This information is relevant for all plans underwritten by Blue Shield of California

The California Department of Managed Health Care (DMHC) is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at the telephone number on your Blue Shield member ID card, or call **(888) 256-3650** if you purchased your coverage directly from Blue Shield or **(855) 836-9705** if you purchased your coverage from Covered California, and use your health plan's grievance process before contacting the DMHC. 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 DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 DMHC also has a toll-free number, **(888) HMO-2219**, and a TTY line, (877) 688-9891, for the hearing and speech impaired. The DMHC's website, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

Department of Insurance review

This information is relevant for all plans underwritten by Blue Shield of California Life & Health Insurance Company:

The California Department of Insurance (DOI) is responsible for regulating health insurance. The DOI's Consumer Communications Bureau has a toll-free number – (800) 927-HELP (4357) or TTY (800) 482-4833 – to receive complaints regarding health insurance from either the insured or his or her provider. If you have a complaint against your insurer, you should contact the insurer first and use its grievance process. If you need the DOI's help with a complaint or grievance that has not been satisfactorily resolved by the insurer, you may call the DOI's toll-free telephone number from 8 a.m. to 6 p.m., Monday through Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or www.insurance.ca.gov.

Confidentiality and privacy

Blue Shield protects the privacy of individually identifiable personal information including Protected Health Information. Individually identifiable personal information includes health, financial and/or demographic information – such as name, address, and Social Security number. Blue Shield will not disclose this information without authorization, except as permitted or required by law.

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of the EOC/ Policy, or by accessing Blue Shield's website at **blueshieldca.com** and printing a copy.

Members who are concerned that Blue Shield may have violated their privacy rights, or who disagree with a decision Blue Shield made about access to their individually identifiable personal information, may contact Blue Shield at:

Correspondence address:

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

Notice of privacy policy

Blue Shield of California Life & Health Insurance Company

(Blue Shield Life) P.O. Box 7725, San Francisco, CA 94120

Blue Shield Life knows that your privacy is important to you. We value you, as our policy holder, and provide you with this notice to explain how we protect your privacy. We need to collect personal information from you, as well as from other people, so that we can provide you with the best possible service. We must use your information and share it with others. This notice tells you about our policies for collecting, using, and sharing your information. It also tells you about our policies for protecting your information. We apply the same policies to information about our former policy holders.

Our privacy standards

Blue Shield Life:

- Does not sell your personal information.
- Does not allow third parties to use information they receive from us for their marketing purposes.
- Has a "need to know" policy. Only members of our workforce and our vendors who need to know your personal information to provide you with our products and services may access your information.

Our privacy safeguards

We use safeguards that comply with federal and state law to protect your personal information. The safeguards we use include:

- Administrative safeguards
- Physical safeguards
- Technical safeguards

We regularly review these safeguards to ensure that they are effective and remain up to date.

Personal information that we collect

We collect information that we need to:

- Provide you with our products and services.
- Advise you of other products and services we have available.
- Provide you customer service.

We collect your personal information in a variety of ways. For example, we may collect:

- Your name, address, date of birth, and other demographic data, as well as medical history, in application, enrollment, and other forms.
- Information about your medical conditions in claims or proof-of-loss forms and from your healthcare providers.
- Financial information about you, such as premium payment history and out-of-pocket amounts you have paid (such as your deductible), from your transactions with us.
- Information about your financial, medical, and credit history from consumer reporting agencies and insurance service organizations.

How we use your information

We use your personal information only for purposes related to our products and services. We use your information to underwrite and rate your policy, process claims, ensure proper billing, administer benefits, offer you other insurance products, and perform other insurance functions.

Why and with whom we share your personal information

Blue Shield Life does not share your personal information with anyone, except as permitted by state and federal law.

We may share any of the information about you that we collect as needed to provide you our products and services. For example, we may share your information with:

- A vendor to help us provide our products and services to you. But, the vendor must agree in writing to use proper safeguards.
- Your healthcare providers, so they know you have coverage and can receive payment for claims.
- Auditors who review the work of our vendors and others who provide services to us (or to you).
- Employers or other groups (when they pay for the products and services you receive from us) to audit our services and operations.
- Actuaries or researchers to perform studies, but only as long as personal information is not shared with third parties.
- State or federal regulators, law-enforcement agencies, or other government authorities pursuant to law.

We also may share information with others as necessary to detect or prevent fraud, material misrepresentations, and other activities that may be criminal or abusive.

Your rights to access and amend information about you

You have the right to review information that we collect about you. You may also obtain a copy of your information. (We may charge a reasonable fee for copies we make.)

We must provide you a list of certain disclosures of your information that we made to other people.

You may request that we correct, amend, or delete information that we have about you. If we do not agree to your request, you may file a statement disagreeing with us. We will provide your change (or your statement) to specific people at your request, if they have received the information recently. We will also provide your change (or your statement) to anyone with whom we share the affected information in the future.

To exercise any of these rights, contact Blue Shield Life's Privacy Office at:

Privacy Office
P.O. Box 272540
Chico, CA 95927

or

(888) 266-8080

Consumer reporting and fraud detection agencies

Third parties may furnish us consumer reports and fraud-detection information. We do not share this information with non-affiliated companies, but the third parties who provide us these reports may keep the reports and share them with others.

blue of california

Notice on the Availability of Language Assistance Services to Accompany Vital Documents Issued in English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198.
(Spanish)

重要通知：您能讀懂這封信嗎？ 如果不能，我們可以請人幫您閱讀。
這封信也可以用您所講的語言書寫。 如需幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。
(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198.
(Vietnamese)

blue of california

50 Beale Street, San Francisco, CA 94105
phone (415) 229-5000